

Medicare Part B drugs and oncology

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Statement of
Mark E. Miller, PhD

Executive Director
Medicare Payment Advisory Commission

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Committee on Ways and Means
U.S. House of Representatives

Chairman Johnson, Ranking Member Stark, distinguished Subcommittee members. I am Mark Miller, executive director of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss MedPAC's work on Medicare Part B drugs and oncology.

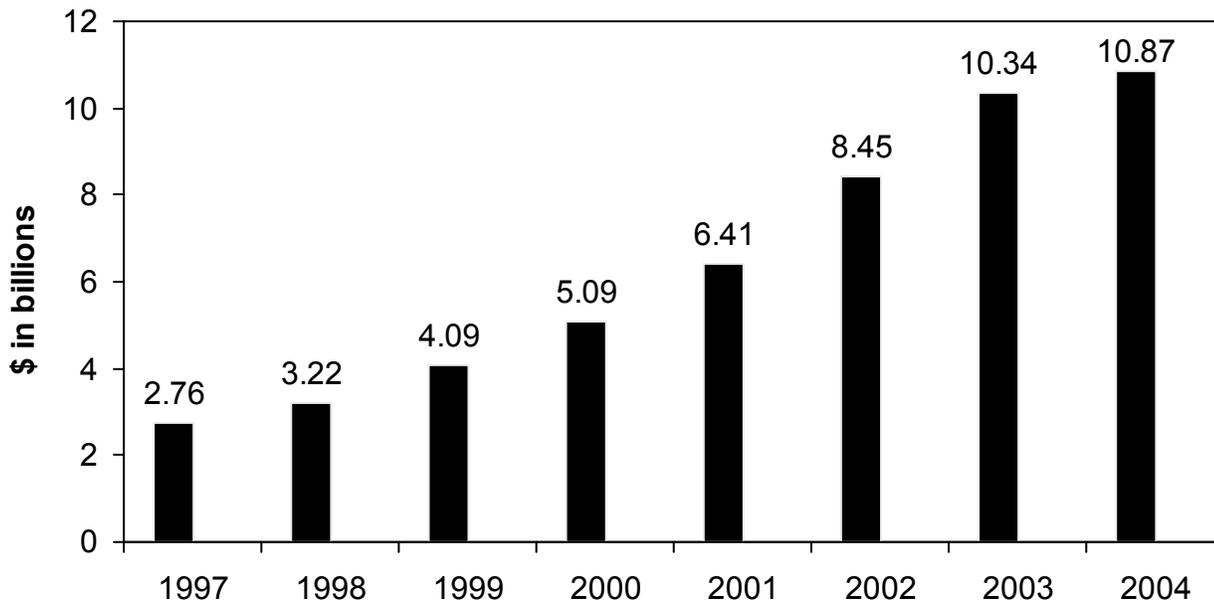
Before 2006, Medicare covered few outpatient drugs but those medications that were covered under Part B were used to treat patients with very serious medical conditions like cancer, hemophilia, and rheumatoid arthritis. Medicare expenditures for these drugs were growing rapidly, rising from \$2.8 billion in 1997 to \$10.3 billion in 2003, representing about 4 percent of Medicare spending. Although policymakers agreed that payment rates for Part B drugs were too high, providers argued that the high rates were necessary to offset drug administration fees that were too low to cover the costs of administering those drugs to beneficiaries.

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) changed the way Medicare pays for both drugs and drug administration services under the physician fee schedule. As intended by the policy, payment rates for drugs were reduced to levels closer to the prices providers were paying while payment rates for drug administration increased. As a result of the payment changes, Medicare spending for Part B drugs declined in 2005 despite increases in the volume of drugs used and the substitution of newer drugs for older less expensive products.

The Congress directed MedPAC to study the effect of these changes on beneficiary access and quality of care. Our first report, completed January 2006, focused on services provided by oncologists. We found that, in general, beneficiary access to chemotherapy drugs remained good and we found no evidence that quality of care declined. For our second mandated report, due in January 2007, we are studying the effects of the payment changes on drug administration services provided by other specialties, such as urologists and rheumatologists.

Although no payment system is without drawbacks, the current system has resulted in Medicare payments that are closer to the price physicians pay and has reversed spending trends for Part B covered drugs. However, the Commission believes that it is important for the Secretary to continue monitoring physician acquisition costs to test the accuracy of Medicare drug payments as the new payment system evolves over time.

Chart 1. Medicare spending and annual growth rates for Part B drugs



Source: MedPAC analysis of CMS data, 1997–2004

Background

Under Part B, Medicare covers drugs administered in physician offices, including drugs used for chemotherapy, drugs used as part of durable medical equipment, blood clotting factor, erythropoietin used to treat anemia in end-stage renal disease patients and cancer patients, and some oral medications such as immunosuppressive drugs used following organ transplants. These drugs are not usually purchased at retail pharmacies. Providers buy the products and then bill Medicare as they administer them to patients. Physician claims account for the majority of Medicare expenditures for Part B outpatient drugs. Physicians in only two specialties—hematology oncology and medical oncology—submitted claims for almost 50 percent of total billing for Part B drugs in 2004, not including drugs provided in dialysis facilities.

Expenditures for Part B drugs increased rapidly, more than 25 percent every year from 1998 to 2003. One of the most significant factors driving spending growth was the payment method. Following the Balanced Budget Act (BBA) of 1997, the Medicare payment rate for covered drugs was set at 95 percent of the average wholesale price (AWP). Despite its name, AWP does not

represent the average wholesale price. Rather, it can be thought of as a manufacturer's suggested list price. It does not have to correspond to any transaction price or average transaction price, which often reflect substantial discounts. Every drug has its own AWP. Individual AWPs are compiled and reported in compendia like the Red Book and First Databank largely on the basis of information supplied by the manufacturers. A series of investigations by the Department of Health and Human Services Office of the Inspector General (OIG) and the Government Accountability Office (GAO) showed that Medicare payment rates were well above providers' acquisition costs.

Policymakers discussed a number of ways to reform the payment system, including continuing to pay based on AWP but requiring a steeper discount, setting payment to a different benchmark tied to transaction prices like the average sales price (ASP) or the average acquisition price (AAP), or using competitive bidding to lower prices. In its June 2003 Report to Congress, the Commission examined these policy options.

Our analysis suggested that continuing to use AWP as a benchmark but requiring steeper discounts would lead to limited savings for Medicare. In many cases, the additional discount would still result in payments substantially higher than acquisition costs. AWP would still not correspond to any transaction price and could not be audited. Providers would continue to have an incentive to switch to drugs with higher AWPs to maximize their profit.

Next, we examined the potential effects of a payment method based on a computed average transaction price such as the average sales price (ASP), or the average acquisition price (AAP). Both of these methods depend upon calculated average transaction prices for products. Although in theory calculations based on ASP and AAP should result in the same payment rate, ASP is based on data collected from pharmaceutical manufacturers while AAP data is collected from physicians and suppliers. Differences might reflect inclusion of the wholesalers' fees in AAP and differences in the way manufacturers and physicians would report the data. Since manufacturers are already reporting average price data to CMS in order to determine Medicaid drug payment rates, the data needed to calculate ASP is more readily available than the data needed to determine the average acquisition price.

We concluded that a competitive system or use of either benchmark (ASP or AAP) would reduce Medicare payments. We recognized that there were drawbacks to every proposed reform of the

payment system but that all options were likely to reduce Medicare payments compared to the AWP system then in place.

All proposals based on these benchmarks anticipated paying providers a specified percentage above the calculated price although they differed as to how high to set the additional payment. The Commission did not recommend that the payment rate be set at any specific percentage above the benchmark. We said that beneficiary access would not be affected as long as the payment rate was set high enough to meet the costs of efficient providers. We also said that payments set too high above the benchmark would encourage price increases and reduce Medicare savings.

Following passage of the MMA, Medicare significantly changed the way it pays providers for physician-administered drugs and drug administration services, generally reducing the payment rate for drugs while increasing payments for drug administration services. In 2005, Medicare began paying for Part B drugs based on 106 percent of the average sales price (ASP). ASP represents the weighted average of manufacturers sales prices for each product that falls within a Medicare billing code. (Medicare billing codes are used for multiple products.) It is based on data submitted quarterly by pharmaceutical manufacturers, net of price concessions such as rebates and discounts and is limited to sales in the United States. The ASP payment rate is set prospectively based on these transaction prices from two quarters prior. Thus, if manufacturers raise prices in the succeeding quarters, purchasers may have difficulty purchasing products at the Medicare payment rate until the ASP “catches up.” On the other hand, if prices go down, either because of competition between therapeutically equivalent branded drugs or because a generic version of a branded drug becomes available, purchasers may buy products at prices significantly below the payment rate until the ASP “catches up.”

MedPAC study

Concerned that the payment changes not affect beneficiary access to needed medical care, the Congress directed the Commission to complete two studies on the effects of the new payment system on beneficiary access, quality of care, and physician practices. Our first report, delivered January 2006, analyzed the effect of the payment changes on beneficiary access to chemotherapy. We are currently conducting a second study on the effect of the payment changes on services provided by other specialties including urologists, rheumatologists, and infectious disease specialists.

Because the legislated changes had not yet been fully implemented and we only had partial data for 2005, the Commission had limited ability to analyze the impact of the changes. We undertook a series of qualitative and quantitative analyses to assess beneficiary access and quality of care.

- We analyzed expenditures and changes in volume for chemotherapy services using Medicare claims data.
- We analyzed a commercial database with prices for drugs used by oncologists to see if prices physicians paid were below the Medicare payment rates, and we measured the variation in prices different physician practices paid.
- We visited community oncologists, hospital outpatient departments, and health plans in five markets to discuss the effects of payment changes on practices.
- We conducted four focus groups with Medicare beneficiaries receiving chemotherapy during 2005 to see how the payment changes affected their experiences.
- We interviewed stakeholders to gain their perspective on how the payment changes affected the buying and selling of physician-administered drugs.
- Finally, we reviewed the literature on pricing for Part B drugs and studies of quality-of-care indicators for chemotherapy.

We found that the payment changes did not affect beneficiary access to chemotherapy services. Physicians provided more chemotherapy services and more Medicare beneficiaries received services in 2005 than in 2004. We saw no indication that quality of care was affected, and patients continue to be satisfied with the care they are receiving. We found no indication of access problems in any region of the country. In general, large practices were able to purchase chemotherapy drugs at lower prices than small practices, but all could buy most drugs at prices below the Medicare payment rate. However, there is one issue to report. In some areas, beneficiaries without supplemental insurance were receiving chemotherapy in hospital outpatient departments rather than physician offices.

Medicare spending on chemotherapy drugs and services

To measure the impact of the 2005 Medicare payment change to ASP, we analyzed carrier claims for the first six months of 2005. We compared our results to spending and volume claims for the same period in 2003 and 2004. We found that beneficiaries received more drug administration services in 2005 than 2004, but that spending remained constant. Medicare expenditures for chemotherapy drugs declined in 2005 because of the change to payment based on ASP. The change to pricing based on ASP also narrowed the gap between the prices paid by the providers who negotiated the best and worst deals with drug manufacturers.

Preliminary estimates by CMS indicate that spending for all Part B drugs in 2005 declined by 3 percent. Drug spending is determined by volume, drug mix, and the payment rate for the drugs. In the case of Part B drugs, volume increases were offset by changes in the payment rate.

To demonstrate the effect of pricing changes from 2004 to 2005, we estimated what Medicare would have paid if the volume of all the specific Part B drugs billed in 2004 were paid according to the Medicare payment rates for October 2005. Using this methodology, we calculated that expenditures for all Part B drugs used in 2004 would have cost 22 percent less in 2005.

However, the spending decrease was not as great as the decrease in prices would have suggested because the mix of drugs used in 2005 was different from the mix used in 2004. In a continuation of previous trends, physicians substituted newer, more expensive single source drugs for older drugs. Many of the new drugs are produced through the use of biotechnology. Not only are these products expensive when initially marketed, they face only limited competition over time because the FDA does not yet have an approval process for generic versions of biologicals. Many of these biologicals are used in the treatment of cancer. Of the ten drugs that accounted for the largest share of Part B drug spending, four received FDA approval in 1996 or later. Additionally, spending on injectables too new to have received their own payment codes accounted for 3 percent of Part B drug spending.

Both the volume and payments for chemotherapy administration increased in 2005. We estimate that physicians provided 13 percent more chemotherapy sessions in 2005 than in 2004. CMS changed its rules to allow physicians to bill more codes for each chemotherapy session, so the

number of services has increased faster than the number of sessions, by 33 percent from 2003 to 2005. In addition, the Congress made two, one-year payment increases for drug administration: in 2004 it increased payments by 32 percent and in 2005 it increased payments by 3 percent over what would otherwise be paid under the fee schedule. Taken together, the volume and payment increases led spending for chemotherapy administration services to rise 182 percent from 2003 to 2005.

We also compared the number of Medicare beneficiaries receiving chemotherapy in physician offices in 2003, 2004, and 2005. We estimate that the number of beneficiaries receiving chemotherapy in physician offices increased 7.5 percent in 2005, based on the most conservative assumption. No matter what set of assumptions we used, Medicare beneficiaries received an increasing number of chemotherapy sessions in physician offices from 2003 to 2005.

In 2005, CMS provided another source of payments for chemotherapy in physician offices. In addition to paying for drugs and drug administration services, CMS implemented a one-year demonstration project to evaluate how chemotherapy affects the level of fatigue, nausea, and pain experienced by patients. All oncologists were eligible to receive \$130 per patient per day for asking chemotherapy patients three questions about how they had responded to treatment. (Beneficiaries were charged \$26 copayments for this demonstration.) We estimate that this demonstration project increased Medicare expenditures by more than \$200 million, further increasing drug administration payments by more than 70 percent over 2003 levels. (In 2006, CMS implemented an alternative demonstration project. The agency required oncologists to provide information on treatment patterns for patients with different cancers at different disease stages. Physicians reporting the required data receive \$23 per patient visit.) The addition of the demonstration project funds complicated MedPAC's ability to evaluate fully the effects of the payment changes.

Payment adequacy

In the course of our site visits, the Commission found that most oncologists could purchase most drugs at rates below the Medicare payment level, but profit margins on these drugs generally were low, as the policy change anticipated. Every practice reported that that they could not buy some drugs at the payment rate. A study by the Office of Inspector General (OIG) (September 2005)

indicated that oncologists could still purchase most drugs at rates below the payment level, although specific drugs posed a problem for some practices. In general, larger practices paid lower prices than smaller practices for the same drugs.

The Commission analyzed the data presented in the OIG report to determine what kinds of drugs provided higher or lower payment margins compared to the Medicare payment rates. We found that the highest payment margins occurred when generic alternatives, such as carboplatin and cisplatin, became available. Purchasers also were able to buy brand name drugs at prices well below Medicare payment rates if the drugs had therapeutic substitutes available. One example would be dolasetron mesylate, one of a number of drugs used to treat nausea in chemotherapy patients.

As providers moved to purchase less costly alternatives, competition between buyers and sellers resulted in lower Medicare payment rates in the following quarters. We found that when the January Medicare payment rate for a drug was more than 15 percent higher than the average price providers paid, the Medicare payment rate fell sharply by October. In particular, payment rates for chemotherapy drugs with high margins in January declined by as much as 72 percent in October.

Changes in both pricing and purchasing patterns may affect the accuracy of drug payments over time. For this reason, the Commission has recommended that the Secretary continue to monitor provider drug acquisition costs in both physician offices and dialysis facilities.

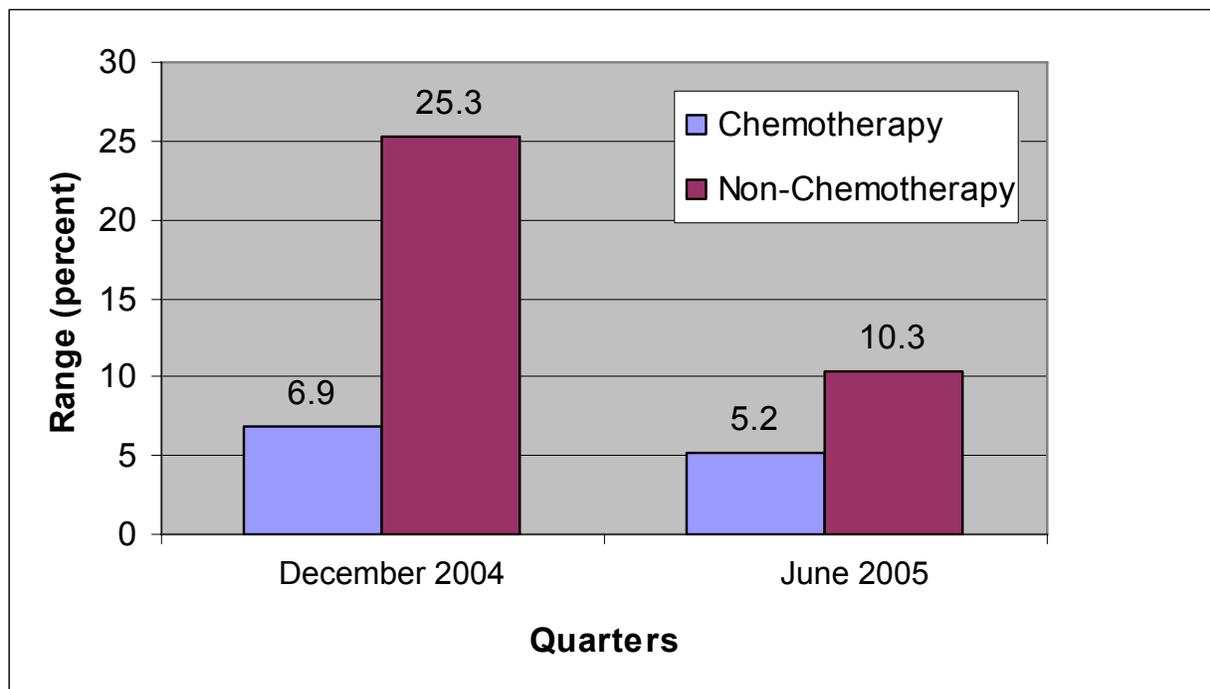
Price variation

Under the ASP method, pharmaceutical manufacturers might narrow the range of discounts offered to purchasers to ensure that all physicians could purchase their products at the Medicare payment rates. Since the market for chemotherapy drugs is limited, manufacturers would want to maximize their customer base. To track changes in oncology prices over time, the Commission acquired pricing information from a commercial data source. (Our contract with the vendor does not allow us to present prices for specific drugs.) Prices are net of discounts but do not include rebates provided by manufacturers after the sale. The database shows variation between the lowest and highest prices the purchaser paid. The Commission purchased data on 26 drugs billed by oncologists for one month of each of the first three quarters of 2005. Drugs include chemotherapy

agents and medications used to treat the side effects of chemotherapy. Many overlap with the drugs identified in the OIG report. The 26 drugs accounted for more than 50 percent of physician-administered Part B drug spending in 2004.

Our analysis of prices paid by physicians showed that price variation for our basket of drugs declined between the first and third quarters of 2005. Next, we looked to see if the decline in price variation was more pronounced for any particular types of drugs. We grouped our drugs in two ways. First, we classified them based on whether they were single source branded drugs or had generic alternatives. Next, we looked at whether the drugs were chemotherapy agents or prescribed to treat the side effects of chemotherapy. For all four categories, the range, defined as the variation between the best and worst price obtained by physicians, narrowed between the first and third quarters of 2005. The range for single source chemotherapy drugs—small to begin with—narrowed least, falling from 6.9 percent to 5.2 percent. The biggest change was in the range for drugs used to treat the side effects of chemotherapy. That range declined 25.3 percent in the first quarter to 10.3 percent third quarter (chart 2). In other words, for this group of drugs there was a difference of about 10 percent between the highest and lowest prices available to physicians.

Chart 2. Change in price variation by chemotherapy and non-chemotherapy drugs



Note: Two drugs have been excluded because generic alternatives became available during the four quarters. Two others have been excluded because of crosswalk problems. The range measures the percent of variability among the prices paid by clinics. It is measured by subtracting the price paid by the 25th percentile from the price paid by the 75th percentile, dividing by the price paid by the 50th percentile, and multiplying by 100. MedPAC's contract with IMS Health does not allow the prices of drugs be named individually.

Source: MedPAC analysis of IMS Health data 2004–2005.

Changes in physician practices

The Congress required the Commission to examine the effect of the payment changes on physician practices. During our site visits, we asked physicians how they responded to the Medicare payment changes. Of course, their answers were subjective. Physicians told us they considered the payment changes significant and changed their practices to get better drug prices, lower costs, and boost revenue. All practices changed their drug purchasing activities. Some also changed their use of drugs, office staffing, mix of services offered, and patient mix.

All the physicians we visited reported that they spent more time and resources shopping for lower prices for drugs than they did before the payment changes. Their choice of ancillary drugs for

treating chemotherapy side effects was more likely to be based on price. Many practice managers reported that they routinely purchased only one drug to treat nausea and one erythroid growth factor to treat anemia for all the physicians in the practice. Physicians also reported that they kept smaller inventories of drugs on hand than previously. This allowed them to respond quickly to price changes and avoid tying up large sums of capital.

Many offices have hired employees to work with patients when they begin treatment to ensure that they can pay their out-of-pocket expenses. This financial adviser estimates the beneficiary's potential liability based upon the treatment plan. If the beneficiary does not have supplemental insurance, the adviser determines whether she qualifies for other assistance, including Medicaid and assistance programs maintained by individual pharmaceutical manufacturers. The beneficiary may be given a payment schedule to make copayments over time.

Practices reported that differences in local coverage policies affected their treatment decisions. Physicians were reluctant to use expensive new therapies that they thought the local carrier might not cover. For example, a carrier might cover a new drug for treatment of one cancer while the physician wanted to use it to treat a patient with another type of cancer. One practice reported sending a patient to the hospital outpatient department for treatment because the local intermediary covered a particular drug and the carrier did not. Practices reported they were less likely to appeal local coverage decisions. They found the appeals process too expensive and time-consuming and the outcome of the appeal uncertain.

Physicians took other actions to reduce costs or improve efficiency. For example, some practices reduced costs by changing their mix of employees, replacing full-time employees with part-time employees or replacing nurses with pharmacy technicians. Similarly, many practices reported that they reduced health and pension benefits for their employees. One practice reported increasing efficiency by hiring workers to do the coding for oncology nurses and freed up their time for patient care. Several practices reported hiring a pharmacist to purchase and mix drugs as well as recommend drugs to the practice based on price and clinical effectiveness.

Some practices tried to increase revenues by providing more services in their offices. For example, some physician practices purchased positron emission tomography (PET) scanning technology in the past few years and increased imaging in their offices. However, this was only possible for

practices with large facilities. Many practices reported they did not have the space or capital to expand in this way.

No physician or office manager reported that the payment changes affected the quality of care in their office. No beneficiary who participated in our focus groups reported that she had seen a decline in the quality of care she was receiving.

Beneficiaries without supplemental insurance

While the new Medicare payment system has reduced prices for existing drugs, it does not have any mechanism to affect prices for new single source branded drugs as they enter the market. New products have become increasingly expensive in the past few years. Beneficiary copayments for these drugs (20 percent of the total payment) are high, and physicians who cannot collect coinsurance from beneficiaries will receive only 80 percent of the Medicare payment rate. Medicare has no limit on the out-of-pocket costs that beneficiaries may face. Medicare beneficiaries without supplemental coverage may be transferred to hospital outpatient departments (HOPDs) and face higher copayments there. However, if beneficiaries who cannot pay cost sharing in physician offices go to HOPDs for chemotherapy infusion, they are unlikely to be able to pay the higher cost sharing there. Instead, their unpaid bills would become bad debt. Medicare pays 70 percent of hospitals' bad debt.

Although we did not find any cases in which beneficiaries could not get chemotherapy services, Medicare beneficiaries without supplemental insurance have more limited choices in some areas of the country. These individuals are more likely than other beneficiaries to receive chemotherapy in HOPDs. In 2004, the Commission found that in some markets, oncology practices had stopped treating Medicare patients without supplemental insurance in their offices. Patients were sent to hospital outpatient departments or safety-net facilities. When we returned to these practices in 2005, we found they were sending more patients to the HOPD. (Hospitals in these markets also reported they were treating more patients with supplemental insurance who required expensive new drugs.)

When patients are sent to the hospital for chemotherapy, the physician continues to manage their care. Physicians still provide evaluation and management visits, some lab work, and other services

in the office setting. The patient only receives the chemotherapy infusion in the hospital. Although quality of care may be equivalent in hospitals and physician offices, beneficiaries face higher copayments in HOPDs and treatment usually takes longer. For example, chemotherapy drugs must be mixed in the hospital pharmacy, where pharmacists are preparing medications for all the other hospital patients. The chemotherapy patient will wait longer until the medication is prepared. Only a few beneficiaries who participated in our focus groups had been referred to the HOPD from physician offices. They emphasized the duplication of tests and increased time commitments caused by the switch. One individual complained about the higher copayments.

As the price of new single source cancer drugs continues to rise, beneficiaries without supplemental insurance may have an increasingly hard time paying their 20 percent coinsurance. Although most physician practices have continued to treat all beneficiaries in their offices, beneficiary inability to meet cost-sharing requirements creates a financial liability for the practices. Many practices have begun to counsel beneficiaries on their estimated out-of-pocket liabilities before treatment begins. A few practices reported instances in which beneficiaries refused treatment because they did not want to travel to a hospital or leave her family with debts caused by her out-of-pocket liability.

We cannot quantify the number of beneficiaries who need help paying their coinsurance for chemotherapy. We have no source of data to determine the number of Medicare beneficiaries without supplemental insurance who are receiving chemotherapy services. Data on supplemental insurance are not captured on Medicare claims. The oncology practices we visited estimated between 5 and 20 percent of their Medicare patients have no source of supplemental coverage. Estimates varied depending on the demographic structure of the market and the availability of Medicare Advantage and retiree health insurance. The Commission (MedPAC 2005a) estimates that, in general, 9 percent of beneficiaries have no source of supplemental coverage. Beneficiaries without supplemental coverage are not the only individuals facing high copayments. Some cancer patients who participated in beneficiary focus groups were concerned that they might exceed lifetime caps on their retiree coverage.

Many pharmaceutical companies offer patient assistance programs to help patients with the cost of their medications. In 2003, pharmaceutical companies provided patients with medications valued at

\$3.3 million. However, this assistance is not readily available for Medicare beneficiaries without supplemental insurance. Most of the assistance goes to patients without any insurance. Less aid is available for individuals needing help with copayments. Yet this cost may be beyond the means of many beneficiaries. For example, one new cancer drug costs Medicare an average of \$12,000 every two weeks. Beneficiaries face copayments of \$2,400 monthly for this medication. They continue taking the medication until the patient's condition worsens.

The Commission is concerned about the burden of cost sharing for beneficiaries with cancer and other catastrophic conditions. We intend to explore the general issue of unlimited beneficiary out-of-pocket liability, which can affect cancer patients and patients with other illnesses, in future work.

Chemotherapy and quality of care

The Congress directed the Commission to report whether quality of care was affected by Medicare payment changes for chemotherapy services. Based on our interviews and site visits, we found no indication that quality of care has been affected by the payment changes. However, few consensus quality indicators for chemotherapy-related services exist and data to evaluate indicators that do exist are limited.

We discussed perceptions of differences in quality of care with physicians and patients in the course of our site visits and focus groups. Not surprisingly, clinicians we interviewed think the quality of services they provide is quite high. We found that physicians' evaluation of differences in quality across settings was subjective and seemed to be dictated by where they practiced. Oncologists in single-specialty practices felt they had more experience in educating patients about their condition and were more likely to hire oncology-certified nurses. They felt they provided more continuity of care and greater convenience for patients. By contrast, physicians practicing in hospital settings pointed to the availability of staff pharmacists to mix drugs, maintaining that this resulted in higher quality and fewer medical errors. They also pointed to greater use of safety guidelines and standard treatment protocols as indicators of higher-quality care.

Beneficiaries who participated in our focus groups received treatment in a variety of settings, including single-specialty oncology offices, outpatient departments of community hospitals,

outpatient departments in university hospital cancer centers, and infusion centers of integrated health plans. Almost without exception, beneficiaries praised the quality of care they received. (The one exception was a beneficiary dually eligible for Medicare and Medicaid who received treatment in the HOPD of a safety-net institution.) None experienced changes in the quality of care received in the past year. Two focus group participants had switched to HOPDs for chemotherapy administration from physician offices in 2005. Neither felt quality of care suffered, although both felt there was less coordination of care and greater out-of-pocket expense in the hospital.

In general, further work is needed to determine quality chemotherapy care. Current public and private initiatives to define and measure quality of cancer care can provide the framework for a pay-for-performance oncology quality initiative. However, there is one instance where the Commission finds that CMS can take action now to monitor the quality of care beneficiaries are receiving.

Erythroid growth factors (Erythropoietin alpha and darbepoetin alpha) are used for the treatment of anemia following chemotherapy as well as some other indications. Medicare expenditures for these products account for the highest percentage of Medicare Part B drug spending. Although the shift to ASP resulted in lower payment rates for both products, volume and expenditures continued to increase in 2005. At the same time, concerns have been raised about drug safety and potential under- and overuse of these products. In 2004, the Food and Drug Administration (FDA) responded to safety concerns about the use of growth factors by issuing new prescribing information. Although some local carriers have attempted to limit the use of erythroid growth factor in accordance with FDA regulations and clinical guidelines, carriers are hampered by their lack of access to all relevant clinical data. In our January 2006 report, the Commission recommended that the Secretary require providers to enter patients' hemoglobin level on all claims for erythroid growth factors. This data should be used as part of Medicare's pay-for-performance initiative.

Conclusion

Policymakers had long agreed that Medicare did not pay accurately for Part B drugs or drug administration services and suggested different alternatives. Although the Commission did not

recommend any particular new payment method, our analysis showed that several of the proposed methods would improve the accuracy of the payment system. Following passage of the MMA, Congress reduced payments for drugs and increased payments for drug administration services. In 2005, Medicare began using ASP to set payment rates for Part B drugs. This change lowered the payment rate for most drugs and decreased Medicare spending for Part B drugs. Payment for drug administration services increased.

Part B drugs are used to treat patients with very serious medical conditions including cancer, hemophilia, and rheumatoid arthritis. The Congress directed MedPAC to study the effect of the payment changes to ensure that access and quality of care for individuals with these illnesses were not harmed. We found that that, in general, beneficiary access to chemotherapy services remained good. Physicians provided more chemotherapy services to Medicare beneficiaries in 2005 than in 2004.

The ASP payment method has generally lowered beneficiary cost sharing for Part B drugs. However, beneficiaries without supplemental insurance may face high out-of-pocket spending, particularly if they need new single source drugs. These drugs are expensive and Medicare has no limit on the out-of-pocket costs that beneficiaries may face. Some physicians are sending individuals without supplemental insurance to hospital outpatient departments for chemotherapy infusions where they face still higher copayments. The Commission is concerned about the burden of cost-sharing faced by beneficiaries with cancer and other catastrophic conditions and we intend to explore this issue in future work.

We found no evidence that the quality of care received by Medicare beneficiaries has declined. However, we are concerned that the continuing increase in use of erythroid growth factor should be monitored to make sure that use falls within accepted clinical guidelines. The Commission has recommended that the Secretary require providers to enter patients' hemoglobin level on all claims for erythroid growth factors. This data should be used as part of Medicare's pay-for-performance initiative.

Overall we found that access to care and quality of chemotherapy services were not harmed in 2005. However, we recognize that no payment system is without flaws. Changes in both pricing and purchasing patterns may affect the accuracy of drug payments over time. For this reason, we

have recommended that the Secretary continue to monitor provider drug acquisition costs in both physician offices and dialysis facilities.

As directed by the Congress, MedPAC is currently studying the effect of the Medicare payment changes on services provided by other specialties including urologists, rheumatologists, and infectious disease specialists. In this report, due January 1, 2007, we will analyze if beneficiary access, quality of care, or physician practices have been affected following an additional year of experience with the new payment system.