From the Editor's Desk

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Pricing, Reimbursement, and Health Care Trends to Watch

As part of your summer doldrums reading, follow me through two trends that are taking place on the medical pricing and reimbursement front. The first is the flurry of interest in erythropoietic stimulating agents (ESAs); the second is the transparency of primary care service pricing; and the last is the emergence of pharmacy benefit management organizations to assist in management of the expensive oral and home injectable anticancer agents we are using for our patients.

Left out of the recent debate about ESA pricing was a coherent overview of the relationship between manufacturer pricing, rebates to physicians, and Medicare payment rates. Since 2005, the Medicare program has based drug payment amounts on 106% of the manufacturer's average sales price (ASP) for the drug. Rebates and other discounts lower the ASP, and therefore the reimbursement amount, just as a hypothetical ASP for printer cartridges, cell phones, or automobiles, if calculated, would consider these discounts. Oncologists overall do not benefit under the Medicare program from rebates, since they receive 106% of the manufacturer's ASP after rebates and discounts are figured into the ASP calculation. The unintended consequence is that some patients, whose drug costs their oncologist more than the ASP and Medicare payment, may not have the drug available to them, as the losses are not subsidized from elsewhere; the drug and its administration is "underwater."

In addition, the ASP for ESAs has fallen in the last 2 years. (For example, in June 2005, the Q0136 [epoetin alfa 1,000 units] Medicare payment was \$9.80, and in March 2007, the Medicare payment for the corresponding J0885 was \$9.32, a 5% drop.¹) Price competitions between two market participants have had these pricing impacts. A third entrant into the market, if it is safe and efficacious, may be able to compete with the two existing oncology products on convenience or efficacy, but is almost certain to lower the prices across the market even further. Whether possible third and fourth entrants into the market will be subject to the regulatory prejudices surrounding "me too" drugs, and development further hindered or abandoned, remains an open question. If they can demonstrate safety and efficacy, then market forces can act to improve patient access. Stay tuned.

The emergence of nurse practitioner (NP) –staffed clinics handling many of the self-limited medical problems managed by primary care physicians, bears watching. These clinics offer convenient locations, convenient hours, and service at a price point roughly equivalent to other personal services—think expensive haircuts or restaurant meals for two. The care is generally provided by NPs practicing by protocol and within guidelines; physician referral is made for more difficult medical problems, and the facilities generally have a publicly posted, fixed price list. Some, but not all, are affiliated with an established primary care physician practice, and some are affiliated or owned by specialty chains. In the competitive Southern California market, one large primary care group now posts its prices for primary care physician services (<http://www.healthcarepartners.com/patients/basicservicefee.asp>). This, too, is a trend worth watching as insured patients with high deductibles and copayments become accustomed to shopping for care.

For the here and now, three of this month's articles continue our theme of optimizing process and benchmarking. Benchmarking of support staff, including infusion nurses, midlevel providers such as NPs and physician assistants, and others, as well as days in accounts receivable, is available from a second round of the provider survey conducted by Akscin et al. This follows up on work reported in the *JOP* in January 2007. The response rate (13% of eligible practices responded to the survey) was low, but the results seem valuable, especially as they are compared with the same group's results from a year earlier. Oncologists who were at the low end of activity in the previous survey seem to be working harder, though at the high end, they seem to be tapped out.

We also look at the use of the Oncotype DX (Genomic Health Inc, Redwood City, CA) breast cancer treatment assay in a small practice in Denver, and feature an accompanying Editorial by one of the *JOP*'s Associate Editors, Gary Lyman. In an Original Research article by Kim et al, we also investigate an example of "lean" methods, which were derived in manufacturing to eliminate waste, and are being applied to service industries including health care. Clinicians tackled a vexing problem at a large institution in a creative way to deliver better service to their patients (and to their medical oncologist colleagues).

Enjoy the summer and your other summer reading.

A handwritten signature in dark ink that reads "Douglas W. Blayney".

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Reference

1. Centers for Medicare & Medicaid Services: New information regarding Medicare payment and coding for drugs and biologics. <http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice>