

Committee on Ways and Means

Medicare Prescription Drug, Improvement, and Modernization Act of 2003

Reimbursement for Part B Drugs: Average Wholesale Price Reform

Old Flawed System Overpaid For Drugs, Underpaid for Services

- For the approximately 450 drugs (primarily chemotherapies and antibiotics) that are currently covered by Medicare, providers were reimbursed at 95 percent of the Average Wholesale Price (AWP) of the drug.
- AWP is not defined by law or regulation. As manufacturers compete, there are incentives for manufacturers to raise the AWP for certain drugs, while reducing the acquisition cost for physicians through discounts and rebates. Manufacturers and physicians play this "spread" between acquisition cost and AWP, creating an upward spiral of overpayment for drugs and costs for Medicare.
- In 2001, according to the General Accounting Office (GAO) and Centers for Medicare and Medicaid Services (CMS), Medicare overpaid for Part B drugs by over \$1 billion annually. In 2002, oncologists collected approximately \$600 million in overpayments.
- The GAO, the Department of Health and Human Services' Office of Inspector General (OIG), and MedPAC have each identified that the present system for reimbursing Part B drugs is seriously flawed and inflationary. For example, MedPAC estimates spending increased almost 35 percent between 2001 and 2002. Spending for oncology therapies increased by 41 percent.
- Despite the nonpartisan research demonstrating overpayments, oncologists and certain other providers argue that the payments received through the physician fee schedule for the administration of these drugs does not fully reflect the true costs of providing drugs to seniors.

Overpayments "Tax" Patients

- These overpayments "tax" patients who must pay a 20 percent coinsurance on the inflated AWP of the drug. The OIG estimated that in 2000, Medicare beneficiaries paid \$177 million in unnecessarily inflated co-payments for physician-administered drugs.

In order to address the underpayment for drug administration and the overpayment for drugs, the MMA makes a number of changes in reimbursement for cancer care.

MMA Increases Fee Schedule Reimbursement For Oncologists

The physician fee schedule payments for oncologists and other specialists are increased significantly to accurately pay doctors for the cost of administering drugs. Specifically, the MMA:

- Directs CMS to use the cancer community's own data to calculate practice expenses, as submitted by the American Society of Clinical Oncologists (ASCO);
- Directs CMS to use the higher average oncology nursing salaries from the ASCO survey data to calculate practice expenses for drug administration, instead of the lower average nurses' salary based on all nurses;
- Directs CMS to add a physician work component to drug administration codes, to recognize the physician's role as a supervisor and team member in chemotherapy administration;
- Allows CMS to pay for "multiple pushes" for drugs administered on the same day, which had been prohibited;
- Requires an examination of existing codes for drug administration and exempts any increases in reimbursement from budget neutrality requirements, so that other providers will not see their reimbursements decrease in response;
- Allows for additional supplemental surveys on practice expenses for drug administration, and exempts any resulting changes in payments from reducing reimbursements to other providers;
- Requires MedPAC to review payment changes as they affect payment and access to care by January 2005 for oncologists, and by January 2006 for other affected specialties;
- Provides for transition costs for oncologists and other affected specialties, such as hematologists, for 2004 and 2005.

CMS estimates that in 2004:

- Oncologists and other specialists administering drugs will see their Medicare reimbursements for these drugs decrease about 12 percent;
- Oncologists and other specialists will see significant permanent increases in reimbursements for chemotherapy administration, averaging about 110 percent, and even greater increases in 2004, due to temporary transitional payment increases of 32 percent;
- In total, practice expense reimbursements for drug administration will increase about \$500 million in 2004;
- On net, increases in practice expenses will completely offset decreases in drug payments for oncologists – with zero net effect in 2004.

Changes beyond 2004:

- CMS estimates that practice expense reimbursements will increase about \$500 million in 2005;

- CMS will determine the effect of a 6 percent add-on to drug reimbursements when data on average sales prices are received in Spring 2004.

MMA Changes Drug Reimbursement For Oncologists

The MMA provides:

- In 2004, reimbursement at AWP-15 percent, compared to AWP-5 percent under prior law.
- In 2005 and thereafter, reimbursement at the Average Sales Price (ASP) – an average of all sales to all payers -- plus 6 percent.
- In 2006 and beyond, physicians would annually select a reimbursement methodology for drugs, ASP plus 6 percent or receive the drugs through a specialty pharmacy or other Medicare contractor.

Defined in law, the ASP represents an average for the final sales prices in the U.S., net of rebates, or other discounts. The Secretary has the authority to adjust reimbursement for a drug when he finds that the ASP does not reflect widely available market prices.

If a physician chooses to receive the drugs through a Medicare contractor, then there would be no billing to the physician. Instead:

- Physicians would write a prescription to be filled by a Medicare-contracted supplier that would then dispense the product to the doctor on a timely basis. Medicare would guarantee the availability of at least two contractors available in each region and would set standards for service and solvency, shipment and delivery, and responses to physician inquiries.
- Physicians would deliver the prescribed drug necessary for the patient, when the patient is seen by the physician. The supplier, not the physician, would be reimbursed by Medicare. The supplier would be responsible for collection of the 20% co-insurance on the drug payment, lowering the bad debt exposure and liability for physicians' practices.