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MEDICARE OUTPATIENT DRUGS

Program Payments Should Better Reflect Market Prices

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Mr. Chairman and Members of the Subcommittee:

I am pleased to be here as you discuss Medicare's payments for covered outpatient prescription drugs. As you know, Medicare pays for only a limited number of outpatient drugs and biologicals—largely those that cannot be self-administered or require certain medical equipment to be administered.[1] The covered drugs are typically provided by a physician, as is the case for chemotherapy drugs, or through pharmacy suppliers, as for respiratory drugs.

Medicare's payments for covered drugs have been scrutinized for several years. Recent studies by the Department of Justice and the Office of the Inspector General (OIG) of the Department of Health and Human Services (HHS) show that Medicare's payment for covered outpatient drugs in some cases is significantly higher than the actual costs to the physicians and pharmacy suppliers who bill Medicare for them.[2] Yet attempts to reduce these payments have been met with provider claims that overpayments for the drugs are needed to cover underpayments for administering or delivering them. In September 2000, the Health Care Financing Administration (HCFA)—now the Centers for Medicare and Medicaid Services (CMS)[3]—took steps to reduce Medicare's payment for covered outpatient drugs by authorizing Medicare carriers, the contractors that pay drug claims, to use prices obtained in Justice Department investigations of providers' drug acquisition costs in setting payment rates. HCFA retracted this authority in November 2000 following concerns raised by providers that reducing Medicare's drug payments could affect beneficiary access to these drugs and related services. In December 2000, as part of recent Medicare legislation,[4] the Congress directed us to study Medicare's payments for covered outpatient drugs and make recommendations for payment methodology refinements. In September 2001, we reported our

[1]For the remainder of this statement, we will refer to "drugs and biologicals" covered under Medicare part B, which generally covers physician and outpatient hospital services, as "outpatient drugs."

[2]For example, see U.S. Department of Health and Human Services, Office of the Inspector General, *Medicare Reimbursement of Albuterol*, OEI-03-00-00311 (Washington, DC: June 2000) and *Medicare Reimbursement of Prescription Drugs*, OEI-03-00-00310 (Jan. 2001).

[3]Our statement refers to HCFA when discussing actions taken under that name.

[4]The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. No. 106-554, App. F, 106 Stat. 2763, 2763A-522).

findings and made recommendations.[5] In October 2001, we also reported on the adequacy of Medicare payments to oncologists for administering chemotherapy drugs as directed by the Congress.[6]

My remarks today will focus on (1) Medicare payment policies for covered outpatient drugs and related services to administer or deliver the drugs and (2) opportunities to improve the appropriateness of Medicare's payments by adapting key features of other federal payers' reimbursement policies. My comments are based primarily on our studies of Medicare payments for covered outpatient drugs and for administering chemotherapy.

In summary, Medicare's payment for covered outpatient drugs is significantly higher than prices widely available to providers. Medicare's method for establishing drug payments is flawed. Medicare pays 95 percent of the average wholesale price (AWP), which, despite its name, is neither an average nor a price that wholesalers charge. Instead, it is a number that manufacturers derive using their own criteria; there are no requirements or conventions that AWP reflect the price of any actual sale of drugs by a manufacturer. Manufacturers report AWPs to organizations that publish them in drug price compendia, and Medicare carriers base providers' payments on these published AWPs.

We found that widely available prices at which providers could purchase drugs in 2001 were substantially below AWP. For both physician-billed drugs and pharmacy supplier-billed drugs, Medicare payments often far exceeded widely available prices. Despite concerns that the discounts available to large purchasers would not be available to physicians with a small number of drug claims, these physicians with low volumes reported that their purchase prices were the same or less than the widely available prices we documented.

Physicians and pharmacy suppliers contend that the excess payments for covered drugs are necessary to offset what they claim to be

[5]U.S. General Accounting Office, *Medicare: Payments for Covered Outpatient Drugs Exceed Providers' Costs*, GAO-01-1118 (Washington, D.C.: Sept. 21, 2001).

[6]This study was mandated in section 213 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. No. 106-113, App. F, 113 Stat. 1501, 1501A-350). See U.S. General Accounting Office, *Medicare Physician Fee Schedule: Practice Expense Payments to Oncologists Indicate Need for Overall Refinements*, GAO-02-53 (Washington, DC: Oct. 31, 2001).

inappropriately low Medicare payments or no such payments for services related to the administration or delivery of these drugs. For administering physician-billed drugs, such as those used in chemotherapy, Medicare makes explicit payments under the physician fee schedule, typically through the practice expense component of the payment. Our October 2001 report on practice expense payments under the fee schedule showed that, overall, payments to oncologists relative to their estimated practice expenses were comparable to those for all specialties. But we also found that HCFA made inappropriate modifications to its basic method of setting these payments, which resulted in a lowering of the average fees paid for the administration of chemotherapy.

While physicians receive an explicit payment for administering drugs, Medicare's payment policies for delivering pharmacy supplier-billed drugs and related equipment are uneven. Pharmacy suppliers billing Medicare receive a dispensing fee for one drug type—inhalation therapy drugs—but there are no similar payments for the other covered drugs, such as infusion therapy or covered oral drugs. Suppliers do receive an additional Medicare payment for the rental or purchase of durable medical equipment (DME) and related supplies that are used to administer drugs, such as inhalation and infusion therapy, that require DME. However, in 1998 we reported two problems with the program's payments for DME—a wide variety of products may be covered under a single fee and fee schedule allowances were out of line with current market prices.[7] These problems may result in overpayments that implicitly compensate for some service delivery costs not covered by Medicare.

Other payers and purchasers, such as private health plans and the Department of Veterans Affairs (VA), employ different approaches in paying for or purchasing drugs that may be instructive for Medicare. In particular, VA uses the leverage from the volume of federal drug purchases to secure verifiable data on actual market transactions and it uses the prices paid by manufacturers' best customers to set Federal Supply Schedule (FSS) prices. VA also uses competitive bidding to obtain lower prices for certain products for its own facilities. These approaches may be instructive for Medicare provided that they are adopted in ways that reflect Medicare's unique responsibilities and characteristics.

[7]See U.S. General Accounting Office, *Medicare: Need to Overhaul Costly Payment System for Medical Equipment and Supplies*, GAO/HEHS-98-102 (Washington, DC: May 12, 1998).

In our view, Medicare should pay for each service appropriately and not rely on overpayments for some services to offset inadequate payments for complementary services. Our recommendation that Medicare begin to establish payment rates using information about actual market transactions for covered drugs at levels that reflect providers' acquisition costs is consistent with this principle. We have also recommended that the CMS administrator use consistent methods in setting physician practice expense fees for all services, including those for administering chemotherapy.

Background

While the traditional Medicare program does not have a comprehensive outpatient prescription drug benefit, the program does cover roughly 450 outpatient drugs. The outpatient drugs with the highest Medicare payments and billing volume fall into three categories: those that physicians bill for and that are typically provided in a physician office (such as chemotherapy drugs); those that pharmacy suppliers bill for and that are administered through DME, such as a respiratory drug given in conjunction with a nebulizer;[8] and those that are also billed by pharmacy suppliers but are patient-administered and covered explicitly in statute.[9] In 1999, spending for Medicare-covered outpatient prescription drugs totaled almost $4 billion.[10]

Small Number of Products Accounts for Majority of Program Spending and Volume

Although Medicare reimburses providers for roughly 450 outpatient drugs, spending is concentrated on a small number of products billed by pharmacy suppliers and a few physician specialties. For example, just 35 drugs accounted for 82 percent of Medicare spending and 95 percent of the claims volume in 1999. These 35 products included certain injectible drugs to treat cancer, inhalation therapy drugs, and oral immunosuppressive drugs, such as those used by organ transplant patients. Physician-billed drugs accounted for the largest share of Medicare program spending, while pharmacy supplier-billed drugs

[8]A nebulizer is a device driven by a compressed air machine. It allows the patient to take medicine in the form of a mist (wet aerosol).

[9]Medicare-covered outpatient drugs that can be self-administered include such drugs as blood clotting factors and some oral drugs used in association with cancer treatment and immunosuppressive therapy.

[10]Spending is defined as Medicare's total payment, of which the program's share is 80 percent and the beneficiaries' share is 20 percent.

constituted the largest share of the billing volume. Drugs provided in physician offices accounted for more than 75 percent of total Medicare spending for drugs in 1999 and just three specialties—hematology oncology, medical oncology, and urology—submitted claims for 80 percent of the total physician billings for outpatient drugs. By contrast, pharmacy suppliers accounted for more than 80 percent of Medicare drug billing volume and less than 20 percent of corresponding payments. Two inhalation therapy drugs accounted for 88 percent of the Medicare billing volume for pharmacy-supplied drugs administered in a patient's home.[11]

Medicare Payments for Drugs Are Based on "Prices" Set by Manufacturer

Medicare bases its reimbursements to physicians and other providers for a covered outpatient drug on the product's AWP, with Medicare beneficiaries contributing 20 percent of the payment. The AWP, however, is neither "average" nor "wholesale;" it is simply a number assigned by the product's manufacturer. The AWP is often described as a "list price," "sticker price," or "suggested retail price," reflecting that it is not necessarily the price paid by a purchaser or a consistently low, or "wholesale," price.

Because the term AWP is not defined in law or regulation, the manufacturer is free to set an AWP at any level, regardless of the actual price that purchasers pay. Manufacturers periodically report AWPs to publishers of drug pricing data. While there is no required frequency for manufacturers to report AWPs, most publishers said they attempt to update AWPs at least annually. The Medicare-allowed amount, or payment level, for each HCFA Common Procedure Coding System (HCPCS) -coded drug is 95 percent of its AWP.[12] Given the latitude manufacturers have in setting AWPs, these payments need not be related to market prices that physicians and suppliers actually pay for the products.

[11]These two drugs are ipratropium bromide and albuterol (unit dose form).

[12]The payment is based on the AWP for all the drugs having the same HCPCS code. A National Drug Code (NDC) identifies an individual drug. The Food and Drug Administration assigns the NDCs, which are the universal product identifiers for drugs for human use. Each NDC specifies a chemical entity, manufacturer, dosage form, strength, and package size. For example, a single drug—marketed by one manufacturer in one form and strength but in three package sizes—would have three NDCs. HCFA defines HCPCS codes, which generally include multiple NDCs. For single-source drugs, Medicare's payment is 95 percent of the drug's AWP. For multisource drugs, generally those available from multiple manufacturers, the payment allowance is 95 percent of the lower of (1) the median AWP of all generic forms of the drug or (2) the lowest brand name product's AWP.

Varying Payment Arrangements Affect Providers' Final Purchase Price

Common drug purchasing arrangements can substantially reduce a provider's actual acquisition price for a drug. Physicians and suppliers may belong to group purchasing organizations (GPO) that negotiate prices with wholesalers or manufacturers on behalf of GPO members. GPOs may negotiate different prices for different purchasers, such as physicians, suppliers, or hospitals. In addition, providers can purchase covered outpatient drugs from general or specialty pharmaceutical wholesalers or can have direct purchase agreements with manufacturers. In these arrangements, providers may benefit from transactions, including rebates and "chargebacks" that also reduce the actual costs providers incur. Rebates offered by drug manufacturers or wholesalers may be based on the number of different products purchased over an extended period. Under a chargeback arrangement, the provider negotiates a price with the manufacturer that is lower than the price the wholesaler normally charges for the product, and the provider pays the wholesaler the negotiated price. The manufacturer then pays the wholesaler the difference between the wholesale price and the price negotiated between the manufacturer and provider.

Medicare's Payment for Covered Outpatient Drugs Is Significantly Higher than Prices Widely Available to Providers

For the outpatient drugs accounting for the bulk of Medicare spending and claims, Medicare payments in 2001 were almost always considerably higher than wholesalers' prices widely available to physicians and suppliers.[13] This was true regardless of whether there were competing drug products or whether a particular drug was available from only one manufacturer. Physicians who had few Medicare claims for covered drugs were able to obtain these wholesalers' prices or even more favorable prices. Physicians and pharmacy suppliers told us that the higher payments are necessary to cover costs of administering and dispensing their drugs that Medicare does not pay. Our work indicates that CMS's method of computing Medicare fees for physician-administered drug claims, which are submitted primarily by oncologists, inappropriately reduced those fees. Furthermore, Medicare's coverage and payment policies for pharmacy supplier-billed drugs are uneven: Medicare pays a dispensing fee for delivering some pharmacy supplier-billed drugs; for

[13]We attempted to analyze prices for 35 high-volume and high-expenditure outpatient drugs, however, our analysis excluded some high-volume and high-expenditure drugs because of inadequate pricing data. Our results are based on wholesaler and GPO prices for 19 physician-administered drugs and 6 drugs provided primarily by pharmacy suppliers. Volume for a drug is measured in terms of the number of units provided.

others, however, Medicare makes no explicit payment for delivery and administration services.

Wide Disparities Exist Between Drug Acquisition Costs and Medicare Payments

Physician-billed drugs account for the bulk of Medicare spending on outpatient drugs. Of those billed by physicians, drugs used to treat cancer accounted for most of Medicare's expenditures. The prices available to physicians through wholesaler and GPO catalogues are far lower than Medicare's payment. The catalogue prices ranged from 13 percent to 34 percent less than AWP for most drugs that we examined and up to 86 percent less for one. These prices indicate that Medicare's payments for physician-administered outpatient drugs were at least $532 million higher than providers' potential acquisition costs in 2000. Further, the overpayment is likely even greater because additional reductions provided to certain purchasers through chargebacks, rebates, and other discounts drive down the actual acquisition costs to providers even more.

Concerns have been expressed that providers who had few beneficiaries requiring chemotherapy drugs either could not or do not obtain such favorable prices. Therefore, we surveyed a sample of physicians who billed Medicare for low volumes of chemotherapy drugs to see if they were able to obtain discounts similar to those of providers with a high volume of claims. More than one-third of these physicians who billed for a low volume of drugs actually belonged to large, hospital-based, or national chain oncology practices that likely had access to widely available drug discounts. The low-volume providers who responded to our survey reported similar or better discounts than the widely available prices we documented, although these discounts may not be as high as those obtained by high-volume purchasers.

Inhalation therapy drugs administered through DME and oral immunosuppressive drugs represent most of the high-expenditure, high-volume drugs billed to Medicare by pharmacy suppliers. As with physician-billed drugs, Medicare's payments for pharmacy supplier-billed drugs generally far exceeded the prices available to these suppliers. Further, the discounts we found were largest for products that could be obtained from more than one source. Based on the discounts for six drugs billed primarily by pharmacy suppliers, we found that Medicare's payments were at least $483 million more than what the suppliers potentially paid in 2000. Specifically, two DME-administered drugs, albuterol and ipratropium bromide, that accounted for most of the pharmacy supplier-billed drugs paid for by Medicare were available to pharmacy suppliers at prices that averaged, respectively, 85 percent and 78 percent less than AWP. Two

other high-volume DME-administered drugs had prices averaging 69 percent and 72 percent less than AWP. Two of the high-volume oral immunosuppressives were available from wholesalers with average discounts of 14 percent and 77 percent. Although wholesale price information on the two other oral drugs was not available, retail prices from online pharmacies were as much as 13 percent and 8 percent below AWP.

Based on our findings, we recommended that Medicare revise its drug payment policies to more closely parallel market prices that providers actually pay to acquire drugs. To set such prices, Medicare needs to use information on actual market prices, accounting for rebates and other discounts. It is important in setting payment levels to be mindful that providers' ability to secure discounts likely varies, and that prices need to be sufficient to ensure that beneficiary access is not compromised.

Current Drug Payments Called Necessary to Offset Inadequate Payments for Related Services

Physicians and pharmacy suppliers contend that the excess in Medicare's payments for covered outpatient drugs compensates for related service costs inadequately reimbursed or not explicitly covered at all. Medicare payment policies for administering or delivering a drug vary, depending on who provides the drug to the patient. Physicians are compensated directly for drug administration through the physician fee schedule. Pharmacy suppliers are compensated for dispensing inhalation therapy drugs used with a nebulizer, which make up the majority of their Medicare outpatient drug claims. No explicit payments are made to pharmacy suppliers for dispensing other drugs, but the suppliers receive payments for equipment and supplies associated with DME-administered drugs.

Medicare pays physicians based on a fee schedule that includes rates for administering chemotherapy. Payments for chemotherapy administration are important because chemotherapy drugs represent the bulk of Medicare payments for physician-administered drugs. Medicare's payment for chemotherapy administration is usually determined by the practice expense component of the fee schedule, as there is generally no direct physician involvement with these services.[14] Payments for practice expenses were revised beginning in 1999. These payments, which had

[14]Practice expenses include the salaries of nurses, technicians, and administrative staff, and rent, utilities, equipment, and supplies. Practice expenses constitute one of three components in Medicare's physician fee schedule. The other two are the physician work component and the malpractice component.

been based on charges physicians had billed in prior years, were recomputed to reflect the relative resources required to provide each service. Implementation of these resource-based practice expense payments has been controversial. This is in part because the Congress required that payments be budget neutral so that if one specialty's fees increased on average, some others would have to be reduced. Such redistributions have occurred, and some are significant. However, Medicare's physician payments were deemed adequate in the aggregate, as almost all physicians participated in Medicare and accepted the program's fees as payment in full, so that budget neutrality appeared unlikely to cause access problems for beneficiaries.

Oncologists argue that Medicare's payments for administering chemotherapy are inappropriately low and that the excess Medicare drug payments based on the AWP are needed to offset their losses. Yet, oncology is one of the specialties to gain from the introduction of new practice expense payments under the physician fee schedule. In our October 2001 study on physicians' practice expenses under Medicare's fee schedule, we showed that practice expense payments to oncologists were 8 percent higher than they would have been if the prior payment method had been maintained; we also showed that overall oncologists' payments relative to their estimated practice expenses were close to the average for all specialties.

While oncologists do not appear disadvantaged overall under the fee schedule, adjustments that HCFA made to the basic method of computing payments reduced fees for some oncologists' services, particularly chemotherapy administration. In those adjustments, HCFA modified the basic method in computing payments for services delivered without direct physician involvement, like much of chemotherapy administration.[15] The modifications were intended to correct perceived low payments for these services, but instead resulted in reduced payments for some of these services, particularly those provided by oncologists. Further, the agency reduced oncology's reported supply expenses, one of the data elements used to compute fees, to keep from paying twice for drugs that are reimbursed separately by Medicare. Oncologists acknowledge that the supply expense estimate needed to be reduced, but argue that the reduction was too large. We recommended in our October 2001 report that

[15]In the case of chemotherapy drugs, the common practice is for a nurse employed by a physician to administer the drug and for the physician to bill Medicare.

CMS revert to using the basic methodology to determine practice expense payments for all services and develop the appropriate data to more accurately estimate oncology supply expenses. If these recommendations had been followed in 2001, we estimate that payments to oncologists would have been about $51 million higher.

Similar to the physicians who bill for outpatient drugs, pharmacy suppliers and their representatives contend that the overpayments for DME-related drugs are needed to compensate them for costs not covered by Medicare—that is, clinical, administrative, and other labor costs associated with delivering the drug. These include costs for billing and collection; facility and employee accreditation; licensing and certifications; and printed patient education materials. Medicare pays a $5 dispensing fee for inhalation therapy drugs used with a nebulizer, the vast majority of the pharmacy-supplied drugs. The fee is higher than dispensing fees paid by pharmacy benefit managers for private insurance plans, which average around $2, and comparable to fees paid by state Medicaid programs, which range from $2 to more than $6.

Besides payments for the DME-related drugs, pharmacy suppliers may receive additional compensation through the payment for DME and related supplies. Our prior work shows that, for two reasons, Medicare DME and supply payments may exceed market prices.[16] First, because of an imprecise coding system, Medicare carriers cannot determine from the DME claims they process which specific products the program is paying for. Medicare's coding system groups products that may have significantly different characteristics and, therefore, different prices. Medicare, however, pays one fee for all products classified under a single billing code, regardless of whether their market prices are below or above that fee.[17] Second, DME fees are often out of line with current market prices. Until recently, DME fees had generally been adjusted only for inflation since the process required to change the fees for any other reason was lengthy and cumbersome. As a result, payment levels may not reflect changes in technology and other factors that could significantly change market prices.

[16] U.S. General Accounting Office, *Medicare: Need to Overhaul Costly Payment System for Medical Equipment and Supplies*, GAO/HEHS-98-102 (Washington, DC: May 12, 1998).

[17]The equipment and supply payment is determined from a DME fee schedule, whose rates are based on a state-specific fee schedule and subject to national minimum and maximum payment limits.

Other Purchasers' Practices Are Instructive for Reforming Medicare Payments for Covered Outpatient Drugs

Private insurers and federal agencies, notably VA, employ varying approaches in paying for drugs, generally using the leverage of their volume and competition to secure better prices. While private payers can negotiate with some suppliers to the exclusion of others and arrive at terms without clear criteria or a transparent process to secure lower prices, some of these practices would not be acceptable for a public program like Medicare, given the program's size and need to ensure access for providers and beneficiaries. VA uses the leverage of federal purchasers to secure verifiable data on actual market transactions by private purchasers to establish FSS prices for federal agency and public hospital purchasers. VA also uses competition to secure even lower prices in purchasing selected drugs for its own facilities. In considering how these approaches might prove instructive for Medicare, the program's unique responsibilities and characteristics need to be carefully considered to avoid untoward consequences for beneficiaries and providers.

VA sets FSS prices based on actual prices paid by private purchasers—specifically, the prices that drug manufacturers charge their "most-favored" private customers.[18] In exchange for state Medicaid programs covering their drugs, manufacturers agree to offer VA and other government purchasers drugs at these prices. To enable VA to determine the most-favored customer price, manufacturers provide information on price discounts and rebates offered to domestic customers and the terms and conditions involved, such as length of contract periods and ordering and delivery practices.[19] Manufacturers must also be willing to supply similar information to CMS to have their drugs covered by Medicaid. The information is the basis for rebates required by the Medicaid program. With Congressional sanction, CMS might utilize this information to determine appropriate prices for Medicare that would be based on actual prices being paid in the market. Medicare prices most likely could not be the prices paid by most favored customers, but would need to be high enough to assure access for all beneficiaries.

[18]Under federal procurement regulations, the government seeks to obtain a price that is intended to equal or better the price that the manufacturer offers its most-favored nonfederal customer under comparable terms and conditions.

[19]Because the terms and conditions of commercial sales vary, there may be legitimate reasons why the government does not always obtain the most-favored customer price. Hence, under the regulations, VA may accept a higher price if it determines that (1) the price offered to the government is fair and reasonable and (2) awarding the contract is otherwise in the best interest of the government.

VA has been successful in using competitive bidding to obtain even more favorable prices for certain drugs for its own facilities.[20] Through these competitive bids, VA has obtained national contracts for selected drugs at prices that are even lower than FSS prices. These contracts seek to concentrate the agency's purchase on one drug within a class of therapeutically equivalent products for the agency's national formulary. In 2000, VA contract prices averaged 33 percent lower than corresponding FSS prices.

Medicare's use of competition has been restricted to several demonstration projects authorized by the Balanced Budget Act of 1997.[21] In one of these demonstrations under way in San Antonio, Texas, suppliers bid to provide nebulizer drugs, such as albuterol, to Medicare beneficiaries. While Medicare normally allows any qualified provider to participate in the program, only 11 bidders for nebulizer drugs were selected to participate under the demonstration. In exchange for restricting their choice of providers to the 11 suppliers, beneficiaries are not liable for any differences between what suppliers charge and what Medicare allows. Preliminary CMS information on the San Antonio competitive bidding demonstration suggests no reported problems with access and a savings of about 26 percent for the inhalation drugs. Expanding competitive bidding for additional drugs could be beneficial. However, use of competitive bidding would not be feasible for all drugs, for example, those that have no or few therapeutic equivalent alternatives, which is the case for many chemotherapy drugs.

Concluding Observations

Our September 2001 study on Medicare payments for outpatient drugs shows that Medicare payments and Medicare beneficiary copayments to providers for these drugs are much higher than necessary, given what the providers likely paid to purchase these drugs from manufacturers, wholesalers, or other suppliers. Unlike the market-based fees paid by VA and other federal agencies, Medicare's fees are based on AWP, which is a manufacturer-reported amount that generally does not reflect actual transactions between seller and purchaser. Physicians contend that the profits they receive from Medicare's payments for outpatient drugs are needed to compensate for inappropriately low Medicare fees for most

[20]U.S. General Accounting Office, *Prescription Drugs: Expanding Access to Federal Prices Could Cause Other Price Changes*, GAO/HEHS-00-118 (Washington, DC: August 7, 2000).

[21]Pub. L. No. 105-33, §4319, 111 Stat. 251, 392.

drug administration services. Similarly, the case argued by some pharmacy suppliers for Medicare's high drug payments is that not all of their costs of dispensing the drugs are covered.

If Medicare were to follow the principle of paying for each service appropriately and incorporate lessons from other payers in setting fees for outpatient drugs, the program would use information on actual market prices, accounting for rebates and discounts, to establish its payments for drugs. Manufacturers whose drugs are used by veterans or Medicaid recipients are already required to provide this information to VA and CMS. Medicare could also determine market-based fees for certain drugs through competitive bidding. If drug payments are tied closer to providers' likely acquisition costs, Medicare would need to ensure that separate and appropriate payments are made to pay for the administration and delivery of covered drugs. Changes to Medicare payments for chemotherapy administration under the current physician fee schedule are needed to make these payments comparable to payments for other services. While Medicare also provides a separate payment for the dispensing of inhalation therapy drugs, dispensing fees for other drugs that physicians do not administer need to be considered. Different methods of determining these payments may be necessary because of differences in the way certain drugs are supplied and administered. Paying for these services explicitly would enable Medicare to eliminate implicit payments that may have been made through excessive payments for DME and the drugs associated with the DME payment.

Any change to Medicare's payments, particularly a reduction in fees, for covered outpatient drugs or related administration or delivery services needs to be accompanied by an ongoing assessment of whether the new fees adequately support Medicare beneficiaries' access to the drugs and services. Such monitoring should involve examining recent use of these services so that prompt fee adjustments can be made if access problems are found.

Mr. Chairman, this concludes my prepared statement. I would be happy to answer any questions that you or other Subcommittee Members may have.

Contact and Acknowledgments

For further information regarding this testimony, please contact me at (202) 512-7119. Kathryn Linehan, James Mathews, and Michael Rose made contributions to this statement.

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