ANNUAL MEETING HIGHLIGHTS: QUALITY VERSUS REIMBURSEMENT... AND OTHER CONUNDRUMS

ACCC Election Results

During the ACCC 15th National Meeting, newly elected board members and board officers were announced. Rodger Winn, M.D., University of Texas, M. D. Anderson Hospital and Tumor Institute, Houston, TX, and Thomas Sawyer, M.D., Orlando (FL) Regional Medical Center, were elected to two-year terms on the ACCC board of trustees. Re-elected board members include Marsha Fountain, The Regional Cancer Center, Springfield, IL; Albert Einstein, Jr., M.D., Virginia Mason Medical Center, Seattle, WA; and James Ungerleider, M.D., St. Elizabeth Medical Center, Dayton, OH.

Board officers for 1989-90 are as follows: Irvin Fleming, M.D., Methodist Hospitals of Memphis (TN), President; Jennifer Guy, St. Anthony's Medical Center, Columbus, OH, President-Elect; Robert Clarke, Memorial Medical Center, Springfield, IL, Treasurer; and Lloyd Everson, M.D., Indiana Regional Cancer Center, Indianapolis, Secretary.

New board members Rodger J. Winn, M.D., (left) and Thomas G. Sawyer, M.D.

1989–90 ACCC Officers...

A CCOP Update

The Request For Applications (RFA) for Community Clinical Cancer Programs (CCOPs) will be issued by NCI between May 1 and May 15, according to Leslie Ford, M.D., Division of cancer Prevention and Control, NCI. Letters of intent will be due on June 15, and grant approvals will be released on August 18.

Ford said the NCI will be utilizing the CCOP network for DCPC research by "increasing participation in DCPC cancer control studies, increasing CCOP access to cancer control protocols, and strengthening NCI's commitment to cancer control clinical trials." She maintained that they will have the "protocols necessary for CCOPs to participate in and to support the accrual of 50 credits per year to cancer control trials," which is equal to the minimum credits required for a treatment research protocol.

Finally, in reference to the establishment of CCOP as an ongoing NCI program, Ford said that the change does not "guarantee" budget levels, but provides the "flexibility to reallocate funds when programs are performing poorly, and it encourages the investment of community resources in CCOPs."

Broder Calls for Honest Dialogue with the Public

"We need to tell the public that there is good and bad news in the detection, prevention, and treatment of cancer," said Samuel Broder, M.D., director of the National Cancer Institute (NCI). Broder, the keynote speaker at the ACCC Awards Luncheon, said that "the public is growing impatient, and its representatives in Congress are asking pointed questions," about advances in cancer treatment. "If we overstate the good news to the exclusion of the bad, or allow the bad news to overshadow how far we have come, we will be in trouble," Broder warned.

Samuel Broder, M.D., *NCI Director, delivered the keynote address at the ACCCC Awards Luncheon.*

Broder had specific examples of how cancer care providers and researchers need to improve communications with the public. For instance, he said, "we need to be careful about the use of the word 'breakthrough,' which means something different to us than it does to the public. The public is hungry for a breakthrough, but I don't believe that incremental advances and breakthroughs compete with each other." However, "we need to know how incremental advances translate into significant treatment advances." And, he said, we need to educate Congress and the public on how basic science and clinical research can and should interact with each other. "Nothing stimulates basic science more than an effective clinical trial."

Another issue that Broder addressed was the use of the term "experimental," which, in NCI's view, is misleading. "In the 1950s and 1960s," Broder pointed out, "experimental was a code word for dan-

gerous therapy. The term carries baggage that we haven't totally eliminated," he contended. And it still carries "more negative than positive connotations when, the fact is, it's the only hope for survival and better treatment."

Congress must understand that "we can't wait for differences in overall end results; we need to act in the interim and improve responses," Broder maintained. "We can't talk about death rates alone; there are quality of life issues that we need to do a better job of explaining to the public." And, he said, we have to publicize mortality percentage changes for common cancers since the initiation of the National Cancer Act. Between 1973 and 1986, "annual death rates decreased for a significant number of common cancers, including colorectal (14 percent), ovarian (24 percent), bladder (30 percent) and cervical (40 percent)," Broder pointed out.

However, Broder conceded that "we are not doing as good a job with people over the age of 65," which will be an NCI priority. "We must ensure that we are not disenfranchising people on the basis of age," Broder warned. For instance, are physicians treating elderly patients as aggressively as younger age groups? Another NCI priority is to decrease mortality in minority groups. There are a number of cancers in which socioeconomic factors cannot account for increased mortality rates in minority populations, he said.

"We also must point out that many of the treatments that are having a major impact have only recently been introduced," Broder said, citing, as one obstacle, the length of time required for FDA approval of a new drug. Other issues that Broder said the NCI and cancer care providers need to address together include reimbursement. In reference to an increasing reimbursement problem—off-label indications—Broder said, "I want to get the FDA out of a reimbursement role," a role that he does not believe the FDA is "comfortable with." "We have to ensure that reimbursement policies help us and don't become impediments to clinical trials," Broder said. "I think impediments to clinical trial accrual, not the disinclination of patients or physicians are hindering people who want to be on clinical trials."

Finally, "we need to simplify new technologies and make them more cost effective," Broder said, but he also expressed concern about the lack of review of long-standing cancer treatments. As a result, "provisional FDA approval" for drugs is being discussed with FDA Commissioner, Frank Young, M.D. "We all have to keep on proving our worth, why shouldn't a drug, which was approved by the FDA 20 years ago, have to reprove its worth?"

Consultant Urges CPT Reform

Unless oncologists and the organizations that represent them unite and fight for CPT reform, "physicians could lose their ability to bill for inpatient oncology services," according to Martin Neltner, Neltner Billing & Consulting Services, Inc., Cincinnati.

"The problem is that current CPT codes for chemotherapy do not recognize a professional component," Neltner explained. He contended that "each CPT chemotherapy code has both a professional and a technical component, but most oncologists are only billing a technical fee." Neltner says it is confusing because, on the surface, a service like IV infusion looks like a technical fee, but the CPT coding is "for the physician's services, not those of the nurse or the technician." He reports that CPT chemotherapy codes have been successfully changed to reflect a professional and technical component in several states, including Ohio, Kentucky, and Michigan. If CPT coding reform is not enacted before the relative value scale system is extended to other specialties besides radiology and anesthesiology, the professional component of inpatient services will not be billable.

However, oncologists must be aware that Medicare requires that a physician be present in the office suite and immediately available when a patients is receiving chemotherapy. If the attending physician or another physician who is associated with the oncologist or contractually related to the attending physician is not present, Medicare will disallow payment for the physician's professional and technical fees.

Congress may use Part B increases to offset revenue shortfalls

Congress already knows that there will be significant revenue shortfalls for coverage of the outpatient drug benefit, according to Theodore Giovanis, Director of Health Care Industry Services, Touche Ross & Company, Washington, D.C.

Giovanis, who provided a health policy legislative update for meeting participants, said that "as premium assessment is phased in, there will have to be increases in Part B premiums to cover those shortfalls," and some members of Congress are already asking what level of increases will be needed.

In the area of long-term care, Giovanis predicted that "although two long-term care bills are expected to be introduced in Congress, the issue will not be acted on this year." The two political issues Congress will deal with are: "health care inflation, which is increasing at twice the general inflation rate, and Medicare Part A expenditures," which Giovanis predicted will be further reduced.

"There will not be any dramatic reform initiated in outpatient services," Giovanis said. However, physician payment reform will be implemented in 1990 or 1991. "Congress will try to enact reform through dramatic reductions in the size of the pie," Giovanis said. "Regulations will address both price and volume, because previous price constraints resulted in volume increases that went through the roof."

Congress will try to deal with the issue of access to care, particularly with regard to the uninsured and proposals for mandated health benefits, but "not until 1990," Giovanis contended. He believes Congress will wait to see if state and private initiatives will help and, thus, prevent a fight over mandatory health benefits in Congress.

ACCC's Reimbursement Initiatives

There are three different, major reimbursement problems that the ACCC is focusing on, according to ACCC Executive Director, Lee Mortenson.

Standard therapy. "More and more insurers are denying payment for off-label indications," Mortenson said. A major difficulty in this area is that policies differ from insurer to insurer and by location. However, Mortenson contended that smaller HMOs, PPOs, and other managed care plans must be targeted. And, he asserted, we cannot change behavior without public pressure. We have a "huge cancer population that must become as organized and vocal as the AIDS community if we are to change reimbursement policies."

New therapy. Insurers' strategy is to demand that any new indications must be approved by the FDA. "Our strategy,"

drug compendia treated as standard references for payment of new drugs and new indications."

Experimental therapy. "We must get across the point that while government is paying $3 billion for NIH research, another arm of the government (HCFA) is denying payment for clinical trial participation."

Congress Focuses on Patient Referrals

Rep. Fortney (Pete) Stark's (D-CA) "Ethics in Patient Referrals Act" has a "good shot of being passed," by Congress, according to Don Yesukaitis, Office of Federal services, Arthur Anderson & Company, Washington, DC. "Fraud and abuse in physician referrals is one of the hottest topics on Capitol Hill and across the country," Yesukaitis explained. In fact, the Inspector General of Health and Human Services is preparing a report on safe harbors in physician financing arrangements; that is, arrangements that will not be held in violation of Medicare's fraud and abuse laws. The proposed rules are due on May 1.

The revised bill that Rep. Stark introduced in February of this year is "much stricter," Yesukaitis said. "Stark is bullish on getting this bill passed, and he has the support of the Blue Cross/Blue Shield Association and the American Association of Retired Persons, as well as a number of physicians."

A key provision of the bill, according to Yesukaitis, is that a physician may not refer a Medicare patient to an entity in which that physician or a family member has an economic interest. If the bill is passed, "Stark probably would provide a transition period for existing arrangements, but has no intention to "grandfather' existing arrangements," Yesukaitis warned.

ACCC President Addresses House of Delegates

The ACCC is "dedicated to seeing that, in the present environment, we continue to provide state-of-the-art cancer care and community clinical research," said Irvin Fleming, M.D., ACCC President. To help ensure those goals, Fleming said that the Association will explore the development of patient advocacy efforts in reimbursement areas, including the possible development of a patient advocacy newsletter.

Kennedy To Reintroduce Health Bill

Sen. Edward Kennedy (D-MA) plans to reintroduce the minimum health benefits bill in April, according to Darrel Cox, Legislative Health Policy Analyst for the Committee on Labor and Human Resources of the U.S. Senate. The bill, which addresses the "growing number of uninsured," would ensure that employers provide physician and hospital services, prenatal care, diagnostic care, mental health services, and a catastrophic limit on out-of-pocket expenses," Cox explained.

Darrel Cox, Legislative Health Policy Analyst, *was the guest speaker at the ACCC Congressional Breakfast*

Two major changes in the bill that will be reintroduced are the inclusion of a public program with a 10-year phase in period that will provide access to health care for all Americans; and hardship pools that will decrease the cost of insurance for small employers (25 or fewer employees) by providing access to insurance coverage at lower rates.

Cox contended that the minimum benefits legislation will result in more "cost shifting than the reallocation of new funding." Analyses have shown that the inflationary impact of the legislation would be comparable to a 10 to 15 cent increase in the minimum wage.

Cox also said that the Committee on Labor and Human Resources of the U.S. Senate, which is chaired by Sen. Kennedy, "submitted a request for an additional one-half billion dollars for NIH funding of NCI-approved cancer centers." In addition, Cox said, construction grant legislation will be reintroduced within the next few months, requesting $150 million for additional space for research centers.

ACCC Breast Cancer Symposium

The Association's one-day breast cancer symposium, held in conjunction with the annual meeting, drew a number of expert researchers, physicians, and other members of the multidisciplinary cancer care team. The speakers at the symposium, which was chaired by William L. Donegan, M.D., chief of the department of surgery at Sinai Samaritan Medical Center, Milwaukee, WI, addressed topics that ranged from epidemiology and screening to surgery and systemic adjuvant therapy.

William L. Donegan, M.D., *Chief, Department of Surgery, Sinai Samaritan Medical Center, Milwaukee, WI, chaired the ACCC Breast cancer Symposium.*

Based on a preliminary review of the meeting participants' evaluation of the symposium, the Association's focus on a scientific, indepth examination of breast cancer was well received. ■

President's Corner

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in support would have a serious impact on the ability to continue clinical trials in the community setting, as well as in university-based cancer centers. However, a more serious problem is that of third-party payers (Medicare, HMOs, and others) denying payment for the medical costs of patients enrolled on clinical trials. Widespread adoption of such a policy could bring clinical research to a halt and, thereby, have an enormous impact on the future care of cancer patients.

It is important that as we identify treatment constraints, we ensure that both patients and health care purchasers understand the limitations that insurers are placing on physicians' ability to provide state-of-the-art treatment. Those involved in cancer management realize the importance of continuing clinical trials in cancer centers, university centers, and the community if their ability to deliver state-of-the-art cancer care is to be sustained.

Irvin D. Fleming, M.D.
President