THE ISSUES

2006 Hospital OPPS Proposed Rule

The 2006 proposed rule for the hospital outpatient prospective payment system (HOPPS) was published in the *Federal Register* on July 25. In brief, the 2006 proposed payment rate for drugs and biologicals will be average sales price (ASP) plus 6 percent, with rates updated quarterly. (See coding column on page 14.) The Centers for Medicare & Medicaid Services (CMS) is proposing to pay an additional 2 percent over ASP to cover costs of pharmacy handling and overhead. The 2 percent add-on does *not* apply to "bundled" drugs (those below the $50/day threshold) *and* radiopharmaceuticals. The Association of Community Cancer Centers (ACCC) sponsored an August 11 conference call to alert members about the details of the proposed rule. About 200 people listened in and asked questions.

A recent Congressionally mandated report ("Issues in a Modernized Medicare Program," Medicare Payment Advisory Commission, June 2005) found that handling costs for drugs, biologicals, and radiopharmaceuticals delivered in the hospital outpatient department are significant—accounting for between 26 and 28 percent of pharmacy departments' direct costs, such as labor, benefits, and supplies.

While CMS is moving in the right direction, some members of ACCC's Oncology Pharmacy Education Network (OPEN) have expressed concern that 2 percent may *not* be adequate to fund pharmacy departments' labor and benefits, space, equipment, supplies, and support contracts, all of which are associated with storage, preparation, transport, and disposal of drugs and biologicals.

In early Aug. 2005, ACCC requested that its OPEN members and Association member institutions participate in a pharmacy cost survey to help its advocacy efforts. At press time, the survey was still underway.

Please note CMS published a correction notice to the proposed HOPPS rule. According to CMS, unintentional errors resulted in publication of lower payment rates and incorrect copayment amounts. All payment rates (except those for drugs and services receiving new technology payments) will increase by 0.4 percent over the amount in the proposed rule as a result of the corrections.

Here is an overview of some of the other changes affecting hospitals:

- *Radiopharmaceutical agents.* As a temporary one-year policy for

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Payments for Physician Services Cut in 2006—Oncology Hit Hard

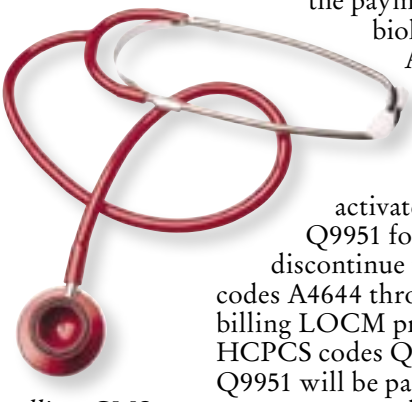
CMS proposed a 4.3 percent drop in its conversion factor for physician pay in its proposed 2006 physician fee schedule released on Aug. 1, 2005. For hematology/oncology practices that maintain their current patient volumes, CMS anticipates a 5.6 percent decrease in overall practice revenue. (CMS used a practice model with a 28 percent Medicare population in its analysis.) This 5.6 percent decrease is due to three factors: 1) the decrease in RVU values, 2) the end of the one-year *Demonstration of Improved Quality of Cancer Care for Cancer Patients Undergoing Chemotherapy* project, and 3) the end of the transitional administration payments.

In the proposed rule, CMS estimated a 2.3 percent decrease in revenue from radiation oncology based on recalculated RVU values.

The proposed rule also included several other important changes to its payment policies that directly affect physicians:

- CMS seeks comments on what services appropriately fall within the scope of a dispensing fee for inhalation drugs—suggesting that this fee will be lower than the current $57 per month.
- The supplying fee for certain Medicare Part B oral drugs is changed to a rate of $24 for the first prescription supplied during a month and $8 per prescription for any prescription, after the first one, supplied to a beneficiary during the same month by the same supplier.
- Payments are reduced for certain diagnostic imaging procedures to reflect their limited additional costs when they are performed on contiguous body parts in the same session with the patient.

ACCC is analyzing the proposed 2006 Physician Fee Schedule and its impact. The proposed rule was published in the Aug. 8, 2005, *Federal Register.* CMS will be accepting comments until Sept. 30, 2005, and will publish a final rule later this year.



2006, CMS is proposing to pay for "separately payable" radiopharmaceutical agents based on the hospital's charge for each radiopharmaceutical agent adjusted to cost.

■ *Threshold Limit/Bundling.* CMS is proposing to continue its existing policy. Drugs, biologicals, and radiopharmaceuticals costing more than $50/day will be paid separately. Payment for those costing under $50/day a day will be "bundled" into the procedures with which they are billed. Oral and injectable antiemetic products will continue to be *exempt* from CMS's packaging rule.

■ *Equitable Adjustment Policy.* In 2005, CMS applied an equitable adjustment to determine the payment rate for darbepoetin alfa (Q0137); however, for 2006, the agency is proposing to establish the payment rate for this biological using the ASP methodology.

■ *Low Osmolar Contrast Media (LOCM).* CMS is proposing to activate Q9945 through Q9951 for hospitals and discontinue the use of HCPCS codes A4644 through A4646 for billing LOCM products. In 2006 HCPCS codes Q9945 through Q9951 will be paid separately at payment rates calculated using the ASP methodology.

■ *Evaluation and management (E&M) services.* Rather than adopting guidelines developed by the AHA/AHIMA expert panel, CMS announced the development of a public listserv. CMS anticipates providing 6 to 12 months notice prior to implementing new E&M guidelines.

■ *Multiple diagnostic imaging procedures.* In 2006, CMS is proposing a 50 percent reduction in the payments for some second and subsequent imaging procedures performed within "identified families." The multiple imaging procedure reduction would apply only to individual services described by codes within one family, not across families. Reductions would apply when more than one procedure within the family is performed on a contiguous body part in the same session. Full payment would be made for the procedure with the highest APC payment rate, and payment at 50 percent of the applicable APC payment rate for every additional procedure, when performed in the same session.

Comments were accepted until Friday, Sept. 16, 2005, and a final rule is scheduled to be published by Nov. 1, 2005.

CAP Implementation Delayed Until July 2006

Scheduled to be implemented Jan. 1, 2006, CMS has since pushed back the implementation date of the Competitive Acquisition Program (CAP) until July 2006, and suspended the current CAP vendor bidding process. According to a CMS press release, the agency issued the suspension in an effort to "give potential vendors the opportunity to more fully assess participation in the CAP program and participate as effectively as possible." CMS restated its intention to release a final rule at the end of the year, and to restart the vendor bidding process shortly after that. Vendor bids will most likely be due no earlier than 30 days after publication of the final rule. A FAQ sheet is available at *http://www.cms.hhs.gov/providers/drugs/compbid/capquestions081005.pdf*

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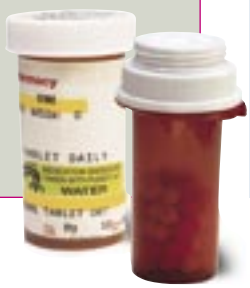
Hospital Inpatient Payments to Increase 3.7 Percent in 2006

In the final rule released Aug. 1, 2005, CMS has increased payments to Medicare's inpatient prospective payment system by an average 3.7 percent. The increase is 0.5 percent above the market basket CMS projected in the proposed rule released in May. Hospitals failing to report health outcome data will only see a 3.3 payment increase as mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). The final rule is available at: *www.cms.hhs.gov/providers/hipps/cms-1500f.pdf.*



ACCC Releases its 2005 Cancer Program Administrator Survey

In May 2005, ACCC sent an email survey to cancer program administrators employed at ACCC-member institutions. Approximately 25 percent provided data for this benchmarking study. In brief, here's what respondents said:

- 70 percent have been in their position for 5 or more years—up from 57 percent in ACCC's 2003 survey.
- 72 percent have attained a Master's degree and 14 percent hold three or more academic degrees.
- 44 percent are licensed as registered nurses.
- 60 percent report that they were already on staff when they applied for the position or were approached by management—up from 47 percent in 2003.
- Overall, financial responsibilities were ranked higher than any other category.
- Average total salary is $109,900—up from $97,600 in 2003.

The full survey is available to all ACCC members. Just log onto *www.accc-cancer.org* and click the link for "Member Login."

ONCOLOGY Q&A 2006 HOPPS Proposed Rule

by Linda Gledhill, MHA

PHOTOGRAPH/COMSTOCK

Q *What will anti-cancer drugs be paid in 2006?*

A In 2006, the Centers for Medicare & Medicaid Services (CMS) has proposed to set the payment for drugs and biologicals—including single-indication orphan drugs—at average sales price (ASP) plus 6 percent. The rate will be set using fourth quarter 2004 data and will be updated quarterly. When no ASP data is available, CMS will use the mean costs from 2004 hospital claims data. CMS has no ASP data on radiopharmaceuticals, so it will use 2004 claims data to determine payment for these agents.

Q *How will drugs without HCPCS codes be reimbursed?*

A Drugs that have not been assigned a HCPCS code will continue to be billed using C9399 (unclassified drug or biological) and the National Drug Code (NDC) number. The rule proposes to pay these drugs at 95 percent of average wholesale price (AWP).

Q *Which oncology drugs are exempt from the $50/day threshold limit?*

A The following oral and injectible anti-emetic drugs are exempt from the "bundling" rule:

- J2405 Ondansetron HCl inj.
- Q0179 Ondansetron HCl 8 mg oral
- Q0180 Dolasetron oral
- J1260 Dolasetron inj.
- J1626 Granisetron HC1 inj.
- Q0166 Granisetron HCl 1 mg oral
- J2469 Palonosetron HCl.

Q *Which oncology drugs are affected by changes in pass-through status?*

A Three common oncology drugs will no longer receive pass-through payments as of Dec. 31, 2005. These are Bortezomib inj. (J9041); Oxaliplatin (C9205), and Palonosetron HCl (J2469). Two common oncology drugs will continue to receive pass-through payment until the end of 2006: Bevacizumab (J9035) and Cetuximab (J9055).

Q *How will pharmacy costs and drug handling costs be reimbursed in 2006?*

A For 2006, CMS proposes paying 2 percent of ASP for separately-paid drugs (see page 10) until sufficient data can be accumulated to determine handling and overhead costs. To gather the necessary data, CMS has proposed three separate categories for billing pharmacy handling and drug overhead charges: Category 1 for oral drugs, Category 2 for injections and single or compounded IV preparations, and Category 3 for agents requiring special handling and cytotoxic agents. HCPCS codes were *not* assigned to these categories in the proposed rule. The data collected will be used to set payment rates for 2008.

Q *Is it true there will be new drug administration codes in 2006?*

A Yes. In 2006, both hospital outpatient departments *and* physician offices will be using new CPT codes to bill for administration of therapeutic and chemotherapy services. While these codes have not been determined, these new codes will require a crosswalk from the current CPT codes to the new codes when billing administration services.

Q *What is the proposed conversion rate for 2006?*

A The conversion rate proposed for 2006 is $59.35. Under the Ambulatory Payment Classification (APC) payment methodology, each payment is based on Relative Value Units (RVUs). The conversion rate is equal to 1.0 RVU. To calculate a payment rate, you multiply the conversion rates times the number of RVUs assigned to each service. The proposed payment rates are also listed in Addendum A and B in the proposed rule.

Q *What does the proposed 2006 HOPPS rule say about outlier payments?*

A Outlier payments are calculated using a multiple of cost and a fixed dollar amount. To qualify for an outlier payment, CMS has proposed that the cost of providing a service must exceed 1.75 times the APC payment rate and in addition, must have a fixed dollar amount of at least $1,575.

Q *What does the proposed rule say about clinic visits?*

A CMS continues to work on developing guidelines for facility clinic visits.

Q *How will observation services be paid in 2006?*

A For 2006, CMS will continue to pay separately for observation services if the patient diagnosis is congestive heart failure, chest pain, or asthma. They will package all other observation services. In 2006 the new status indicators will be "M" (not payable under HOPPS) and"Q" (packaged service subject to separate payment).

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