MD Group Scrutinizes Medicare Part B Proposal

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

WASHINGTON — Members of a Medicare physician advisory group have reservations about the Centers for Medicare and Medicaid Services' proposed new program for paying for physician-administered outpatient drugs under Medicare Part B.

Medicare currently pays physicians the average sales price (ASP) of the drug—a number that is supposed to represent the total paid for the drug by all buyers divided by the number of units sold—plus an additional 6%. But under the proposed rule, beginning next year physicians would have a choice: they could either stick with the current system or obtain the drugs directly from a vendor that will be selected by Medicare via a competitive bidding process.

The system would require that physicians choose one system or the other for all the drugs commonly furnished to their specialty; they could not get reimbursed ASP plus 6% for one drug and then buy another drug directly from the vendor, according to Don Thompson, director of outpatient services at CMS's Center for Medicare Management.

But Ronald Castellanos, M.D., a Cape Coral, Fla., urologist and chairman of the Practicing Physicians Advisory Council, said at a council meeting that an all-or-nothing system wouldn't work very well in his practice. "There are certain drugs that I use that I can't buy for ASP plus 6%."

Mr. Thompson said that while Dr. Castellanos couldn't pick and choose what system he would use for which drug, he could try to influence which urology drugs will be included in the program. "The categories could be structured differently; your comment [on the proposed rule] could be, 'I think the category should include these drugs and not these other drugs,'" Mr. Thompson said at the meeting. "But once a drug is in a category, the physician cannot opt in and out for that drug."

Dr. Castellanos proposed that the council, which advises Medicare on matters of interest to physicians, urge CMS to revise the rule to allow physicians to pick and choose which system they would use "on a drug-by-drug basis." That recommendation passed easily.

Both Dr. Castellanos and council member Barbara McAneny, M.D., an Albuquerque oncologist, expressed concern about what would happen to beneficiaries—usually, those without Medicare supplemental coverage—who couldn't afford the copays for the drugs. "I want manufacturers to show up with free drugs for patients who have no bucks," Dr. McAneny said. "Physicians, because we're not good businessmen, have eaten that money, but now it's hard to do that because we're not making enough on ASP plus 6%."

'Because we're not good businessmen, [we] have eaten that money, but now it's hard to do that because we're not making enough on ASP plus 6%.'

Dr. Castellanos wondered whether the drug vendors who are going to contract with Medicare would be required to provide drugs for beneficiaries even if they didn't have the needed copays.

"The contractor would be required to supply that drug to you," Mr. Thompson replied. "If you're asking if a contractor would waive coinsurance for that particular beneficiary, there's no separate requirement for vendors that would be any different from physicians," who can waive the copay on a case-by-case basis, he said.

Dr. Castellanos pressed further. "These patients have ongoing treatments that can last for years. You're telling me that even though a patient is unable to pay coinsurance, that the contractor will bill the patient, but still has to supply the drug?" he asked.

Mr. Thompson seemed to answer in the affirmative. "We did not propose any mechanism for a contractor to deny supplying drugs to a beneficiary," he said.

Council members also wanted to make sure they could get drugs for off-label use under the new system. They recommended that CMS require contractors to provide drugs for off-label use "when the evidence supports such use." ■