CMS-2175-IFC

Submitter : Mrs. Helen Cothran
Date & Time: 03/05/2004 12:03:00
Organization : Purchase Cancer Group
Category :
Nurse
Issue Areas/Comments

GENERAL

As a professional healthcare giver, I am obviously distressed to deal with medicare and medicaid patients who must now go to the outpatient department of the hospital to receive treatments of chemotherapy. the hospitals are over crowded and treatments are delayed. The question asked of me is how will this affect my overall response to the chemotherapy and will it affect my prognosis if my treatment is not given on time. I see a hiher amount of stress to patients who do not need more stress at this time in their life. I feel the only way we will get any attention to this issue is when someone who is making the major decisions now has to experience this first hand. this issue affect so many families and this will only increase with the baby-boomers reach the age of needing health care more as time elapses. sincerely. Helen Cothran.R.N.

CMS-2175-IFC-2

Submitter : Mrs. Dawn Holcombe
Date & Time: 03/08/2004 12:03:00
Organization : Oncology Network of CT
Category : Congressional
Issue Areas/Comments
GENERAL

Re: CMS-2175-IFC There are significant flaws in the concept of competitive bidding in 2006: The majority of cancer care uses single source drugs, for which there are few opportunities for cost savings. Manufacturers tend to sell product to wholesalers for the same price, and the wholesaler margins are fairly tight, allowing for little variation in pricing of drug to physicians or even CMS under a competitive bidding scenario. Competitive bidding by CMS to wholesalers or pharmacy benefits managers will achieve little in direct
savings regarding actual drug costs. No one in cancer care will be well served by preferred vendor contracting except the preferred vendors, who will take their profits out of the system one way or another, by adding cost or cutting corners and sabotaging already risky and toxic cancer care. A payment system that pays for physician costs of acquiring and handling drugs would remove the stigma of the historically used AWP rates without
compromising quality.

CMS, as a single volume purchaser, would achieve far more significant results by negotiating directly with manufacturers for rebates on known volume of drug used for Medicare patients. Physicians could provide vial specific NDC numbers that will allow CMS to track that volume.

Cancer practices run very efficient drug inventory systems that allow for just in time use for their full mix of patients. Any solution that would isolate certain groups of drugs for one insurer will dramatically increase the inventory costs and practice resources required to manage that inventory, not to mention increased waste and spoilage.

Cancer care cannot be delivered by prescription. The majority of patients coming for care on any given day are sick, with symptoms that require care intervention and monitoring. The Hippocratic Oath statement of, First, do no harm, will be directly violated if physicians were required to write a prescription for cancer treatment and make the patient wait 24 hours or more to receive that medication. Patient chemistries can and do change dramatically from hour to hour. Oncologists must continue to provide care on an as needed basis based upon clinical information and assessment of the patient at the moment and hour the patient presents for care. To do that, requires a drug inventory that is general, not patientspecific.

Cancer drugs are prone to interference between manufacturer and end user, and require specialized and precise handling during every step. Preferred vendor contracting by insurers in Florida and other states

have demonstrated that removal of competition will lead to abuse of that trust at varying levels along the distribution chain. It only took a few short years for organized crime to infiltrate the drug supply chain in Florida and other states where preferred vendor contracting channeled the flow of millions of dollars of cancer drug business. The consequences of greed and profitmotivated individuals have lead to patient deaths, treatment failures, and horror stories of patients, already dealing with cancer, having to deal with the betrayal of drugs that were supposed to help either having no more effect than sugar water, or worse, making their illness worse. No one in cancer care will be well served by preferred vendor contracting except the preferred vendors, who will take their profits out of the system one way or another, by adding cost or cutting corners and sabotaging already risky and toxic cancer care.

Cancer Care Centers, especially those in physician offices more closely resemble acute care centers than a traditional physician?s office. About three-quarters of chemotherapy treatments are multiple combinations of drugs, and the management of the administration, timing, mixing and monitoring patient reactions to these cocktails is intense. Patient reactions can occur in seconds, and can be fatal if not caught by staff trained in such care management.