

Medicare revenues for oncologists. In 2002, oncologists received approximately \$3.8 billion in Medicare revenues for drugs, \$1.1 billion for physician fee schedule services and \$0.1 billion for all other services. Taken together, oncologists received approximately \$5.0 billion in 2002 Medicare revenues for all services. Using 2002 utilization, we estimate that total physician fee schedule payments to oncologists would have increased by \$150 million as a result of using oncology survey data and other changes to the practice expense methodology. Allowing payment for multiple drug administration by the push technique would have increased oncology payments another \$25 million. The estimated additional payment of \$175 million to oncologists represents a 17 percent increase in their physician fee schedule revenues and a 58 percent increase in their payments for drug administration services. If we had adopted one of the proposals described above to revise drug payments in 2002, Medicare revenues to oncologists would have increased \$80 million or 2 percent from applying comparability. Medicare revenues to oncologists would have declined by \$570 million or 8 percent from applying an average list AWP discount of 80 percent.

2. Clotting Factor

As mentioned earlier, in January 2003 the GAO issued a report entitled "MEDICARE: Payment for Blood Clotting Factor Exceeds Providers' Acquisition Costs" (GAO-03-184). GAO recommended that we establish Medicare payment levels for clotting factor that are more closely related to providers' acquisition costs and then establish a separate payment for the cost of delivering clotting factor to Medicare beneficiaries by hemophilia treatment centers and homecare companies. In following the GAO's recommendation, at the same time that we establish an appropriate price for clotting factor, we plan to establish a separate payment to hemophilia treatment centers and homecare companies for the administrative costs associated with furnishing the clotting factor. GAO estimated that total delivery costs in 2000 and 2001 ranged from \$0.03 to \$0.08 per unit of clotting factor sold by hemophilia treatment centers. GAO did not receive enough data from homecare companies to estimate their costs. We are proposing to create a payment of \$0.05 per unit of clotting factor provided to Medicare beneficiaries by hemophilia treatment centers and homecare companies to appropriately pay for the administrative costs

associated with furnishing the clotting factor. Note that we are not proposing the creation of separate payment for furnishing the clotting factor for individuals or entities other than hemophilia treatment centers and homecare companies, for example hospitals. The administrative costs of these other individuals or entities associated with furnishing clotting factor are already paid for in their respective payment systems. We also note that GAO indicated that providers may also furnish other services for which they are not separately reimbursed, such as patient education and community outreach. However, these services are not Medicare-covered benefits and they are generally targeted to younger patients who are not Medicare beneficiaries. We are proposing not to include such non-Medicare covered services in the separate payment that we plan to establish for furnishing clotting factor. Section 429(b) of BIPA authorizes the Secretary to establish payment for clotting factor delivery. Therefore, we plan to assure that the total amount of Medicare expenditures for both clotting factor and delivery of such factor does not exceed the amount that Medicare would otherwise spend for clotting factor in the absence of adjustment in payment for the drug and establishment of a separate fee for furnishing the drug. We are seeking public comment and data related to the appropriateness of a fee for furnishing clotting factor under each of our four options for revising the current payment methodology.

3. Separately Billable ESRD Drugs

Medicare pays ESRD facilities a prospective payment, the composite rate, for each hemodialysis treatment furnished. The composite rate is designed to cover the facility's costs of ESRD services furnished to beneficiaries. ESRD facilities can also bill Medicare separately for certain drugs paid outside the composite rate, including erythropoietin, vitamin D analogue, and calcitrol. By law, Medicare payment for erythropoietin furnished by ESRD facilities is \$10 per 1,000 units. The other separately billable drugs are paid under the current 95 percent of list AWP methodology.

In its March 2003 report to Congress, MedPAC concludes that after taking into account the combined payments to ESRD facilities for both the dialysis treatment and the separately billable drugs, the aggregate Medicare payments for outpatient dialysis services appear to be adequate. However, MedPAC found that in 2001, Medicare's composite rate payment did not cover the costs of

providing dialysis services. MedPAC indicated that the profitability of erythropoietin and other separately billable drugs is subsidizing the lower margins under the composite rate. The finding regarding the profitability of the separately billable drugs is consistent with two earlier studies by the OIG. The OIG also found that Medicare's payment rates for these drugs were high relative to providers' costs and the rates paid by the VA and Medicaid programs.

We believe that it is important to pay appropriately for the composite rate and separately billable drugs and not have payments for one cross-subsidize the other. It is our preference for the Congress to provide explicit authority to increase the composite rate when we reduce payments for ESRD separately billable drugs. However, we believe that Congress intended for us to establish additional payments for ESRD facilities to account for increased costs resulting from revised drug payment rates. Section 429(b) provides that the Secretary may provide for additional payments to providers or suppliers for the administration, handling, and storage of drugs and biologicals. While the citation in section 429(b) is to a provision of the statute that no longer exists, we believe that in light of other provisions in section 429, Congress intended the Secretary to provide for additional payments to ESRD facilities for increased costs related to the administration of drugs and biologicals to offset revised Part B payments rates if the Secretary determined it was appropriate. We believe based on the MedPAC analysis that it is appropriate to increase ESRD payments to offset the savings that will occur as we reform drug payments under the current methodology. This would result in the same amount of money being paid to ESRD facilities in 2004, but with more accurate payment for separately billable drugs. This would not involve the bundling of payment for these drugs or the drug savings into the composite rate, but a separate payment from the composite rate. After we have selected an AWP reform option, we would determine the average first year savings from the ESRD separately billable drugs per hemodialysis treatment and create a separate ESRD facility payment per hemodialysis treatment equal to this amount. As stated earlier, we would prefer for Congress to provide explicit authority for us to bundle the savings from reforming the separately billable ESRD drug payments into the composite rate.

We are requesting comments from the public on our interpretation of the BIPA