Q&A Reimbursement

Representatives from CMS and the House Energy and Commerce Committee speak out about oncology reimbursement.

ACCC's 11th Annual Oncology Presidents' Retreat, held Jan. 31-Feb. 1 in McLean, Va., drew leaders from 40 state oncology societies plus representatives from national oncology associations and patient advocacy groups. Lowering payment for drugs given in the physician office setting without an appropriate increase in payment for services was foremost on the minds of those who attended the meeting.

Speaking at the retreat were Don Thompson, director of the Ambulatory Services Division of the Centers for Medicare and Medicaid Services (CMS), and Chuck Clapton, counsel for the House Energy and Commerce Committee, which has been working for several years to address the adequacy and accuracy of Medicare reimbursement in the physician office setting. Both Thompson and Clapton spoke about reimbursement policy as it affects the oncology community, and engaged in an extensive question and answer period with meeting attendees. Here are their remarks and their responses to questions.

PHOTOGRAPH BY PICTUREQUEST.COM

Chuck Clapton: Oncologists did not create this reimbursement system.

"Congressman Tauzin wants to ensure that Medicare beneficiaries have access to cancer treatment and that oncologists are reimbursed fairly so they can continue to practice medicine. I want to tell ACCC that this is an issue that the chairman of the Energy and Commerce Committee cares very passionately about and certainly wants to see resolved.

"A January 26, [2003,] article in the *New York Times* was quite unfavorable to oncologists. In the last few days, I've talked to a number of oncologists and heard them express frustration and regret about how their profession is being portrayed. Perhaps one of the greatest [attributes of] oncologists is the way they acknowledge the critical role they play in saving lives. The people I spoke to were really baffled by how they are being portrayed in the press. Chairman Tauzin and I also share that regret.

"But I have to caution that, as I look around the country, there are many ongoing investigations into drug pricing for Medicare and Medicaid. Currently 21 pending criminal investigations of this nature are going on at the state level by state attorneys general, with at least two state attorney offices undertaking similar investigations and one pending investigation by the Department of Justice. This issue is not going to go away and, unfortunately, it will continue to generate stories like the one you saw in the Sunday *Times*.

"We need to work together to come up with a solution. I understand the frustration that all of you have. Oncologists did not create this reimbursement system. It was designed by Medicare and by private insurers, yet

oncologists are being blamed for the bad consequences the system produces. The question then becomes what can we do to fix it so stories like the one that ran in the *New York Times* won't run again?

"Chairman Tauzin has been very active for three years now. I remember that when we first started this process, he emphasized to me where his priorities lay, starting with his 80-year-old mother who lives in Louisiana and is a three-time cancer survivor. Oncologists saved his mother's life not once, but three separate times. The chairman wants to ensure that Medicare beneficiaries continue to have access to the kinds of treatment that saved his mother's life. At the same time, he wants to ensure that reimbursement is set fairly.

"How do we set a policy that will reimburse oncologists adequately so they can continue to practice medicine, but will also ensure that Medicare beneficiaries' copay amounts are not more than the physicians' drug acquisition costs? If there were an easy solution to this problem, it would have been enacted already.

"Right now, the committees with the jurisdiction in the House are trying to come up with a solution. This task has been in the works now for two years. House committees have been working closely with ACCC and ASCO [the American Society of Clinical Oncology], and their input will lead to a better product. In fact, ASCO is also soliciting data that will help improve reimbursement to oncologists.

"We will continue to work on other important pieces of legislation, including a prescription drug bill, that impact oncology practices. The drug bill will probably go through the House by April or May of this year and could very well include AWP [average wholesale price] reform. We expect to work with all of the associations that represent oncologists to solicit their input.

"There are other issues that the Committee on Energy and Commerce has been working on over the past few years. One is reversing physician reimbursement reduction, which Congressman Tauzin is very passionate about. He is working on legislation to fix that problem.

"The committee is also working closely with ACCC to fix the hospital outpatient reimbursement system. We have not been able to find a solution, but welcome any input that oncologists can provide."

Don Thompson: If Congress does not act, then CMS will take regulatory action.

"This is an inopportune time for me to be speaking to you since CMS is currently exploring administrative options to reform AWP and that keeps me from providing certain details on this issue.

"I would like to echo some of the comments Mr. Clapton made. We [CMS] understand the difficulty of this issue. If there were an easy solution, it would have been found a long time ago. We are struggling with it.

"CMS Administrator Tom Scully has mentioned on more than one occasion that our preference is for a legislative solution. We do not want to act administratively on this issue. We would much prefer that Congress and the legislative process develop a solution. Administrator Scully has also said that if Congress does not act, CMS will do something on the regulatory front, and that's what we're working on right now. These deliberations will be a completely open process. Should it come to an administrative fix, there will, of course, be a proposed rule and ample opportunity for public comment. But again, we hope that it doesn't come to that and we are seeking a legislative solution.

"On the practice expense side, Administrator Scully has also said on more than one occasion that AWP reform should include paying appropriately for drug administration. We are working closely to ensure that whatever is done on AWP reform is done in the context of paying appropriately for furnishing the services. We are reviewing the ASCO survey and will have some follow-up questions.

"Whatever actions we may take administratively on the drug side, the timing of those actions will be in sync with the physician fee schedule update.

"Unfortunately, I cannot provide a great deal of detail at this time. I would like to say that the *New York Times* article created quite a stir in CMS. I don't think it fully addressed the practice expense side and perhaps didn't fairly portray the problem either. We hope to move forward on the federal side and to address both those issues."

> *If there were an easy solution to this problem, it would have been enacted already.*
>
> —Chuck Clapton

Q & A Session with Clapton and Thompson

Question: *This is the first time I have heard a federal authority say that he knows we didn't invent this process. HCFA [the Health Care Financing Administration] invented this policy, along with the RBRVS [resource-based relative value scale] rules and regulations, in recognition of the fact that reimbursement was below par in some areas.*

It seems that we have parallel legislative and administrative tracks going this year. If you want a proposed

rule out, it needs to be issued around May to allow for public comment. So, does this mean Congress will have to act before May, or can this issue move along both tracks simultaneously? What is the process?

Thompson: The timetable would be a Jan. 1, 2004, implementation, which would coincide with the annual fee schedule update. For that to occur and have time for public comment, the proposed rule would need to be issued earlier.

Clapton: President Bush will unveil his budget plan on Monday [Feb.3]. It is widely believed that his budget plan will contain a new prescription drug proposal that will provide prescription drugs for Medicare beneficiaries. As a result, Congress will consider the development of a prescription drug bill, which will probably come to the floor of the House by late April or early May. There is a good likelihood that average wholesale price [AWP] reform could be included in the legislation at that time. After that, the Senate might take action. Given the fact that 2004 is a presidential election year, Congress may pass, and the President may sign into law, some type of prescription drug bill before the end of this calendar year.

On AWP reform, we're not simply talking about fixing the drug side, but addressing physician reimbursement issues.

Question: *What action does Congress need to take before May 1, when CMS plans to take action?*

Clapton: Administrator Scully has been very clear with us that if a prescription drug reform bill is not enacted by Congress at some point, CMS will need to take some action.

Question: *This question is for Chuck Clapton. You mentioned briefly the hospital outpatient payment system. ACCC represents some 600 hospitals, most of which perform outpatient chemotherapy administration. The payment system seems to affect every hospital because, for every dose of chemo delivered, the hospital will lose significant revenue that it will have to make up on the administrative side. The pressure will come down from the president of the hospital about how long hospitals can make outpatient chemotherapy delivery available under these circumstances.*

Clapton: The hospital outpatient prospective payment system [OPPS] is set up to reflect reimbursement for essentially a bundled service. It's not just oncology but a variety of services that are provided in outpatient settings.

OPPS was set up to be budget neutral, so that if more money was given to a particular specialty or a particular code, reductions would be made across-the-board, which would affect everyone else. As is typically the case, when you have a system that impacts everyone, everyone says they are adversely affected and no one is happy with the outcome.

Congress has been grappling with this since the prospective payment system was implemented for outpatient services. Each year, CMS goes through a process of refining and recalibrating data and gathering new data. For instance, this is the first year that actual claims data were used to recalibrate some claims. Each year, CMS is refining and improving the process. We want CMS to have better data and continue to use that data to refine reimbursement.

You need to be aware that hospital outpatient reimbursement is going to be very different from physician office reimbursement until AWP is reformed. Practices are going to be paid more money until the payment system is fixed. How will this impact where patients receive care? How will this impact the quality of care and access to care? This is the first year we have seen a significant reduction in oncology reimbursement in the outpatient setting. What can we do?

Until we deal with the physician side of the equation, we will always have this disparity. We need to make sure that hospital outpatient rates are refined or do whatever else needs to be done.

Question: *We use, in part, the mark-up from drugs to pay for the large number of indigent patients we see who otherwise could not get chemotherapy. In the plan, could there be consideration of a GPCI (geographic practice cost index) to correct for the different numbers of uninsured patients in the various states?*

Also, health insurance plans expect about a 20 percent profit. Do you think there is an "acceptable" profit line for physicians? If so, what is it?

Thompson: In terms of the profit margins, that issue has definitely been discussed. There are acquisition costs, costs above the acquisition costs, and handling costs—and they must be paid as part of the practice expense or part of the drug payment. I think you can make a case that handling the drug is perhaps a practice expense. Then what is the profit margin on the drug and what is the appropriate profit margin on the drug? That determination has not yet been made, but those discussions are underway.

Clapton: The determining factor from a legislative per-

The advantage of a legislative solution is that Congress can indicate that *it does not want the practice expense increases on the physician side to be budget neutral.*

—Don Thompson

spective is access. How much needs to be paid to ensure that oncologists can still treat Medicare patients? I think that question will be the mechanism for whatever reimbursement system is eventually decided on.

This problem goes across all of medicine. It is very difficult for a payment system to be designed to deliver the level of profit that should be made available. Ultimately, oncologists will make the decision about what level of reimbursement they need to treat Medicare patients.

On the issue of indigent care, although we have heard a great deal about the issue, suggestions on how to address the problems have not been forthcoming. We recognize that work needs to be done on this issue.

Question: *This is directed to the administrative side. Given the track record on the legislative side, it is unlikely that in three to four months there will be a legislative solution on AWP. If the administrative side reaches a decision in May or June, what options are available on the administrative side to handle practice expenses?*

Thompson: That would come in the form of refining the practice expense side of the codes. That would possibly not occur in the drug rule but could possibly be addressed in the proposed rule for the physician fee schedule.

The advantage of a legislative solution is that Congress can indicate that it does not want the practice expense increases on the physician side to be budget neutral. They could do that in a non-budget neutral fashion.

In the absence of legislation (and no matter what changes are made to practice expense), funding remains an open question. Funding could come from the other services under the physician fee schedule, but the solution needs to be budget neutral.

Administrator Scully has publicly said on more than one occasion that he wants to pay appropriately for furnishing the services.

Question: *I have heard recently that Mr. Scully said that if he reduces AWP that the reimbursement to oncologists for practice expenses would be between $100 million and $200 million. If that is true, how does this figure into the plan?*

Thompson: One of the data sources on refining practice expense is the ASCO survey. We need to look at the numbers in that survey to determine the impact on practice expense.

Question: *At the University of Wisconsin Hospitals and Clinics where I am director of oncology at the cancer center, the hospital has purchased its chemotherapy drugs at a lower rate than Medicare pays, and yet the hospital has lost $1 million in 2002 under the new Medicare payment rates. How can a hospital continue to lose that kind of money and have a viable cancer program?*

Also, patient access to cancer care services should not be driven to either the hospital setting or the physician practice. Access to care should be adequate for both settings.

Clapton: Chairman Tauzin would like to have cancer patients receive the best care, depending on what the clinical outcome should be and not what the reimbursement should be. In fact, reimbursement should not be the driving factor. It is incumbent upon Congress or the Bush Administration to deal with this issue. However, we need to get better data before we can design a better system and solve these problems and the issue of migration of care.

Question: *Would specific examples of data from a given institution over a year be helpful?*

Clapton: We have gotten data from some cancer centers and have been reviewing them. APC data is based on historical plans.

Question: *There is a disconnect between what the federal government does on a global basis and the needs of individual institutions, where CEOs are being pressured by their boards to keep their institution or group of programs viable.*

Clapton: An inherent problem with the prospective payment system is setting averages. The more data cancer centers can submit to the federal level the better.

Question: *What about Medicaid?*

Clapton: Within the last year, there has been a renewed focus on the Medicaid program. Medicaid covers more people than Medicare does. Chairman Tauzin plans to closely analyze Medicaid at an upcoming congressional hearing. From the physician perspective, Medicaid has always been a problematic program in terms of reimbursement, administrative burdens, and treatment. These issues will be closely analyzed to reform and improve a 1960-model health care program. We want to provide 21st century quality health care to Medicaid recipients. Congress will also look at this because our $60 billion budget deficit is primarily due to the Medicaid program.