THE ISSUES

Concerns Over Final 2003 Outpatient Payment Rates

The final hospital outpatient prospective payment system (OPPS) rule was released by the Centers for Medicare and Medicaid Services (CMS) on Oct. 31, 2002. The rule lists the final payment rates for hospital outpatient services beginning Jan. 1, 2003.

ACCC drafted a legislative proposal in 2002 that suggested several ways CMS could preserve patient access to cancer drugs as it set payment rates for 2003. The proposal was introduced in Congress in September by Rep. Clay Shaw (R-Fla.) as H.R. 5450, but was largely ignored by the agency. While Congress adjourned before acting on H.R. 5450, efforts are underway to reintroduce similar legislation in 2003. Here's how H.R. 5450 compares with the final rule:

1 H.R. 5450 asks that all drugs receive separate ambulatory payment classifications (APCs) so that hospitals can continue to track costs versus reimbursements, which will give them an incentive to code properly. CMS, however, insists on "bundling" drugs under $150 per encounter in with their associated administration payment. Even worse, rather than increasing the administration payments for these bundled drugs, the final rule actually reduces many administration payments in 2003.

Example: A hospital that received $91.63 for administering a supportive care drug, and up to $150 for the drug itself in 2002, will receive only $59.12 for the bundled payment in 2003.

2 H.R. 5450 asks that all cancer drug payments be maintained at 95 percent of average wholesale price (AWP) until the agency's data and methodology for annually setting payment rates are improved, so that oncologists can afford to prescribe them. The final rule creates a "dampening policy" that is supposed to ensure that no drug payment will fall more than 15 percent below last year's payment rate. Despite this dampening policy, the final rule reduces payment for many cancer drugs even further than the August 2002 proposed rule.

Example: The payment rate in January 2002 for Herceptin (a sole-source cancer drug) was $52.83. In August 2002, CMS proposed that hospitals receive only $34.33 for Herceptin, which had hospitals extremely concerned about their ability to give their patients this drug. After application of the "dampening policy," the payment for Herceptin, starting in January 2003, will be $32.84.

3 H.R. 5450 asks CMS to review and revise its methodology for setting payment rates so that Congress does not have to become involved each year when the rates are set so low as to be below acquisition costs for many hospitals. While CMS examined data for an additional quarter year, it did not revise any of its rulings for cancer drugs (see above example). Furthermore, while CMS acknowledged that problems with its methodology exist and promised to look into them in the future, CMS refused to make any adjustments to compensate for these problems before the January 2003 rates go into effect. CMS simply said it was not aware of any empirical data to suggest that hospital charging patterns in the real world might make its cost-to-charge methodology unworkable.

4 H.R. 5450 asks for further study on how pharmacy costs are reimbursed. Even after ACCC provided anecdotal information from hospitals indicating that their pharmacy costs are billed to and reimbursed from the AWP drug payment, CMS restated in the final rule that it believes these costs are paid from administration payments. CMS in no way acknowledged that hospitals were billing for these costs differently in the real world.

Even worse, rather than increasing the administration payments for these bundled drugs, the final rule actually reduces many administration payments in 2003.

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5 H.R. 5450 requests that a pro rata reduction not be implemented until the payment rates are more reflective of true costs. Although no pro rata reduction will occur in 2003, so many oncology drugs have been taken off the pass-through list that the benefit of this accommodation has been eliminated. The lack of a pro rata reduction would have been more helpful if the drugs had remained on the pass-through and had continued to receive 95 percent of AWP while data and methodology problems were resolved.

For more details on the final 2003 OPPS rule, turn to page 32 for an analysis by Mary Lou Bowers of ELM Services, Inc.

APC Rate Changes for Radiation Oncology

A brief analysis of the final 2003 OPPS rule saw mixed results for radiation oncology. Increases for complex conformal daily treatment will benefit most

programs, because payment for each case is expected to increase approximately $2,350. However, payments for newer therapies, such as IMRT, decreased slightly in the final rule. Using the IMRT example, the APC payment went down about $20. Furthermore, significant problems exist in the final rule regarding the bundled prostate brachytherapy reimbursement.

Hospitals must carefully review their radiation charges *now* because CMS is using these hospital claims to set bundling rules and payment rates for future years. CMS admits that it "doesn't understand…the high-tech services" that are part of radiation oncology. It also notes that hospital claims are inconsistent; out of 12,000 claims CMS received for prostate brachytherapy only "25 were alike." Most importantly, CMS states that it is *not* responsible for paying claims properly if the claim data are wrong.

Stay tuned. An in-depth analysis of the final 2003 OPPS rule and its effect on radiation oncology will appear in the March/April 2003 *Oncology Issues.*

Physicians Face More Cuts in Medicare Payments

The 2003 Medicare physician fee schedule published in the Dec. 31, 2002 *Federal Register* resulted in the expected 4.4 percent cut in Medicare reimbursement. Although the publication of the final rule was delayed twice, efforts to administratively "fix" the physician payments were unsuccessful.

The 2003 Medicare physician fee schedule is effective as of March 1. Claims for services provided on or after January 1 and before March 1 will be paid under the higher 2002 fee levels, CMS said. Log onto ACCC's web site (*www.accc-cancer.org*) for more information about the 2003 physician fee schedule.

The 2003 cuts come on top of the 5.4 percent reduction in physician payments that occurred in 2002. While 97 percent of physicians chose to participate in the Medicare program despite the 2002 payment cuts, the American Medical Association said many physicians limited the number of new Medicare patients they accepted. Faced with a second year of payment reductions, many physicians may choose not to participate in the Medicare program—a move that many in the industry fear will compromise patient access to quality care.

Debate Continues Over AWP

Average Wholesale Price (AWP) methodology and the idea that Medicare is overpaying for drugs as a result of using AWP were topics discussed again at a

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recent hearing of the House Ways and Means Subcommittee on Health. While the discussion was similar to that heard at past meetings, CMS Administrator Tom Scully's testimony was dramatically different. Stating that CMS plans to administratively implement changes to AWP in 2003, Scully spoke about a two-part plan that would save Medicare $500 million by making changes to the drug payment methodology.

First, Scully said that CMS plans to conduct a survey of its carriers and their estimation of drug acquisition costs in the near future. CMS will then pick the carrier it believes has the most reliable information and use its data to set the reimbursement rates for all drugs. Scully estimated that this step alone would save Medicare $100 million in the short term. On Dec. 4, 2002, CMS issued a program memorandum setting one national price. The agency will use Palmetto's numbers for the nation. The savings achieved as a result of this new policy remain unclear. For more information, visit *www.accc-cancer.org*.

Second, CMS would study the costs of drugs to the under-65-year-old population and use this information to set future rates for drugs. Scully estimated that this change would save an additional $400 million for Medicare.

Scully reiterated that, while CMS does have the administrative authority to change AWP, it does not have the authority to effectively reform practice expenses and stop underpayments in this area. In other words, CMS cannot add new money to the practice expense component of reimbursement or make changes about how practice expenses are paid without legislation giving it the authority to do so.

The Pitfalls of Value-Based Decision-Making

At a recent meeting on Medicare payments for new technologies, MedPAC placed great emphasis on such concepts as "value-based" and "cost-effective" decision-making. While these terms may seem like common sense, ACCC is concerned that such concepts can easily translate into Medicare taking over the role of the physician and making inappropriate medical decisions.

Cost-effective or value-based decision-making can be implemented in three ways—the provider, the beneficiary, or CMS options. ACCC's goal is to ensure that patient access to quality cancer care is not significantly undermined, regardless of which option is used.

The Provider Option. Broadening Medicare payments to encompass the treatment for entire conditions or diseases and then requiring physicians to determine how to best manage those dollars was one suggestion brought up at the MedPAC meeting. For example, Medicare would reimburse a standard amount for all individuals diagnosed with non-small cell lung cancer, and the amount would cover the entirety of the patient's treatment.

This option forces physicians to apply cost-effective analysis to treatment decisions so that the newest and most expensive option is not chosen first. However, accurately determining treatment costs in advance is nearly impossible for a patient with cancer, since every

patient's response to treatment is different and an "average" patient or case does not exist.

The Beneficiary Option. This proposal establishes a system of sliding beneficiary co-payments. Beneficiaries using cost-effective analysis to make medical decisions would pay less for services. Under such a system, beneficiaries using newer, more experimental, and more expensive treatment options pay a larger portion of the treatment costs. A similar structure is being considered for a prescription drug benefit, where the amount of a beneficiary's co-payment would vary based on whether the patient chose a brand name or generic drug.

If this method is tied to overall treatment as discussed at the MedPAC meeting, two potential problems arise. First and most alarming is that the quality of a beneficiary's treatment—and potentially his or her prognosis—would be tied in large part to the individual's financial status. Second, asking patients to pay for 30 to 40 percent of the treatment costs places an increased burden on providers already struggling to collect the current 20 percent Medicare co-payment. Providers who are worried about the financial risks of offering expensive treatment and whether they will be able to collect higher patient co-payments may choose to offer fewer or cheaper treatment options to their Medicare patients.

The CMS Option. CMS recently tied reimbursement to treatment efficacy in its final hospital OPPS rule by introducing the concept of "functional equivalence." In its proposed rule, CMS paid significantly different amounts for two "similar" cancer drugs, as one drug qualified for an additional pass-through payment because it was considered new

Are Tobacco Control Programs Reaching Those Most at Risk?

The states with the highest rates of lung cancer are spending the least amount of money per capita on tobacco control programs, according to an analysis of tobacco settlement data and lung cancer statistics conducted by the *It's Time to Focus on Lung Cancer* campaign. The campaign is a partnership between the nonprofit organizations Cancer Care, Inc., and the CHEST Foundation.

"The multi-billion dollar Masters Settlement Agreement is not living up to its promise and most states are spending far less money on tobacco control than was recommended by the Centers for Disease Control (CDC)," said Peter Bach, M.D., a pulmonologist and epidemiologist at Memorial Sloan-Kettering. The states are missing a tremendous opportunity to save lives." Bach is a co-author of a study published in the October 3, 2002 *New England Journal of Medicine* called, "State Expenditures for Tobacco Control Programs and the Tobacco Settlement."

The 10 states with the highest rates of lung cancer in men between 1994 and 1998 were Kentucky, West Virginia, Louisiana, Missouri, Delaware, North Carolina, Rhode Island, Maryland, Texas, and South Carolina.

During this same time period, the 10 states with the highest rates of lung cancer in women were Kentucky, Nevada, Delaware, West Virginia, Rhode Island, Florida, Alaska, Missouri, Washington, and New Hampshire.

These states spent an average of $1.93 per capita for tobacco-control programs for men and $2.67 per capita for women during the study period. The average CDC recommendation is $7.47 per capita. Kentucky, the state with the highest rates of lung cancer for men (122 per 100,000 people) and women (59 per 100,000 people), spent just 84 cents per capita on tobacco control programs. Nevada, which has the second highest rate of lung cancer in women, spent 59 cents per capita. Of all the states, Pennsylvania spent the least amount of money—10 cents per capita—and had some of the highest rates of lung cancer. Louisiana, which has the third highest rate of lung cancer among men, spent 37 cents per capita.

On average, the 50 states spent $3.49 per capita for tobacco control programs in 2001, far less than the $7.47 recommended by the CDC.

The Masters Settlement Agreement was reached with the tobacco industry in November 1998, giving the states $206 billion over the first 25 years and continuing in perpetuity. Although one of the goals of the settlement agreement was to "support tobacco-related public health measures," most states are not meeting that goal. In 2001, the average state received $28.35 per capita for an average total of nearly $164 million, yet allocated just 6 percent for tobacco control and 4 percent for research. Forty-one percent was spent on other health care issues and 40 percent covered other state budgetary items.

States that have used their settlement money for tobacco cessation programs have seen big returns on their investment. Strong programs in California and Massachusetts caused dramatic declines in smoking rates, and the incidence of lung cancer has dropped 14 percent in California, saving 33,000 lives.

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technology. However, in the final rule, CMS determined that the two drugs were essentially "interchangeable" or "equivalent" and would receive the same payment per average encounter. (For more details about the effects of functional equivalence, turn to page 34.)

This controversial decision means that CMS is now making clinical judgments about new drugs. ACCC believes these decisions should be made by the beneficiary's physician. These decisions are particularly critical in oncology because cancer treatment methods are so complex and varied and each patient's disease and treatment course is so different. Granting CMS the authority to determine how certain new drugs or treatments compare clinically to current drugs or treatments, and to tie reimbursement to the findings were heavily debated at the MedPAC meeting.

If the Medicare program, which sets the standards for private payers, removes the financial incentives for developing new cancer treatments or more efficient medical devices, the lifesaving clinical advances we have made will slow down. Improving Medicare's ability to efficiently purchase health care *must not* undermine its beneficiaries' ability to obtain quality care.

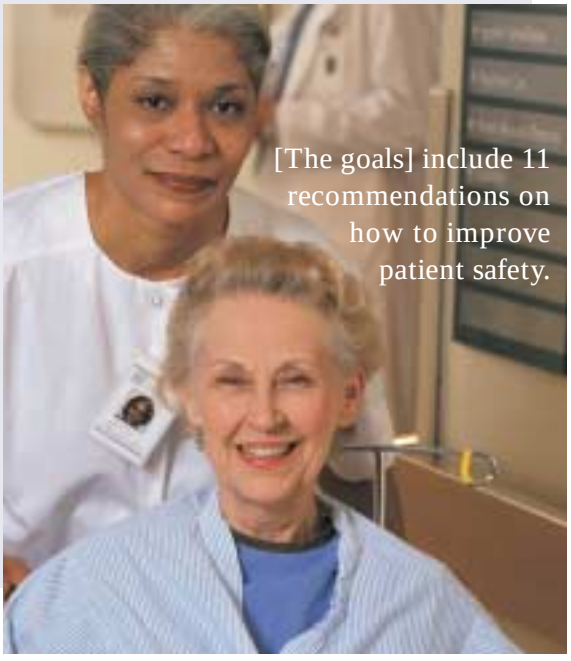
JCAHO Announces 2003 National Patient Safety Goals

The board of directors of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has implemented six national patient safety goals, which include 11 recommendations on how to improve patient safety in health care organizations. The patient safety goals were effective Jan. 1, 2003.

Although JCAHO surveyors will be allowed to promote these recommendations to the facilities they evaluate as suggestions for improvement, the surveyed organizations can voluntarily put them into practice. The recommendations will *not* be assessed and scored on JCAHO evaluations. For 2003 the patient safety goals are:

- Improve the accuracy of patient identification
- Improve the effectiveness of communication among caregivers
- Improve the safety of using high-alert medications
- Eliminate wrong-site, wrong-patient, wrong-procedure surgery
- Improve the safety of using infusion pumps
- Improve the effectiveness of clinical alarm systems.

For more information about these new patient goals and their associated recommendations visit *www.jcaho.org.*



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Radiation Oncology Clinical Trials Expanded in Populations with Disparities in Health Care

The National Cancer Institute's (NCI's) Radiation Research Program currently has open a request for applications (RFA) entitled "Cooperative Planning Grant for Cancer Disparities Research Partnerships" (CA-03-018) or CDRP. CDRP provides resources for the cooperative planning, development, and implementation of radiation oncology clinical research trials in institutions that have not been traditionally involved in NCI-sponsored research and care. These clinical trials must involve "a disproportionate number of medically underserved, low-income, ethnic, and minority populations."

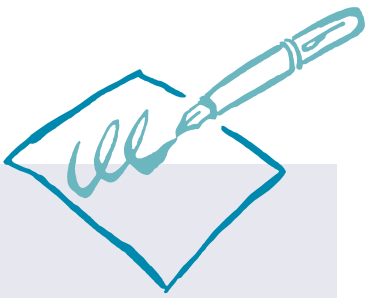
The grant will also support the development and maintenance of support/mentor partnerships, by teleconferencing and telemedicine consultation when necessary, between these institutions and more experienced facilities that have strong NCI research backgrounds.

The total budget for CDRP is $27 million over five years. The NCI made two awards in FY 2002, and anticipates making four additional awards in FY 2003. The deadline for the letters of intent is February 20 and the completed applications must be received by March 20.

Facilities applying for the grant must provide radiation oncology services that meet current standards, including having a minimum of one board-certified radiation oncologist and one full-time Ph.D. or M.S. physicist on staff. The institution must also serve one or more of the target populations at a rate greater than the state population average, and serve a population that exhibits cancer incidence and/or mortality greater than the national average.

NCI encourages institutions that meet the requirements to submit an application. Clinical investigators from NCI-designated Cancer Centers, RTOG participating institutions, or other NCI-sponsored cooperative group institutions are encouraged to identify and approach potential applicant institutions in their respective regions.

For more information about NCI's RFA visit *www.grants.nih.gov/grants/guide/rfa-files/RFA-CA-03-018.html.*



Know Your Payer's Billing and Coding Requirements

by Carolyn Travers

Each payer has its own documentation requirements and manuals, so practices and hospital billing departments must gather as much payer-specific information as they can. Insurance carriers (commercial and Medicare) often require different kinds of documentation from providers before they will pay for a specific service. Some carriers have time limits on filing or paying claims, or different reimbursement values. Providers should review each carrier's requirements, which are stated in the carrier contract, prior to a patient's visit.

Obtain a provider manual from each carrier with whom you participate. Although the carrier's provider services representative is the first person to call to procure a copy of the provider manual, contacting the regional representative may also be necessary.

The Provider Manual

The provider manual should include patient referral and preauthorization requirements, timely filing limits, claims payment timeframes, and copies of the front and back of the patient insurance identification card, among other items.

The patient identification card will list specific contact information for primary care referrals and should also have a preauthorization/precertification phone number.

Some carriers require providers to attach a paper referral to each claim submitted. Other carriers will only accept an electronic version of the referral, which must be obtained via a phone call to the primary care physician and/or the carrier. Some services require preauthorization/precertification before specific services can be performed. The provider of service is responsible for knowing which services require preauthorization, and must list the preauthorization number on the claim for those services. Each referral and/or preauthorization is only good for a certain number of visits or expires after a certain date. After that date or after the stated number of visits, the practice must begin the referral or preauthorization process again.

Timely filing limits also vary by carrier. Medicare has a limit of 18 months from the date of service to file the claim, but commercial carriers range from 30 to 180 days from the date of service for the initial filing. Time limits for "refiles" or corrected claims also vary by carrier. Refiling information is located in the Insurance Denials section of most provider manuals. Often resubmissions/refiles must be directed to an address that is different from the one where the original claim was filed.

The provider manual will also say how long the carrier will take to respond to a clean claim. Many states have laws that require a carrier to respond to providers by a certain deadline. If that response time is not met, the carrier may have to pay interest on the claim filing.

The copayment/coinsurance collection process should also be included in the manual. Phone calls to the Verification of Benefits office listed in the manual will provide 1) the exact copayment/coinsurance amount that needs to be collected from the patient, 2) the time at which the copayment/coinsurance payment should be collected, and 3) a list of which services are covered or not covered under the patient's contract.

Fee Schedules

Fee schedules are another important part of the payer contract, and will list the reimbursement rates for each procedure. (The procedures will be listed by their procedure codes.) Fee schedules also provide some guidance on how to bill certain procedures. Since many carriers have several different product lines, fee schedules should be available for all the services a carrier covers.

For instance, Medicare requires HCPCS Level II codes Q0083 through Q0085 for chemotherapy administration in the outpatient hospital setting. Some commercial carriers require CPT codes 96400 through 96549, while other commercial carriers follow Medicare guidelines for these same services. Before coding a patient's visit, find out what the coding requirements are for each carrier for each service.

Make Your Software Work

If your software is not set up to automatically default to each carrier's specific codes, modify the software so it offers these capabilities. Otherwise the codes must be entered by hand to meet each payer's requirements.

To create a win-win situation, providers should have as much payer-specific information available as possible and update their computer systems for claims compliance.

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