THE ISSUES

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From CACs to MACs

"A silent revolution is underway in how Medicare is administered in the states," said John V. Cox, DO, chair of ASCO's Clinical Practice Committee, speaking at the 14th Annual Oncology Presidents' Retreat (for more, see page 42).

In 2006, CMS began re-organizing the administrative structure for Medicare's fee-for-service programs. Through Medicare contracting reform, CMS will integrate the administration of Medicare Parts A and B fee-for-service benefits to new entities called Medicare Administrative Contractors. State Carrier Advisory Committees (CACs) may be subsumed by these new MACs, which are organized geographically by multistate regions. The aim is to integrate Medicare Part A fiscal intermediaries (FIs) and Part B carriers so that one group will adjudicate *all* Medicare fee-for-service claims that come from Part A and Part B. The administrative structure is to be transitioned into place in stages, starting in 2005 and ending in 2011. Twenty-three MACs, 15 of which primarily service Part A/B (see Table 1), will be awarded through a competitive bidding process. Four specialty MACs will service durable medical equipment (see Table 2) and four will service home care and hospice benefits.

"Although the goal is to increase organization efficiencies and, thereby, save money, the risk is that services may not be adequately coordinated across service areas," said Mary Lou Bowers, MBA, vice president of ELM Consulting. "Every region has different policies, and no one knows exactly *how* these different polices will be merged or brought together."

"There are a number of risks involved in this new process, including coordinating services across different geographical areas," continued Bowers. "But perhaps the most concerning change is the lack of a defined structure for physician input into medical decision making."

Bowers went on to say that these changes are "a big deal" for hospitals because they will no longer be able select their fiscal intermediaries. In addition, the final rule does not mention what role (if any) the existing CACs or the carrier medical directors will play. In its Request for Proposal (RFP), CMS makes no mention of a medical director; the

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Table 1: Proposed Roll-out of MACs

Jurisdiction	Included States	RFP Released	Contract Awarded
1	CA, HI, NV	Sept. 2006	Sept. 2007
2	AK, ID, OR, WA	Sept. 2006	Sept. 2007
3	AZ, MT, ND, SD, UT, WY	Sept. 2005	June 2006
4	CO, NM, OK, TX	Sept. 2006	Sept. 2007
5	IA, KS, MO, NE	Sept. 2006	Sept. 2007
6	IL, MN, WI	Sept. 2007	Sept. 2008
7	AR, LA, MI	Sept. 2006	Sept. 2007
8	IN, MI	Sept. 2007	Sept. 2008
9	FL, Puerto Rico, U.S. Virgin Islands	Sept. 2007	Sept. 2008
10	AL, GA, TN	Sept. 2007	Sept. 2008
11	NC, SC, VA, WV	Sept. 2007	Sept. 2008
12	DE, DC, MD, NJ, PA	Sept. 2006	Sept. 2007
13	CT, NY	Sept. 2006	Sept. 2007
14	ME, MA, NH, RI, VT	Sept. 2007	Sept. 2008
15	KY, OH	Sept. 2007	Sept. 2008

Source: Centers for Medicare & Medicaid Services. *www.cms.hhs.gov.*

Table 2: Durable Medical Equipment MACs

Jurisdiction	Included States	DME MAC
A	CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI, and VT	National Heritage Insurance Company
B	IL, IN, KY, MI, MN, OH, and WI	AdminaStar Federal
C	AL, AR, CO, FL, GA, LA, MS, NM, NC, OK, Puerto Rico, SC, TN, TX, U.S. Virgin Islands, VA, and WV	Palmetto Government Benefits Administrator
D	AK, American Samoa, AZ, CA, Guam, HI, ID, IA, KS, MO, MT, NE, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, and WY	Noridian Administrative Services

Source: Centers for Medicare & Medicaid Services. *www.cms.hhs.gov.*

agency only asks competing organizations to identify the individual who will make medical necessity coverage determinations.

As CMS's RFP only requires organizations to offer "transactional analysis," another concern is that MACs may be awarded to companies outside of the healthcare arena, such as American Express. However, the four new Durable Medical Equipment (DME) MACs, which were awarded in December and which go into effect on July 1, are all organizations with extensive healthcare experience (see Table 2).

With all of these unknowns, the oncology community will closely monitor the first primary A/B jurisdiction scheduled to be rolled out—Jurisdiction 3.

States Challenge Medicare's Part D "Clawback" Provision

California and four other states plan to file a lawsuit against the new Medicare Part D drug program, announced California Attorney General Bill Lockyer on Feb. 1. (The four other states have since been identified as Kentucky, New Jersey, Missouri, and Texas.) Specifically, the lawsuit is challenging the so-called "clawback" provision of the federal law, which requires states to pay the federal government a portion of the state's estimated savings under the new prescription drug plan.

Under the "clawback" provision of the drug benefit, Medicare will assume the prescription drug costs for dual eligibles, but states will have to pay the federal government as much as 90 percent of the estimated amount they would have spent on Medicaid coverage for dual eligibles. (This rate will decrease to 75 percent over time.)

The lawsuit alleges that the federal government is overbilling states for drug costs because of flaws in the formula for calculating the payments, reported the *Los Angeles Times* on Feb. 2, 2006. The *Los Angeles Times* article went on to say that, "Congress had assured states that the new program would lower their costs of providing drug coverage by 10 percent, [California] state officials estimate that, by the middle of next year, California will have paid $161 million more than it would have under the old system."

Lockyer is expected to appeal directly to the U.S. Supreme Court.

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MedPAC Recommends Continued Payment Cuts for Hospitals, 2.8 Percent Hike for Physicians in 2007

During its Jan. 10, 2006, public meeting, the Medicare Payment Advisory Commission (MedPAC) recommended continued Medicare payments cuts in fiscal year 2007 for hospital outpatient departments (HOPD), while physicians would receive a 2.8 percent increase in the FY 2007 update. The recommendations will appear in MedPACs 2007 March report to Congress.

Currently, hospitals are scheduled to receive the full market basket increase of 3.4 percent for FY 2007. However, MedPAC's recommended payment update for dialysis services and the hospital inpatient and outpatient prospective payment system (HOPPS) would equal the projected increase in the market basket minus 0.45 percent, or 2.95 percent. This would reduce HOPD payments by $50-200 million in FY 2007 and under $1 billion over five years.

Despite forecasted 2006 Medicare margins of -2.2 percent in 2006, MedPAC's analysts suggested that continued beneficiary access to care, increases in volumes of services, satisfactory quality of care, and continued hospital access to capital indicate that Medicare payments to hospitals are generally adequate.

The recommended update for physician services would increase Medicare spending by less than $1.5 billion in FY 2007 and $5 billion to 10 billion over five years.

MedPAC commissioners also approved a recommendation that would require the Secretary of the Department of Health and Human Services (HHS) to establish an expert panel to identify overvalued physician services and review recommendations from the Relative Value Scale Update Committee (RUC) of the American Medical Association. The RUC makes determinations on the values of physician services, known as relative value units (RVUs).

HHS would be required to consult the expert panel and initiate the five-year review of services that have experienced substantial changes in lengths of stay, site of service, volume, expense, and other factors that may indicate changes in physician work. Some new physician services also would be referred to the RUC for review as soon as practicable and not postponed until the next five-year review. To ensure the validity of the physician fee schedule, all services should be reviewed periodically, the recommendations stated.

MedPAC's analysts also issued a critical overview of the payment problems associated with the sustainable growth rate (SGR). SGR is a cumulative target for Medicare spending growth over time and is widely cited as the cause of scheduled cuts in physician payments over the next several years. According to Jennifer Podulka, a MedPAC analyst, SGR is a "one size fits all" method that treats all physician specialties and volume increases the same and creates little incentive for individual physicians to control volume.

Instead, the analysts suggested applying SGR to smaller target pools could be more effective. Examples cited included differentiating between geographic regions, types of services, membership in both organized group practices and hospital medical staffs, and physicians who are "outliers" in terms of volume, possibly due to the health conditions of their patients.

The pending budget reconciliation legislation (S.1932) would require MedPAC to submit a report to Congress on alternative mechanisms by March 2007.

ISSUES

Coding For Hospitals

From APC to ASP: Coping with the Change

by Barbara Constable, RN, MBA

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In 2006, drug reimbursement in the hospital setting moved from the Ambulatory Payment Classification (APC) payment system to the Average Sales Price (ASP) payment system. Under ASP, your hospital could potentially see some payment reductions this year. To help mitigate the harm to your bottom line, your cancer program must know:

- The cost of your drugs compared with your reimbursement rate
- Whether you are billing for drug waste
- That your drug formulary is current
- That your codes are up to date with the code changes for CY 2006
- If your formulary units correlate with billing units.

The start of a new year—especially one that brings such change—is a prime opportunity for administrators and pharmacists to review their drug formularies, including drug acquisition costs and reimbursement payments. To help you get started, Tables 1 and 2 compare 2005 APC drug payment rates to 2006 ASP +6 percent drug payment rates. While some drugs are now paid more in 2006, the dollar losses for other drugs will have a significant effect on hospital-based cancer programs.

Billing is another area where hospitals could face significant losses. Incorrect billing units on drug formularies, claim denials because new drug codes were not updated, and not reporting for drug waste can add up to large losses for hospital-based cancer programs. In the final HOPPS rule, Table 25 lists all drugs, biologicals, and radiopharmaceuticals with temporary C-codes that have been deleted and replaced with permanent Healthcare Common Procedure Coding System (HCPCS) codes for CY2006. For example, starting Jan. 1, 2006, the old code for paclitaxel protein-bound particles, 1 mg (Abraxane inj, C9127) was replaced by HCPCS code J9264. A regular review of your drug formulary will protect and perhaps even improve your bottom line.

Barbara Constable, RN, MBA, is a consultant for ELM Services, Inc., in Rockville, Md.

Table 1: Anticancer Drugs with Reduced Payment Rates

Drug Name	APC Payment	ASP + 6 Payment	Difference (Dollars)	Difference (Percentage)
Aredia® (pamidronate inj.)	$128.74	$40.63	-$88.11	-68%
Neulasta® (pegfilgrastim)	$2448.50	$2078.07	-$370.43	-15%
Paraplatin® (carboplatin)	$129.96	$35.25	-$94.71	-73%
Zoladex® (goserelin acetate)	$390.09	$175.04	-$215.05	-55%
Lupron® (leuprolide acetate)	$543.72	$224.42	-$319.30	-59%

Table 2: Anticancer Drugs with Increased Payment Rates

Drug Name	APC Payment	ASP + 6 Payment	Difference (Dollars)	Difference (Percentage)
Argatroban	$12.45	$40.62	+$28.17	326%
Ethyol® (amifostine)	$395.75	$439.31	+$43.56	11%
Doxil® (doxorubicin hydrochloride)	$343.78	$364.53	+$20.75	6%
Rituxan® (rituximab)	$437.83	$455.92	+ $18.09	4%
Hycamtin® (topotecan hydrochloride)	$697.76	$763.80	+$66.04	9%

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Coding For Practices CAP is Coming...

by Barbara Constable, RN, MBA

Medicare's competitive acquisition program (CAP) is a voluntary program for physician practices mandated under the Medicare Modernization Act of 2003 (MMA). Physicians who elect to participate in CAP will acquire their anticancer drugs from vendors selected by CMS in a competitive bidding process. Practices that choose to participate in CAP will *not* purchase and bill for any anticancer drugs under the current average sales price (ASP) methodology. Instead, CAP participating physicians will acquire their anticancer drugs from CAP vendors. The CAP vendors will bill Medicare for the administered drug and bill the beneficiary for any applicable co-payment or deductible. Each year, physician practices will elect to participate in the CAP program for a 12-month period. The CAP enrollment period will be from Oct. 1 to Nov. 15, with the program starting on Jan. 1 of the following year.

Because of last year's decision to push back implementation of the CAP program, 2006 offers physician practices a unique opportunity—two enrollment periods. While CMS has yet to announce a firm date, the first enrollment period is likely to be in the spring of 2006. Physicians who enroll during this time will begin participating in CAP on July, 1, 2006. The second enrollment period is likely to be in Nov. 2006 for a Jan. 1, 2007, start date. Physician practices that are uncertain about whether to participate in CAP can adopt a "wait and see approach" and see how their colleagues fare under this new system.

Physicians who elect to participate in the first enrollment period will enroll for six-months (July to December 2006.) These physicians must complete a participating CAP physician's election agreement and abide by the following requirements:

- Share information with vendors to facilitate deductible and coinsurance collection
- Promptly file drug administration claims
- Promptly pursue claims that are denied for lack of medical necessity
- Accept assignment for CAP drug administration claims
- Notify the vendor when a drug is not administered
- Agree to comply with emergency drug replacement rules
- Agree to requirements for using "furnish as written" provisions
- Maintain an inventory record for each CAP drug
- Support approved CAP vendors during administrative appeals of drug administration claim denials.

Coinsurance Payments, Collections, and Vendors Withholding Drugs?

Eighty percent of Medicare recipients have supplemental insurance that covers their coinsurance payment, but exactly *who* is responsible for collection of this coinsurance? In its final rule, CMS stated that coinsurance collection is the responsibility of the vendor; however, physicians may voluntarily enter into an arrangement with CAP vendors to collect coinsurance and deductibles on their behalf *if* the arrangement complies with applicable laws.

Physicians are particularly concerned about what happens if the coinsurance requirements are *not* met. CMS has established a 45-day window after the patient receives the bill for vendors to receive payment *before* vendors can refuse to send medications to cover the treatment plan. CMS also changed the language in Section 414.914 to state that "approved CAP vendors *must* inform beneficiaries" on sources of coinsurance assistance instead of the patient needing to request this information. Once a patient is referred for assistance, vendors must wait an *additional* 15-day grace period before stopping delivery of medications. If the vendor withholds patient medication, CMS stated it is the responsibility of the CAP vendor to notify the beneficiary about the withholding of medications, and the physician needs only to direct the patient to the vendor grievance process when necessary.

Should the CAP vendor refuse to make further drug shipments for that patient, physicians can opt out of that particular drug category within the CAP program. Physicians should know that the initial CAP program has only *one* drug category. This means that physicians who opt out of that one drug category would be opting out from the *entire* CAP program for the remainder of their agreement period. Physicians are required to immediately notify CMS and the CAP vendor if they are planning to opt out of the CAP program.

Another area of physician concern is whether CAP vendors will attempt to "dictate" the medications prescribed in treatment plans. If a medication is medically necessary and is *not* furnished by the CAP vendor then the "furnish as written" option allows physicians to obtain the drug and bill Medicare. Physicians will use the "furnish as written modifier" (J3) and bill for the drug under the ASP system. Physicians that use the "furnish as written" option must document the medical necessity in the patient record.

Additional CAP information can be found online at: *http://www.cms.hhs.gov/CompetitiveAcquisforBios/Downloads/pfs112105fr.pdf*. Approved CAP drugs are listed in Addendum F, "Revised Single Drug Category List."

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