ACCC's 32nd Annual National Meeting Opens with Special Pre-Conference on Medicare Part D

More than 500 people attended the Association of Community Cancer Centers' (ACCC) 32nd Annual National Meeting, *Strategies & Tools for Quality Care*, March 14-17, 2006, in Arlington, Va. The meeting was preceded by a special pre-conference on Medicare Part D, held March 14.

"Medicare beneficiaries will look to providers for assistance in selecting the appropriate plan and navigating the appeals process," said presenter Loreen M. Brown, MSW. "Beneficiaries should be directed to use the resources and support services being provided through Medicare and other organizations."

Beneficiaries face a bewildering variety and number of Part D plan choices. There are 86 organizations offering stand-alone plans, most using four or more tiers. Washington, D.C., alone, for example, offers seniors 47 options. Those options increase when you add in Medicare Advantage plans. Florida alone has 43 prescription drug plans and another 257 Medicare Advantage plans.

Brown cautioned that some CMS resources may not always have the most up-to-date information. For example, the Medicare Prescription Drug Plan Finder does not always have a plan's complete list of covered drugs. "Start with this CMS tool, then go to the individual plan's website, and finally call the plan to double-check that it actually does cover the drug in question."

Most Part D Plans are not offering coverage in the 'donut hole', according to presenter Liz Fowler of Health Policy Alternatives. "About 6.9 million out of 29 million beneficiaries could experience out-of-pocket spending in the donut hole," she said. The donut hole refers to coverage under the

continued on page 10

NCI, FDA Must Change, Says von Eschenbach

ACCC keynote Speaker Andrew von Eschenbach, MD, director of the National Cancer Institute (NCI) and newly-nominated U.S. Food and Drug Administration (FDA), Commissioner addressed attendees at ACCC's 32nd Annual National Meeting on March 15, providing an inspirational vision of the future of cancer care.

"A metamorphosis is underway in the fields of biomedical research and medicine from the macroscopic and microscopic to a molecular perspective," said von Eschenbach.

"For the first time we are able to begin to not only perceive, but understand, a disease like cancer and other diseases based on the genetic and molecular mechanisms that are responsible for those diseases. That transition… is so profound that it is truly a metamorphosis," he said.

Dr. von Eschenbach emphasized that the metamorphosis he described, would not happen without hard work and willingness to change.

"Now we are going to have to come to grips with the fact that NCI has to change, FDA has to change, the community has to change, CMS has to change. We have to change because we don't have any choice," he said.

"A molecular metamorphosis in oncology provides the opportunity to understand cancer at the very fundamental genetic and molecular level. It is a process that will also likely lead to the transformation of health and healthcare across the discovery, development, and delivery continuum," von Eschenbach said.

With keynote speaker Andrew von Eschenbach, MD, (center) are ACCC Executive Director Christian Downs, JD, MHA, (left) and former ACCC President E. Strode Weaver, FACHE, MBA, MHSA.

He described a near-future era of medicine in which the opportunities to understand and intervene with the disease process will "enable us to make medicine and oncology personalized, predictive, preemptive, and ...participatory." These transformational changes will affect not just how we deal with cancer, but the systems that will need to be put into place to support this new era in medicine and healthcare.

Responding to audience questions, von Eschenbach acknowledged that the transformations he described are occurring incrementally. When asked about hurdles to greater involvement in the process at the community level, in particular due to increased bureaucracy and paperwork barriers, von Eschenbach indicated that it might be time to re-visit HIPAA and some of the bureaucratic issues related to reimbursement.

standard benefit in which the patient pays 100 percent of the cost of a drug from $2,251 to $5,100, after which there is 5 percent co-insurance (for $5,100 and beyond).

Congress and the Centers for Medicare & Medicaid Services (CMS) are under pressure to fix Part D on the beneficiary side, according to Fowler. Congress is considering a number of Part D changes. "The Part D enrollment period could be extended beyond May 15, 2006," she said. Congress may also have to increase protections for beneficiaries with regard to formularies, cost-management tools, pharmacy access, exceptions/appeals, and transparency. "There is a great need for simplification," said Fowler.

continued on page 12

Expert Panel Discusses How New Regulatory Policies are Affecting Cancer Economics and Quality Care

One focus of ACCC's 32nd Annual National Meeting was on the effects that new regulatory policies are having on cancer economics and delivery of quality cancer care at both hospitals and oncology practices. Participants at a special panel that looked at cancer economics included Albert B. Einstein, Jr., MD, Executive Director, Swedish Cancer Institute; ACCC Executive Director Christian Downs, JD, MHA; Tom Gallo, MS, Executive Director, Virginia Cancer Institute; and Deborah Walter, MPA, former ACCC Senior Director, Policy and Government Affairs.

"For hospital-based cancer programs, chemotherapy and drug reimbursement continue to be our biggest issue," said presenter Albert B. Einstein, Jr., MD. Specifically, CMS's decision to take away the 2 percent add-on payment for pharmacy costs in the 2006 final rule. After looking at 2004 claims data, CMS decided that ASP +6 percent was adequate, and that pharmacy costs are, in fact, included with hospital charges. This move was particularly surprising coming after Medicare's APC Advisory Panel, which recommended a 2 percent add-on was the "minimum" amount needed to adequately reimburse hospitals for pharmacy handling and waste. Several studies have found pharmacy costs to be as much as 30 percent of total drug costs.

Deborah Walter, MPA, also voiced concern about declining reimbursement from CMS.

Pictured with ACCC's Executive Director Christian Downs, JD, MHA, (standing) are "Cancer Economics & Delivery in 2006" panelists (front row) Albert Einstein, Jr., MD, Tom Gallo, MS, and Deborah Walter, MPA.

"For the 115 most commonly used cancer drugs, hospitals are losing $200 million to $250 million under the 2006 Final OPPS Rule," said Walter.

ACCC has led stakeholder discussions to help the oncology community speak as one voice to raise awareness among legislators and CMS that an add-on payment for pharmacy costs is imperative. "ACCC continues its advocacy efforts on behalf of its hospital members, attending congressional committee and White House meetings," said Walter.

The economics of cancer care in the oncology practice setting is also troubling.

"In 2005 average reimbursement in my practice was down 14 percent. Of 13 breast cancer regimens, our practice saw an average 17 percent [Medicare reimbursement] decline in 2005 versus 2004," said presenter Tom Gallo. "Of 9 lung cancer regimens, there was an average 5 percent decline in reimbursement." At the same time Gallo saw his expenses climbing steadily. From 2000 to 2005 malpractice insurance expenses increased 249 percent; health insurance, 74 percent; rent, 58 percent; and payroll 35 percent. The Medicare conversion factor increased just 4 percent over the same time period.

Gallo advised practices to focus on practice efficiency, service line diversification, cost containment, and zero bad debt tolerance. "And be more selective in your private practice contracting," he said.

Declining reimbursements in oncology practices may be having an effect on hospital cancer care. "Physicians are already sending some patients and regimens to hospitals for infusion," concluded Einstein. "This may increase if reimbursement continues to decline."

Turn to page 12 for more on ACCC's 32nd Annual National Meeting.

Highlights from ACCC's 32nd Annual National Meeting

On Wednesday, March 15, ACCC presented its new Community Clinical Scientist Awards to James N. Atkins, MD, clinical associate professor at Wake Forest University School of Medicine in Winston-Salem, N.C.; Luis Baez-Diaz, MD, FACP, of the San Juan VA Hospital in San Juan, Puerto Rico; and Lee B. Riley, MD, PhD, FACS; of St. Luke's Hospital & Health Network in Bethlehem, Pa. The three award winners are now lifetime members of ACCC's National Academy of Community Oncology Scientists. For more information on the award recipients, log onto *www.accc-cancer.org* and go to ACCC Media Room. Interested in submitting a nomination for the Community Clinical Scientist Awards? Contact Diana Lees at *dlees@accc-cancer.org.*

Regulatory Update

A standing-room only audience listened to Peter Bach, MD, MAPP, special assistant to CMS Administrator Mark McClellan, MD, PhD, who briefed attendees about findings to date of the 2005 Oncology Demonstration Project. The oncology demonstration "had extraordinary high participation" and showed that "doctors can use G-codes to submit quality-related information," according to Bach.

CMS learned that the scope of measurement can be broader. "We can use claims systems for quality measurement," said Bach. "However, focusing on chemotherapy alone may be too limiting. We put on blinders to everything else that happens." That's why in 2006 CMS "delinked the demonstration from chemotherapy to E&M visits," according to Bach.

Bach also spoke on the need for longitudinal data, which will lead to an understanding of disease/treatment patterns, help benchmark efficiencies, and build the groundwork for estimating prospective costs for disease management.

On Friday, March 17, outgoing ACCC President E. Strode Weaver, FACHE, MBA, MHSA, presented ACCC's Annual Achievement Award to H. Lee Moffitt for his long-standing dedication and commitment to ensuring patient access to high-quality cancer care.

At this same session, CMS Deputy Director Tamara Syrek Jensen, JD, Coverage and Analysis Group, discussed trends in evidence development. Jensen said that the second draft of the CED guidance document, "in which we will be more clear about our intent," should be available in spring or summer 2006. It had been due out in winter 2006. The initial CED draft guidance was issued in April 2005.

An expert panel presented on key new technologies and answered questions about how community cancer centers can afford to invest in cutting-edge treatment options. Afternoon breakout sessions provided more in-depth discussion of each new technology and issues surrounding adoption of the technology for community cancer centers.

Jensen acknowledged that a second iteration of the guidance has been delayed as the agency tries to remedy "some of the mistakes we made in the last year on CED." The revised draft guidance will "fit better" within the agency's policies regarding Part B national coverage determinations, according to Jensen, who also noted that CED will be used when Medicare coverage would otherwise be denied.

Patient Advocate Focus: Lung Cancer Alliance

The Lung Cancer Alliance is dedicated to patient support and advocacy for people living with lung cancer and those at risk for the disease. Its initiatives aim to educate public policy leaders of the need for greater resources for lung cancer research while changing the face of lung cancer and reducing the stigma associated with the disease.

This year the Lung Cancer Alliance issued its first "Report Card on Lung Cancer," which graded seven categories, such as number of deaths, five-year survival rate, and the number of new treatment and diagnostic options in the last 30 years. The majority of grades received were failing. The report card is available online at *www.lungcanceralliance.org.*

Other programs include the Lung Cancer Hotline (800.298.2436); the Phone Buddy program; a peer-to-peer support network; Lung Cancer Awareness Month; a quarterly newsletter; and advocacy alerts about important lung cancer issues.

PHOTOGRAPH/GETTY IMAGES

Update: **Competitive Acquisition Program**

by Linda Gledhill, MHA

In 2006, private physician practices have the opportunity to participate in the Competitive Acquisition Program (CAP). Developed by the Centers for Medicare & Medicaid (CMS), CAP eliminates the need for practices to purchase Part B drugs for Medicare beneficiaries by designating a specific pharmaceutical vendor that will supply Part B drugs to participating practices. Participating practices will continue to submit claims for *all* services, including the administration of drugs and the drugs themselves. Practices will attach a modifier to the drug code indicating that the drug administered was supplied by CMS through the CAP program. This new claims process allows the vendor and CMS to reconcile the drugs that were supplied to the physician's office with the invoice CMS received from the vendor.

Q. *Is CAP participation mandatory for all Medicare providers?*

A. No. Interested physician practices must complete an election agreement by May 18, 2006. The agreement goes into effect on July 3, 2006. With a few exceptions, physician CAP election is for a one year period. In the fall, vendor and drug lists will be posted again for practices that would like to participate in CAP starting January 1, 2007.

Q. *If a physician practice elects to participate in CAP this year, and then decides not to participate next year, can it return to billing for drugs and being reimbursed at average sales price (ASP)+6 percent?*

A. Yes. Physician office contracts are renewed each year; however, this year practices have the option to participate for only half a year (from July-December). If a practice decides *not* to continue CAP participation, it would simply not complete the election agreement for the following year.

There are exceptions for getting out of the CAP prior to the end of contract cycle, including when a vendor refuses to supply drugs to a patient—usually because of unpaid claims. For more information about these situations, see "CAP is Coming" on page 14, March/April 2006 *Oncology Issues*.

Q. *How do practices file a claim for a drug supplied by the CAP program?*

A. Three modifiers have been created to indicate a drug administered was supplied by the CAP program:

- J1 (CAP drug, no-pay submission)
- J2 (CAP drug, restocking emergency drug)
- J3 (CAP drug not available as written. Reimburse under ASP.)

When a beneficiary receives a drug ordered through the CAP program, the billing must include the HCPCS code for that drug, as well as the attached J1 modifier.

Practices will use the J2 modifier in two circumstances: when an existing drug supply is used by the physician in an emergency situation or when the drug use could not be anticipated in advance. The practice will then order a drug to restock the existing supply and bill for the restocked drug. When the J2 modifier is used, a J1 modifier must also be used in the first modifier position.

The use of the J3 modifier tells CMS that the drug administered was not available through the CAP program and should be reimbursed through Part B at ASP+6 percent. These drugs are referred to as "furnish as written."

Q. *How should practices code for the waste from a single dose vial supplied through the CAP program?*

A. As mandated by CMS, when a portion of a single dose vial is *not* used, practices will attach the JW modifier together with the J1 modifier (CAP supplied drug).

Q. *What is the Prescription Order Number and must it be included on claims containing CAP supplied drugs?*

A. The Prescription Order Number is assigned by the CAP vendor and consists of the vendor ID number, the HCPCS code for the drug, and the vendor controlled prescription number. Any claim submitted with a J1 modifier (CAP drug) must also include the prescription number. Claims that do not include *both* the modifier and the prescription number will be denied as "not able to process."

Q. *Will the CAP program supply all drugs used for Medicare beneficiaries?*

A. This answer depends on the formulary you use for each patient. According to CMS, some drugs may be excluded from CAP because they will not have a significant savings to the program or because they may impact patient access. CMS published a list of the drugs that are included in the CAP program in Addendum A of the Competitive Acquisition Program Interim Final Rule, 42 CFR Part 414.

Q. *How many CAP vendors are there, and how often will they have to submit an application to become a CAP vendor?*

A. Currently, between two and five national vendors will be providing CAP services to physician practices. Their contracts will run for three years. To date, BioScrip has been the only vendor name published.

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