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REIMBURSEMENT IN SPOTLIGHT ON NATIONAL, STATE, AND LOCAL LEVELS

Marilyn M. Mannisto

Consumer, business, and public advocacy groups have joined federal, state, and local governments in focusing on health care reimbursement and its effect on health care quality and access.

AIDS activists, state legislatures, physicians, consumer advocates, patients, cancer organizations—the list goes on as an increasing number and diversity of individuals and groups become aware of, and attempt to improve, a reimbursement system that is increasingly affecting health care providers' ability to deliver quality care and patients' access to that care.

This article will review pending and current actions on the national, state, and local levels, from the progress to date in the movement toward a relative value scale of payment for physicians to attempts to legislate reimbursement policies at the state level.

Physician Payment Reform

Despite reports that the government has 4,000 employees working on the physician payment reform package, there is little progress to report on the development of a relative value scale-based (RVS) method of Medicare payment for physicians. Many critical issues remain to be resolved before 1992, the first year of the system's four-year phase-in. (For an in-depth report on those issues, see the article, "Medicare Physician Payment Reform" in the Winter 1990 issue of *Oncology Issues*.)

The Health Care Financing Administration (HCFA) is required to produce a model fee schedule for Congress on September 1 of this year, based on the relative values then available. Expect a "thin model," says Terry Coleman, counsel to the law firm of Fox, Weinberg & Bennett, Washington, DC, because William C. Hsiao and his colleagues at the Harvard School of Public Health, who are under contract to HCFA to develop relative value scales for the various specialties, will not be releasing data until as late as September 30.

At this time, Hsiao's group is still analyzing data on 14 physician specialties, including oncology and hematology and radiation oncology services. These data include the estimated time and intensity of physician work, practice expenses, and the cost of professional liability insurance. After Hsiao's data are released, the Physician Payment Review Commission (PPRC) will be requesting input from specialty societies about potential problem areas in Hsiao-surveyed services, including cross-specialty services, families of services, and benchmark services that are extrapolated from one specialty to another. The PPRC is expected to complete its refinement of the system by mid-1991.

One element of the payment reform plan is already being implemented: Medicare volume performance standards (MVPS). HHS Secretary, Louis Sullivan, M.D., approved an FY 1990 rate of increase of 9.1 percent for both surgical and nonsurgical services. Although payments for physician services will not be withheld if these suggested rates of increase are exceeded, conformance with the standard will be one of the factors considered in setting the annual fee update under an RVS system of payment.

However, recommended FY 1991 targets announced by Secretary Sullivan in April have already drawn protests from physician groups. The Secretary recommended a rate of increase of 8.7 percent for surgical services and 10.5 percent for nonsurgical services. The rate of increase is based on increases in inflation (3.6 percent), the number of Medicare enrollees (1.2 percent), the aging of the Medicare population (0.1 percent), and expanded Medicare benefits (0.1 percent for surgical services and 1.9 percent for nonsurgical services). In particular, the Secretary has been criticized for recommending only a 3.7 percent combined increase for changes in technology, access to physicians' services, and utilization of physician services in the face of a projected 7.4 percent increase in those factors.

However, in May, the PPRC, which is required to review the Secretary's proposed rate increases, recomended that Congress approve slightly higher rates of increase (9.3 percent for surgical services and 12.1 percent for nonsurgical services). Congress must make its final determination no later than October 15. If Congress fails to act, a default provision in the legislation, which is based on the Medicare Economic Index (MEI), the growth in beneficiaries, and other factors, automatically goes into effect. Although groups such as the AMA contend that the Congressional option to legislate rate increases is a significant improvement over an automatic, formula approach to volume targets, past experience with the prospective pricing system hospitals paints a different scenario. Congress has never defaulted in setting annual DRG rate increases; however, every year those increases have proved to be less than the rate increase would have been if the statutory formula approach had been used.

The aim of the RVS system is to develop median charges for specific procedures in particular geographic locations. Therefore, the reimbursement level for physicians whose charges for a particular procedure are higher than those of the majority of physicians in the same area will be negatively affected. Physicians who provide a multiplicity of services may find that while reimbursement for cognitive services (i.e., consultations) increases signficantly, reimbursement for other services (i.e., x-rays, laboratory work) will decrease.

The problem with an RVS system of payment is that the overall increase or decrease in payments is dependent on the volume and intensity of services and the

mix of services a particular physician provides. As result, experts say that an RVS-based system could very well change the face of medicine. For instance, it could provide incentives for multi-modality physicians to shift their focus into areas that are reimbursed at a higher level and/or services that represent a lower risk of liability (i.e., patient examinations vs. x-ray interpretations).

Furthermore, private health insurers are likely to follow Medicare's lead and adopt an RVS system for paying their beneficiaries. In fact, the Health Insurance Association of America (HIAA) has already commissioned a study of the potential impact of RVS on commercial insurers.

Finally, HCFA must submit its recommendations to Congress on whether or not the payment system's geographic conversion factor should be based on statewide localities or metropolitan statistical areas rather than current Medicare localities. How HCFA chooses to rationalize geographic variations and, if it attempts to strike a balance between locations as diverse as Billings, MT, and San Francisco, CA, the effect on practitioners in high-cost areas could be devastating.

CPT Coding Reform

The American Society of Clinical Oncology (ASCO) has successfully lobbied the American Medical Association's CPT Coding Committee to revise the 1990 preamble to the chemotherapy codes eliminating language that potentially excludes reimbursement for a chemotherapy administration fee in hospitals or home care settings. A letter to that effect was distributed by the AMA in June.

Unfortunately, according to Joseph Bailes, M.D., Chairman of ASCO's Clinical Practice Committee, "it is still the individual carrier's decision" to reimburse or not to reimburse. However, he says that "most of the feedback" the Committee has received from ASCO members has been positive and, on a state-by-state basis, many carriers have been willing to convert codes in line with ASCO's recommendations. (See the article on page 14 for an indepth look at how to cope with the current, 1990 CPT-4 coding revisions.)

ASCO will continue to urge HCFA to adopt a mechanism that "explicitly recognizes a chemotherapy administration code," Bailes says. In terms of the move to a relative value scale of payment, Bailes says that "until Hsiao's data are released, we don't know what will be elucidated for chemotherapy administration." In the meantime, ASCO is studying the issue internally to ensure that if administration services are not "accurately represented" in Hsiao's relative values for oncology services, "we will have a basis for discussion with the PPRC." However, Bailes predicts that we will "probably see a system that recognizes coding in both office and non-office settings."

Third-Party Initiatives

Earlier this year, a task force of the HIAA issued guidelines for coverage of experimental drugs that cancer care providers welcomed, including reliance on peer-reviewed literature and the medical compendia for coverage of off-label uses, potential coverage of Treatment IND and NCI Group C drugs, and consideration of hospital stays and other medical costs associated with investigational trials. However, HIAA does not have any data on member compliance with the guidelines. In fact, the HIAA has yet to print the recommendations and formally distribute them to member organizations.

Jude Payne, a senior policy analyst with HIAA, says that most of HIAA's member companies handle such reimbursement issues on a "case-by-case basis." But, she believes that the "companies with sophisticated technology assessment departments are behaving responsibly."

In the meantime, Blue Cross and Blue Shield plans are replenishing their coffers through the use of cost containment strategies that will be stepped up. Plans saved $21 billion during 1987 and 1988 because of utilization review, preadmission certification, and other strategies. Nevertheless, the national Blue Cross and Blue Shield Association is maintaining its stance of not paying for Treatment IND, Group C, or the medical costs associated with "experimental" treatments. It will be interesting to see the figures for cost containment savings in 1989—the year in which ACCC began receiving numerous reports of increased denials for cancer therapies (i.e., off-label uses) from oncologists and their staffs.

State Legislation

Citing studies and data from ACCC, a bill in New York that will prohibit insurers from denying payment for the off-label use of antineoplastic drugs passed both the State Assembly and the Senate by overwhelming margins (142 to 1 and 55 to 0, respectively) in late June. The only modification in the final wording of the bill was to change the statement "you shall pay" for off-label drug use to "you shall not deny payment" for off-label use. The bill states that physicians can prescribe drugs for off-label uses as long as they are included in the medical literature and/or in one of three compendia published by the U.S. Pharmacopeia, the American Medical Association, and the American Society of Hospital Pharmacies.

Diane Blum, Executive Director of CancerCare, Inc., an affiliate of the National Cancer Care Foundation in New York City, and a major supporter of the legislation, is "pleased that it was passed," and hopeful that similar legislation will be introduced in other states.

Moreover, cancer organizations are optimistic that the legislation will be signed by Governor Mario Cuomo after receiving only one dissenting vote in the legislature. Nevertheless, New York-based ACCC members are urged to write to Governor Cuomo in support of the legislation.

Meanwhile, in California, proposed legislation that prohibits the denial of payment for 1) drugs approved by the FDA under a Treatment IND, open protocol, or Group C designation; 2) drugs recommended by the NIH, the Centers for Disease Control, or any of the three compendia; and 3) the medical services associated with the use of such prescription drugs, narrowly passed the state's 80-body Assembly by a vote of 47 to 30. At *Oncology Issues* deadline, the Senate Insurance Committee was scheduled to act on the bill as early as the first week of August.

The legislation faces a "tough" fight in the Senate Committee, according to Alan Lofaso, Legislative Advocate for Life AIDS Lobby, Sacramento, CA, which first raised the issue of amending California's Health and Safety and Insurance Codes to ensure adequate insurance coverage for experimental and off-label

therapy. Despite the support of state and national AIDS and cancer organizations, the bill could be "killed" in the Senate Committee which, Lofaso contends, is "typically more sensitive to the concerns of [the insurance] industry."

Lofaso's group may get help from a newly formed state organization of medical oncologists in Northern California. The group, headed by Peter Eisenberg, M.D., targeted the issue as one of its top priorities.

GAO's Off-Label Survey

The General Accounting Office's (GAO's) survey of almost 1,500 oncologists' off-label use of drugs has been completed, according to Tom Laetz, Ph.D., of the GAO's Denver office. The GAO is reporting a response rate of approximately 60 percent. In late June, GAO staffers briefed the Senate Committee on Labor and Human Resources, which requested the study, on its preliminary findings, based on the first 200 questionnaires that were received. The disclosure of those preliminary results is "up to the purview of the Senate Committee," Laetz explains, "but suffice it to say that off-label use if prevalent."

As a special interest group that was instrumental in the development and testing of the survey, ACCC has requested that the Senate Committee share its information on the survey results prior to the release of the final study, which is expected to be completed in September.

The Lasagna Committee

At *Oncology Issues* deadline, Armand Hammer, Chairman of the President's Cancer Panel, was expected to present the Lasagna Committee's report on current procedures for approval of new drugs for cancer and AIDS to President Bush in late July. After Dr. Hammer meets with the President, the report will be available to the public.

Based on a statement the Committee made earlier this year in response to Medicare's proposed rulemaking on coverage determinations by HCFA, it is expected that the report to the President will reinforce the reimbursement coverage policies that ACCC and other concerned groups have been promulgating. For instance, the previous statement recommended coverage of Treatment IND drugs and associated clinical care costs; reliance on authoritative medical compendia for the coverage of unlabeled indications as a more valid basis for reimbursement than FDA labeling; development of a mechanism within HCFA to rapidly review new indications supported by the medical literature and clinical practice, but not as yet approved in the compendia; and coverage for the hospital, physician, and medical care costs for patients involved in cancer and AIDS investigational trials.

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