

Community Oncology Alliance Warns Medicare Drug Negotiation Could Threaten Community Cancer Care

COA Urges CMS and Congress to Keep Patients and Practices Out of the Middle of Drug Price Negotiation and Protect Access to Cancer Treatment

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EINPresswire.com/ -- The Community Oncology Alliance (COA) is warning that the current approach to implementing Medicare drug price negotiation for physician-administered Part B drugs could threaten the viability of independent community oncology practices and patient access to cancer treatment.

In comments to the Centers for Medicare & Medicaid Services (CMS), COA urges the agency to address fundamental problems with how the Medicare Drug Price Negotiation Program's Maximum Fair Price (MFP) will be implemented for Part B drugs beginning in 2028.

COA supports lowering drug costs for Medicare beneficiaries but warns that the current framework puts community oncology practices and patients in the middle of negotiations between Medicare and drug manufacturers, creating significant reimbursement, operational, and administrative challenges.

- [Read COA's full comments on CMS's 2028 MFP effectuation guidance.](#)

"Community oncology strongly supports making cancer drugs more affordable for patients, but physicians and patients should not be stuck in the middle of negotiations between Medicare and



Community Oncology Alliance Logo

drug manufacturers,” said Debra Patt, MD, PhD, MBA, FASCO, president of COA. “The current approach risks undermining the practices responsible for delivering these lifesaving treatments. We have time to fix this before negotiated Part B prices take effect, and we need to get it right.”

Part B Drug Negotiation Could Dramatically Cut Oncology Payments

Under Medicare’s current buy-and-bill system, community oncology practices purchase physician-administered cancer drugs and are generally reimbursed based on Average Sales Price (ASP) plus six percent. The Part B add-on payment helps support the clinical and operational infrastructure necessary to safely provide increasingly complex cancer treatments.

Beginning in 2028, the add-on payment for negotiated drugs will instead be based on MFP, which is expected to be substantially below ASP for many selected drugs. COA is also deeply concerned that including MFP transactions in ASP calculations could erode ASP itself, further reducing reimbursement across Medicare and potentially Medicare Advantage and commercial insurance.

An Avalere analysis found that Medicare fee-for-service add-on payments for three oncology and hematology drugs could [decline 39 percent to 64 percent](#), with an estimated [\\$12 billion to \\$19 billion in lost oncology and hematology add-on payments](#) across Medicare and commercial markets from 2028 through 2032.

“This is not a minor reimbursement change,” said Ted Okon, MBA, executive director of COA. “We are talking about potentially enormous cuts to the Part B add-on payments that help practices provide some of the most expensive and complex treatments in medicine. If we get this wrong, practices could be forced to stop providing certain therapies, consolidate, or close, threatening patient access and driving more cancer care into higher-cost hospital settings.”

Keep Practices and Patients Out of the Middle

COA is also concerned that CMS’s proposed MFP effectuation process could require practices to navigate different manufacturer processes to access negotiated prices or receive retrospective refunds after purchasing a drug. For community oncology practices managing millions of dollars in cancer drug inventory, this could create significant cash-flow exposure, reconciliation challenges, and administrative burden.

COA supports a straightforward solution: continue reimbursing providers based on ASP plus six percent and require manufacturers to return the difference between ASP and MFP directly to Medicare. This would preserve the savings generated through Medicare negotiation while removing physicians and patients from the middle of the process.

COA supports the bipartisan Protecting Patient Access to Cancer and Complex Therapies Act (H.R. 4299) to address the issue legislatively. COA is also urging CMS to use its existing authority

to prevent MFP transactions from eroding ASP.

COA further urges CMS to ensure practices can access selected drugs at MFP, provide prompt and predictable reconciliation when retrospective refunds are necessary, and minimize new administrative burdens and costs associated with MFP effectuation.

Getting Part B implementation wrong could threaten patient access to community-based cancer care and accelerate the shift of care into higher-cost hospital settings. COA urges CMS and Congress to act before negotiated Part B prices take effect in 2028 so that Medicare can deliver savings to patients and taxpayers without putting community oncology practices and patients in the middle of the negotiation process.

Read COA's full comments on CMS's Draft Guidance for Manufacturer Effectuation of the Maximum Fair Price in 2028 at <https://mycoa.communityoncology.org/publications/comment-letters/coa-comments-on-proposed-cy2028-ipay-effectuation>.

About the Community Oncology Alliance (COA)

The Community Oncology Alliance (COA) is a nonprofit organization dedicated to ensuring that patients have access to the highest-quality, most affordable, cutting-edge cancer care close to home. COA is the only national organization focused exclusively on community oncology, where the majority of Americans with cancer receive treatment. Through policy, advocacy, and community, COA works to support independent community oncology practices and advance access to high-quality cancer care for patients nationwide. Learn more at www.communityoncology.org.

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