HIGHLIGHTS OF THE FALL LEADERSHIP CONFERENCE

Developing a Bone Marrow Transplant Program

The number of bone marrow transplants performed in 1990 will increase to as many as 2,000, compared to slightly more than 1,000 in 1987, predicted James Armitage, M.D., Professor and Vice Chairman of Medicine, University of Nebraska Medical Center, Omaha. "It's a technology that is rapidly disseminating," Armitage said. However, specific facility, staffing, and patient care needs, as well as other issues, must be addressed if a bone marrow transplant (BMT) program is to be successful.

- **Facilities:** Specific rooms need to be identified for BMT patients and furnished with isolation equipment. Armitage also noted that a BMT program requires access to a high-quality blood bank to meet the increased need for blood quantities and types, as well as a designated area for radiating blood. Programs also need access to a sufficient number of operating rooms, and must rely on responsive support from laboratory and x-ray departments.
- **Staffing:** Nurses are the most important part of the BMT team, according to Armitage. The program must be able to identify a sufficient number of nurses (he suggests one nurse for every two patients). Other necessary personnel include specialized cleaning staff to maintain patient rooms; social workers that can perform a variety of financial and patient/family support services; coordinators to provide expertise in insurance issues, to facilitate patient communications, and to perform routine procedures; and physical and therapists, due to the fact that BMT patients, who are hospitalized an average of six weeks.

Armitage also noted that BMT programs require a huge amount of physician support in the areas of pulmonary medicine, infectious disease, dermatology, nephrology, surgery, pediatrics, surgical pathology, radiation oncology, and psychiatry (for both patient and staff support).

- **Patients:** The volume of patients must be sufficient to support the program. Armitage suggested, as a rule of thumb, 15 to 20 patients per year, or a number that will ensure that the BMT unit is never empty.

Other specific issues that Armitage said need to be dealt with include reimbursement. "Reimbursement is difficult for diseases other than aplastic anemia, leukemias, and lymphomas. You must know the climate in your area." And, he added, you must know the difference between costs and charges and your ability to control costs. "PPOs and other managed care companies may offer to reimburse transplants at a reduced rate, i.e., $108,000 for each patients vs. your current charge of $150,000."

Finally, Armitage stressed the importance of formulating a strategy for the program. "You can focus on a specific disease, a specific therapy, or on becoming a referral center for a particular area; it doesn't matter, but you must have a strategy."

Antineoplastics Excluded From Home IV Benefit

Because the Food & Drug Administration (FDA) was "uncomfortable with the inclusion of antineoplastic agents" in the home IV drug benefit of the outpatient prescription drug amendment of the Catastrophic Health Act, "all antineoplastic agents have been excluded" from the list of approved drugs and indications for home IV use set forth in proposed regulations issued by the Health Care Financing Administration, according to Robert Wren, Director, Office of Coverage Policy and Reimbursement, HCFA, Baltimore, MD.

The FDA's concern centered around agency labeling for antineoplastics which cite the need for "supervision of a physician or the direct monitoring of a laboratory," Wren explained. He also noted HCFA'sconcern that there is "incomplete professional agreement on the safety of administering [specific] antineoplastics in the home setting."

However, Wren emphasized that the regulations excluding antineoplastics from the home IV benefit are "proposed regulations," and he advised cancer care providers to supply HCFA with their comments, as well as copies of "published studies that document effectiveness and safety."

Robert Wren

Classifications of agents that are included in the proposed regulations include antibiotics, anti-infectives, and agents used in hydration therapy.

As far as covered agents in the overall drug prescription benefit, Wren noted that drug benefit regulations published in the *Federal Register* on September 8 state that HCFA will "use the compendia recommended by Congress to determine coverage of prescription drugs and their indications." He went on to say that "using drugs in accordance with any of these compendia will meet our requirements for coverage."

Lee Mortenson, ACCC Executive Director, urged cancer care providers to send HCFA comments and appropriate documentation protesting the exclusion of antineoplastics before the comment period ends in November. At *Oncology Issues* deadline, ACCC planned to send a Presidential Communique on the issue to all ACCC members and conference participants.

Speakers Criticize Stark Bill

The physician self-referral bill sponsored by Rep. Fortney (Pete) Stark (D-CA) contains "blanket regulations that are so poorly worded" and exceptions that are so vague, the current bill "can't be applied to the simplest physician transactions," according to Robert Rosenfield, Partner, McDermott Will and Emery, Los Angeles.

Rosenfield told conference participants that "physician ownership and compensation get dramatically different treatment. There is "no moral core" to the bill, Rosenfield contended. "Certain groups are favored and others are not favored."

Nevertheless, the issue of physician self-referral "has little grass roots support," said Joseph Miltenberger, Executive Director of the National Alliance of Outpatient Cancer Therapy Centers, Washington, DC. And, because of the "lack of constituency for defeating the Stark bill," he predicted that there will be a "self-referral law enacted by the end of this Congress."

However, the Alliance is working to have cancer therapy centers exempted from the proposed legislation. "The Alliance disputes that implications of fraud and abuse problems exist in therapeutic radiation therapy centers," he said, noting the "close parallels between cancer centers and renal dialysis centers," the later of which have already been exempted from the Stark bill.

Robert Porter, Senior Vice President, Memorial Medical Center, Springfield, IL, urged hospitals and physicians currently involved in joint ventures to "insist that proposed joint ventures stand as good business investments, separate and apart from physician inducements to invest. If they can't withstand that test, you should not joint venture," he said. And, although he stated that the Stark bill is "incomplete, poorly drafted, and not yet final," hospitals and physicians should "be prepared to disassemble or to restructure joint ventures" to abide by the proposed legislation.

James Armitage, M.D.

The Effect of CPT Coding and RBRVS Payment Reform

It is "critical that CPT codes recognize the professional component of chemotherapy administration prior to the implementation of a resource-based relative value scale (RBRVS) of payment for physicians," said Joseph Bailes, M.D., a member of the Clinical Practice Committee of the American Society of Clinical Oncology (ASCO).

As part of a panel on CPT coding and an RBRVS for Medicare payment to physicians, Bailes said that interpretation of chemotherapy codes "varies from oncologist to oncologist and from one regional Medicare carrier to another." ASCO is "actively involved in seeing that CPT coding recognizes the professional component of chemotherapy services regardless of the setting in which the care is delivered."

"It's important to have uniformity in RBRVS and CPT coding," said Richard Trachtman, Director of Federal Affairs, the American Society of Internal Medicine (ASIM), Washington, DC. "But currently, in regard to cognitive services, specialties are treated differently," he noted.

James Haug, Director, Socioeconomic Affairs, the American College of Surgeons (ACoS), Chicago, also stressed that the "prerequisite for RBRVS is a uniform set of definitions." He stated that 44 different policies are used in 56 Medicare carrier areas to pay for surgical services. "We need improved definitions for physician services provided under Medicare."

The remedy proposed by the Prospective Payment Assessment Commission is to "revise codes so they are based on the time spent and the class of the visit by delivery setting (i.e., initial vs. intermediate office visit)," Trachtman said. To that end, "A committee comprised of representatives of the AMA, the CPT Advisory Board, insurance carriers, and other concerned parties will form a consensus panel and determine how to construct definitions for different levels of services, taking into account time, resources, etc."

Meanwhile, panelists urged practicing medical oncologists to provide input on the special requirements of chemotherapy administration to legislators and to HCFA. "Different requirements, such as the need for trained oncology nurses, laminar flow hoods, special waste disposal needs, etc., will all translate into the determination of Medicare fee schedules for an RBRVS type of payment system," Bailes said.

"Decisionmakers on these issues need to hear from practitioners," Trachtman said. He advised cancer care providers to "keep informed and keep your legislators informed about the potential effect on you and your patients."

ACCC President Details New Initiatives

The "most exciting" new initiative being pursued by the Association is the "Development of state and local chapters," according to ACCC President, Irvin Fleming, M.D., Methodist Hospitals of Memphis (TN). "Reimbursement problems cannot be addressed solely on a national basis," he told participants at the ACCC luncheon. As a result, "ACCC is interested in promoting and fostering state organizations' ability to function within ACCC." He noted that currently about 20 states are at some level of developing a state oncology society. "The leadership of such organizations is potentially important to the leadership of ACCC," he said. Similarly, "ACCC can transfer its expertise on the national level to the state level and facilitate communications between states that face similar problems."

ACCC President Irvin Fleming, M.D.

Fleming also noted that more than 40 delegate member institutions were scheduled to participate in a prostate screening and information program from September 24 thru September 30. ACCC headquarters received more than 120 phone calls from interested member institutions.

Finally, because of the number of ACCC members that are involved in clinical trial activity and working with new biologicals and pharmaceuticals, "ACCC is in the planning stage of forming a collaborative group that would match members with firms conducting clinical trials. We see this as an important way to provide members with access to new clinical trials and to funding for those trials." ■