April 1, 2013

The Honorable Kathleen Sebelius  
Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Washington, DC 20201

Dear Secretary Sebelius:

Today, the Administration is implementing its sequestration policy, which reduces Medicare payments across the board, including cuts to the fixed, pass-through costs of cancer-fighting drugs. This will have a devastating impact on seniors fighting cancer and the nation’s cancer care delivery system, which is already in crisis. We urge immediate action to avert this disaster.

Unless the Centers for Medicare & Medicaid Services (CMS) exercises its authority to modify implementation of the sequester payment cut to exclude Part B drugs, sequestration – a move intended to reduce federal spending – will actually jeopardize patient access to cancer care and result in higher overall costs for both seniors and the Medicare program by forcing patients into costlier, institutional treatment settings.

Community Cancer Care in Crisis

The United States enjoys the world’s most respected and most successful cancer care delivery system. More than 60 percent of US cancer patients rely on Medicare, and until recently, over 80 percent of the nation’s cancer patients were treated by physicians in the community setting. According to recent studies by Milliman¹ and Avalere,² community oncology clinics provide the most cost-efficient model for delivering high-quality cancer services to elderly Americans. Despite this, a series of changes to Medicare reimbursement over the past decade have imperiled this vital national resource.

Medicare reimburses for cancer drugs at average sales price (ASP) plus a 6 percent service payment to compensate community cancer clinics for operational expenses (e.g., storage, inventory, waste, disposal, pharmacy, and admixture facilities). Aside from the sequester effective today, Medicare’s drug payment rate at ASP plus 6 percent has failed to reimburse adequately for the total costs incurred by community cancer clinics in acquiring essential cancer-fighting therapies. In part, this is because the ASP formula produces ASP values that are below the actual prices cancer clinics can obtain in the

¹ Site of Service Cost Differences for Medicare Patients Receiving Chemotherapy. Milliman, October, 2011.
² Total Cost of Cancer Care by Site of Service: Physician Office vs Outpatient Hospital. Avalere Health, March, 2012.
marketplace. CMS has interpreted the ASP statutory formula to include prompt pay discounts, but these are discounts pharmaceutical manufacturers extend to distributors for timely payment. They are not extended to clinics. This artificially lowers Medicare payment for life-saving anti-cancer drugs and results in reimbursement below cost for many critical cancer drugs. As a result, many community cancer clinics have already closed, consolidated, or reported financial problems within the past five years. Over the past four and a half years, 241 community cancer clinic sites have closed and 442 practices (often with multiple clinic locations) are struggling financially.  

Impact of the Sequester

The Administration has decided to apply the sequester cut both to payments for Part B drugs and to the 6 percent services payment. The result, after accounting for patient copayments, will be to cut reimbursement to ASP plus 4.3 percent. Reducing the services payment from 6 percent to 4.3 percent effectively imposes a 28 percent cut for payments intended to compensate for the significant operating expenses of procuring, storing, preparing, and handling Part B drugs.

This compounds current underpayment for cancer therapies and places community cancer clinics in the untenable position of routinely providing services below their cost. A recent survey shows the sequester will force 72 percent of community cancer clinics to stop seeing new Medicare patients, not see any Medicare patients without secondary insurance, and/or send all Medicare patients elsewhere for treatment. When community cancer clinics are forced to close their doors or limit services, access to cancer care is compromised for all cancer patients, especially the vulnerable population of seniors who rely on Medicare.

The Administration has placed physician payment reform high on its list of policy priorities and the oncology community has been actively engaged toward that end. However, this initiative requires healthy practices and a period of stability in Medicare reimbursement to achieve this ambitious goal. Cutting cancer drug payments under sequestration will further destabilize an already strained system and undermine efforts to promote value and reform.

Authority of the Secretary to Act

Fortunately, the Secretary of Health and Human Services has the authority to protect against further destabilization of the community cancer care safety net. The Office of Management and Budget (OMB) directed all federal agencies to “use any available flexibility to reduce operational risks and minimize impacts on the agency’s core mission in service of the American people” and to “identify and address operational challenges that could potentially have a significant deleterious effect on the agency’s mission or otherwise raise life, safety, or health concerns.” Further, the Social Security Act compels the Secretary to adhere to the ASP-based formula that Congress established under the Medicare Modernization Act of 2003. The Social Security Act expressly mandates that the Secretary reimburse physicians at 106 percent of ASP for office-administered drugs, providing detailed directions to the Secretary on how to calculate the average sales price. Congress has distinguished the

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3 Community Oncology Practice Impact Report; Community Oncology Alliance, March, 2012
4 National Medicare Sequestration Survey; Community Oncology Alliance, March 2013
6 Sections 1847A and 1842(o) of the Social Security Act.
Medicare drug payment methodology, and these provisions warrant deference under sequestration and guidance from the OMB.

In light of these facts – and on behalf of America’s cancer care specialists and the patients they treat – the undersigned organizations urge the Secretary to revise the Administration’s sequestration implementation plan and exclude Part B drugs from the sequester cut. At the very least, the Secretary should exercise authority to apply the 2 percent sequester cut only to the 6 percent service payment, not the underlying fixed drug cost (ASP).

If a 2 percent reduction in Medicare drug reimbursement remains in effect for any extended period of time, devastating damage will result for the community-based oncology practices that currently serve Medicare beneficiaries throughout the United States.

Sincerely,

The American Society of Clinical Oncology
Community Oncology Alliance
International Oncology Network/AmerisourceBergen
The US Oncology Network

cc: White House
Members of Congress and US Senate