You Deserve To Know!

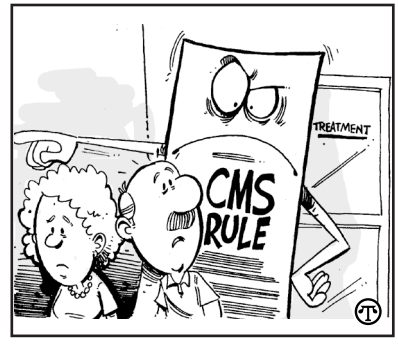
Federal Regulation Denies Medicare Patient Access To Cutting-Edge Medical Therapies

by Kathryn Schmidt

(NAPSA)—Imagine you have just been told that you have a rare form of cancer. The doctor says the disease can be fatal without the right treatment. The only problem is that the treatment is no longer available at hospitals where it should be administered.

You think this could never happen? Think again. Since Jan. 1, 2003 the Centers for Medicare and Medicaid Services (CMS), the federal agency that runs Medicare and Medicaid programs, has taken a scalpel to Medicare reimbursement for many drugs and therapies administered in the hospital outpatient setting. As a result, access to lifesaving cancer treatments and "orphan drugs"—therapies that treat rare diseases affecting fewer than 200,000 Americans—is severely threatened.

The hospital Outpatient Prospective Payment System (OPPS), a payment system used by CMS to reimburse hospitals for services and supplies provided to patients in the outpatient setting, is at the heart of the controversy. Under an OPPS regulation that was implemented in January, CMS has employed a flawed methodology to calculate reimbursement rates for hospital outpatient drug treatments. As a result, hospitals have seen reimbursement rates for certain cutting-edge medicines drop by an average of 35 percent. In many instances, payment rates are less



than what the hospital pays to acquire, let alone administer, store and handle, the therapies.

Although many hospitals have absorbed the cost of the treatments despite large budget deficits, this effort cannot last long. Hospitals will be forced to discontinue these treatments if the Medicare reimbursement situation does not change. Further, many of these therapies that are being jeopardized by the rule improve patient quality of life by allowing people to continue working, to live at home and to lead active and productive lives. Certainly, that must count for something.

In addition to applying a flawed payment scheme, CMS has come up with other avenues for denying Medicare patient access to innovative medical therapies on the basis of cost. For example, the agency adopted a new policy of comparing new outpatient therapies with existing products. Using this practice, if CMS determines that a newer product is "functionally equivalent" to an older product, the agency will reimburse at the rate of the cheaper product. The policy, which was adopted without an opportunity for comment by physicians, patients, or hospitals, does not take into account that newer products may provide significant benefits to patients, such as less frequent dosing, fewer side effects or an improved mode of administration.

Further, CMS took it upon itself to ignore FDA classifications by redefining diagnostic and therapeutic radiopharmaceuticals as no longer "drugs" or "biologicals." Again, this decision was made without consulting doctors, hospitals or patients.

As Congress begins working on Medicare drug coverage legislation this summer, it must adopt measures that fix the OPPS problem and restore appropriate reimbursement rates for important drugs and other therapies. Hospitals must be sufficiently reimbursed for the life-improving, life-saving treatments they utilize, so that Medicare patients may continue to receive these therapies. If not, patients will suffer, and state-of-the-art pharmaceutical and biological innovations will become a thing of the past.

For more information about the CMS rule or to learn how to ask your lawmakers if they support legislation that will correct the problems created by the rule, log on to www.within-reach.org.