

Endangering Patient Access and Increasing the Total Cost of Care: Physician Perspectives on Proposed Medicare Drug Payment Changes



Recently, the Medicare Payment Advisory Commission (MedPAC) and other stakeholders have proposed changes to the Medicare Part B drug reimbursement policy. Two suggested approaches include:

- Revamping the previously tested Part B Competitive Acquisition Program, now dubbed by MedPAC, as the “Drug Value Program” (DVP). The DVP is described as a pharmacy benefit manager (PBM) -like model that would use a small number of private vendors to negotiate prices and offer providers shared savings. To be able to negotiate, DVP vendors would establish formularies and utilization management criteria. This program would be voluntary for providers, but the traditional average sales price add-on (currently 4.3%) would be gradually reduced.
- Moving physician-administered drugs out of the Part B program and into the Part D prescription drug benefit.

The Community Oncology Alliance (COA) recently commissioned a surveyⁱ of 100 oncologists/hematologists and 50 rheumatologists about the drug payment proposals. The survey was fielded to gather provider perspectives on how these policies could affect patient access and affordability, provider prescribing and autonomy, and practice operations. Providers expressed the view that the types of programs proposed by MedPAC and others could impact their ability to treat patients and provide timely, affordable access to care.

Drug Value Program (DVP)	Shifting Drugs From Part B to Part D
<ul style="list-style-type: none">•75% of providers believe a DVP would increase the administrative burden for their practices•61% of providers believe a DVP would diminish their prescribing autonomy and ability to tailor prescriptions to the patient•88% of providers believe a DVP would take care decisions away from the person in the best position to make that decision, and•More than 87% believe a DVP will limit their ability to provide the best care to patients	<ul style="list-style-type: none">•93% of providers believe moving Part B drugs to Part D will increase administrative burden•85% of providers are concerned it would create affordability issues for patients•89% of providers believe it could delay treatment access, and•92% believe a shift would reduce treatment choices

COA is concerned with the unintended consequences that these types of sweeping, uninformed changes to the Medicare program would have on patients.

Introducing third-party, PBM-type entities to Medicare Part B, or shifting some prescription drugs currently paid for under Part B to a Medicare Part D program that is dominated by PBMs, would be a fatal mistake.

The MedPAC proposal is oblivious to the scrutiny PBM middlemen are currently under for actually *increasing* costs to Medicare and beneficiaries as well as Part D drug prices. With the DVP proposal, PBM-type middlemen will be the ones to capture the profits, while beneficiaries and Medicare pay more. That is the lesson now being learned with Part D. Policymakers should be reining in PBM abuses, not increasing their power and influence.

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While much of the debate over PBMs focuses on economics, there is often not enough discussion about the impact PBMs have on patients. The sad fact is that PBMs make more money by delaying or denying patients access to necessary medications. Every pill they stop from being dispensed is money they can pocket. COA has documented real-life patient [horror stories](#) from practices and physicians about patients battling cancer who have suffered at the hands of PBMs due to delayed coverage decisions, denial of coverage, arguments with physicians over proper treatment, and failure to receive medications in a timely manner. These concerns are clearly reflected in the results of the survey.

COA and community oncology are determined to find solutions to expensive therapies while ensuring that patients continue to receive the highest quality cancer care. As the front-line providers for the majority of Americans with cancer, community oncologists understand better than anyone the realities and problems with the increasing cost of cancer care.

History shows that the rush to make massive changes in our health care system can backfire and have unintended consequences for patients. The cancer care system is a perfect example of that. Americans today are experiencing unprecedented consolidation of our nation's cancer care system into the much more expensive hospital setting, which has increased drug prices and negatively impacted patient access to cancer care, particularly in rural communities. The [recently released 2018 COA Practice Impact Report](#) found that, over the last decade, 1,653 community oncology clinics and/or practices have closed, been acquired by hospitals, undergone corporate mergers, or reported that they are struggling financially. Much of the consolidation and change in our nation's cancer care system can be traced back to bad public policies and their unintended consequences.

COA and its member practices are seeking solutions using data, market facts, and the real-world medical experience of physicians, nurses, administrators, and others on the front lines of cancer care to craft viable, patient-centric solutions. This includes providing practices with the support that they need to succeed in the Centers for Medicare & Medicaid Innovation Oncology Care Model (OCM), as well as looking to the future by developing the OCM 2.0, a universal model of oncology payment reform.

The MedPAC recommendations are the antithesis of this and, if enacted, will only make the nation's cancer care delivery system more unstable, unfriendly, and unaffordable for beneficiaries, Medicare, and taxpayers.

The Community Oncology Alliance (COA) is a non-profit organization dedicated solely to preserving and protecting access to community cancer care, where the majority of Americans with cancer are treated. COA leads community cancer clinics in navigating an increasingly challenging environment to provide efficiencies, patient advocacy, and proactive solutions to Congress and policymakers. Learn more about COA at www.CommunityOncology.org.

ⁱ A web-based survey of providers (N=151) was conducted in March 2018. Participation was voluntary and fully blinded. An honorarium was paid to survey respondents. Physician representatives were classified as oncologist/hematologists or rheumatologists with their primary site of care in community hospitals (N=32) or physician offices (N=119). The research and analysis was conducted by Xcenda.