

Illinois Medical Oncology Society



**LEGISLATIVE & MEDICARE
UPDATE
NOVEMBER 13, 2009**



Matthew Farber
Director, Provider Economics & Public Policy
Association of Community Cancer Centers



ACCC
Association of Community Cancer Centers

*The premier education and advocacy
organization for the oncology team*

Regulatory and Legislative Overview



- **2009 Legislation**
 - Stimulus, SGR, other oncology legislation
- **2010 Final Physician Fee Schedule**
- **Quality Reporting**
 - PQRI, E-Prescribing
- **2010 Final Hospital Outpatient Prospective Payment System (HOPPS)**
 - Physician Supervision
 - Pharmacy Overhead Pool
- **Compendia Updates**
- **MACs & RACs**
- **ICD-10**
- **ACCC Efforts**

2009 Economic Stimulus



- **American Recovery & Reinvestment Act**
- **Roughly \$150 Billion in health care related funds**
 - **\$500 million to address workforce shortages**
 - ✦ \$75 million for National Health Service Corps and other loan repayment
 - **\$9.5 billion for NIH**
 - **Comparative Effectiveness: \$1.1 billion**
 - ✦ \$300 million to Agency for Healthcare Research and Quality (AHRQ)
 - ✦ \$400 million to NIH
 - ✦ \$400 to Secretary of HHS to distribute
 - **HIT**

Comparative Effectiveness



- To conduct, support, or synthesize research that compares the clinical outcomes, effectiveness, and appropriateness of items, services, and procedures used to prevent, diagnose, or treat diseases, disorders, and other health conditions
- Bills in Congress, aspects of Health Care reform may further define scope, methods
 - Look for studies in disparities, devices, other low-lying fruit

Health Information Technology



- **Goals related to HIT use:**
 - Preventing 1 million heart attacks and strokes by 2015
 - Reducing heart disease so it is no longer leading cause of death
 - Reducing medication errors by 50%
 - Reducing racial/ethnic gap in Diabetes control by 50%
 - Reduce preventable hospital admittance by 50%

HIT



- **For Physician Offices (money is per physician):**
 - 1st Year: \$18,000 (if 2011 or 2012), \$15,000 if later
 - 2nd year: \$12,000
 - 3rd year: \$8,000
 - 4th year: \$4,000
 - 5th year: \$2,000
 - 6th year and beyond: 0
 - If in a Secretary-designated health professional shortage area, may be increased by 10%

HIT cont.



- **Sample, courtesy of eHealth Initiative**

Assume the following:

- 20,000 discharges
- 34,000 Medicare bed-days
- 100,000 total bed-days
- 1,000,000,000 in hospital charges
- 200,000,000 in charity care

Formula 1: $2,000,000 + ((20,000 - 1,150) \times 200) =$
 $\$5,770,000$

Formula 2: $34,000 / (100,000 \times ((1,000,000,000$
 $- 200,000,000) / 1,000,000,000 = 0.425$

Sample cont.



- **First Year Payment: \$5,770,000 x 0.425 = \$2,452,250**
 - **In succeeding years, a transition factor would be introduced that would reduce this number to $\frac{3}{4}$, then $\frac{1}{2}$, then $\frac{1}{4}$**
 - **Second Year: \$1,839,188**
 - **Third Year: \$1,226,125**
 - **Fourth Year: \$613,063**
- Total Payments: \$6,130,626**

Kennedy-Hutchinson Bill



- **Comprehensive bill**
 - More money for NIH, NCI
 - More money for prevention
 - Survivorship
 - Patient Navigator program
 - Biomarkers
 - Guidelines
 - Workforce
- **Bill has been put on back burner until after health care reform**
- **Again, loss of Sen. Kennedy puts future in doubt**

Sustainable Growth Rate (SGR)



- Current method for determining physician reimbursement by Medicare
- Without action, Physicians face a 20% cut Jan 1, 2010
- Congress stepped in to halt the projected 10.6% cut in July, 2008.
- Each year, a “band-aid” fix is implemented
- Hopefully we will see a long term fix in the works this year
 - May be part of Health Care reform, but not included in all bills
 - Not included in House bill; however, House introduced a separate SGR fix to be voted on after HCR
 - CMS will pull drugs from formula for future
 - ✦ Will lessen future cuts

Final Updates to 2010 Physician Fee Schedule



- **E/M Services**
 - Evaluation & Management Codes : slight increase in 2010
 - ✦ Due to elimination of consult codes
- **Drug Administration**
 - Most codes related to Chemo admin. saw decrease
 - Overall reimbursement for Med Onc. will decrease by ~6%
 - Cuts to be phased in over 4 years; therefore about -1% for 2010
 - Cuts due to changes in RVUs, increase to Primary care, not much data from AMA survey
 - Conversion factor: \$28.3208; a decrease of 21% from 2009
 - Radiation Oncology will not face proposed 19% cut
 - 90% utilization rate only to be applied to MRI & CT, not therapeutic
 - Also to be phased in over 4 years; -5% in total, -1% in 2010
 - 6% and 5% figures assume Congress will halt 21% cut
- **Drug Reimbursement**
 - ASP+6%

Equipment with Costs > \$1 million



Description	PRICE
SRS system, Lincac	\$4,350,000
SRS system, SBRT, six systems, average	\$4,000,000
Gammaknife	\$3,870,000
room, PET-CT	\$2,136,283
accelerator, 6-18 MV	\$1,832,941
room, MR	\$1,605,000
accelerator, 4-6 MV	\$1,408,491
room, angiography	\$1,386,816
room, PET	\$1,328,996
room, CT	\$1,284,000
IMRT CT-based simulator	\$975,000

This will result is very large cuts to IDTFs

Final Admin Rates

Physician Fee Schedule Drug Administration Rates		2009	2010	% change	2013
96360	Hydration iv infusion, init	\$56.62	\$53.74	-5%	\$47.61
96361	Hydrate iv infusion, add-on	\$16.59	\$15.15	-8.7%	\$12.98
96365	Ther/proph/diag iv inf, init	\$68.89	\$66.72	-3%	\$60.23
96366	Ther/proph/dg iv inf, add-on	\$22.00	\$20.56	-6.6%	\$19.12
96367	Tx/proph/dg addl seq iv inf	\$34.62	\$32.46	-6.2%	\$27.05
96368	Ther/diag concurrent inf	\$20.56	\$19.12	-7%	\$16.95
96369	Sc ther infusion, up to 1 hr	\$149.68	\$145.71	-2.7%	\$129.12
96370	Sc ther infusion, addl hr	\$15.87	\$14.79	-6.8%	\$14.79
96371	Sc ther infusion, reset pump	\$72.49	\$75.38	4%	\$78.99

96372	Ther/proph/diag inj, sc/im	\$20.92	\$21.28	1.7%	\$21.64
96373	Ther/proph/diag inj, ia	\$18.03	\$18.03	0%	\$18.03
96374	Ther/proph/diag inj, iv push	\$54.46	\$52.66	-3.3%	\$46.53
96375	Ther/proph/diag inj add-on	\$23.80	\$22.00	-7.6%	\$18.75
96401	Chemo, anti-neopl, sq/im	\$67.44	\$66.72	-1.1%	\$61.31
96402	Chemo hormon antineopl sq/im	\$36.79	\$34.98	-4.9%	\$27.77
96405	Chemo intrales'l, up to 7	\$84.40	\$82.23	-2.6%	\$72.13
96406	Chemo intrales'l over 7	\$116.50	\$114.33	-1.9%	\$101.71
96409	Chemo, iv push, sngl drug	\$111.81	\$107.48	-3.9%	\$89.81
96411	Chemo, iv push, addl drug	\$63.84	\$60.23	-5.6%	\$50.85
96413	Chemo, iv infusion, 1 hr	\$147.51	\$140.66	-4.6%	\$115.41
96415	Chemo, iv infusion, addl hr	\$33.54	\$30.30	-9.7%	\$25.97

96416	Chemo prolong infuse w/pump	\$160.86	\$153.64	-4.5%	\$125.87
96417	Chemo iv infus each addl seq	\$73.58	\$69.25	-5.9%	\$57.71
96420	Chemo, ia, push technique	\$107.84	\$103.87	-3.7%	\$87.28
96422	Chemo ia infusion up to 1hr	\$173.84	\$166.63	-4.1%	\$137.05
96423	Chemo ia infuse each addl hr	\$77.54	\$75.74	-2.3%	\$64.20
96425	Chemotherapy,infusion method	\$171.32	\$167.71	-2.1%	\$146.79
96440	Chemotherapy, intracavitary	\$597.98	\$653.89	9.3%	\$760.64
96445	Chemotherapy, intracavitary	\$285.29	\$277.35	-2.8%	\$240.92
96450	Chemotherapy, into CNS	\$208.10	\$198.73	-4.5%	\$161.94
96521	Refill/maint, portable pump	\$126.95	\$123.71	-2.6%	\$108.92
96522	Refill/maint pump/resvr syst	\$107.84	\$104.95	-2.7%	\$91.97
96523	Irrig drug delivery device	\$25.25	\$24.53	-2.9%	\$20.20
96542	Chemotherapy injection	\$134.17	\$126.59	-5.6%	\$100.27

Elimination of Consult Codes



- CMS finalized proposal to no longer recognize office and inpatient consult codes
- Reassigns (crosswalk) work RVUs from consult codes to office, hospital and nursing facility codes in budget neutral fashion
- Rationale:
 - Codes are misused
 - CPT is inconsistent with CMS policy
 - Work is “clinically similar”

Impact of Consultation Proposal on Oncology Specialties



Specialty	2009 ALWCHG (\$ mil)	2010 CHG w/o CMS proposal (\$ mil)	2010 CHG w/ CMS proposal (\$ mil)	% Change
92-Radiation Oncology	\$81	\$84	\$72	-14.4%
82-Hematology + 83- Hematology/Oncology + 90-Medical Oncology	\$862	\$940	\$912	-3.0%

Problems with Crosswalk



			Code
99243: 40 min, \$122	50%	99203: 30 min, \$103	99203
	50%	99213: 15 min, \$69	99204
			99205
99244: 60 min, \$182	50%	99204: 45 min, \$159	99213
	50%	99214: 25 min, \$102	99214
			99215
99245: 80 min, \$224	50%	99205: 60 min, \$198	99243
	50%	99215: 40 min, \$138	99244
			99245

Physician Quality Reporting Initiative (PQRI)



- **Bonus payment will be 2%**
 - Bonuses paid out as lump sum
- **Extension of PQRI into 2010**
 - Quality reporting of some kind is here to stay
- **More ways to participate included in proposal**
 - More info. at www.cms.hhs.gov/PQRI
- **CMS implemented a new Help Desk for PQRI**
 - Call 866-288-8912 or email qnetsupport@sdps.org with questions
- **CAP program has been suspended, but proposals included**
 - We may see CAP back in future
 - Changes to make the program more attractive to certain specialties

Incentives for Electronic Prescribing (E-Prescribing)



- “Successful electronic prescribers” will be eligible for an incentive payment equal to 2.0 percent of the total estimated allowed charges for all covered professional services furnished during the 2010 reporting period.
- The electronic prescribing measure has 2 basic elements. These include: (1) a reporting denominator that defines the circumstances when the measure is reportable; and (2) a reporting numerator.

Incentives for Electronic Prescribing (E-Prescribing): “Successful Electronic Prescribers”



- Currently, the determination of a successful electronic prescriber is based on the eligible professional’s reporting of the electronic prescribing measure in at least 50 percent of applicable cases.
- CMS finalizes that an eligible professional would be required to report at least 1 prescription for a Medicare Part B FFS patient created during an encounter that is represented by 1 of the codes in the denominator was generated using a qualified e-prescribing system for at least 25 times during the 2010 reporting period.

Incentives for Electronic Prescribing (E-Prescribing)



- In CY 2009, an eligible professional must report one of 3 G-codes:
 - One G-code is used to report that all prescriptions in connection with the visit billed were electronically prescribed (G8443)
 - Another G-code indicates that no prescriptions were generated during the visit (G8445);
 - a third G-code is used when some or all prescriptions were written or phoned in due to patient request, State or Federal law, the pharmacy's system being unable to receive the data electronically or because the prescription was for a narcotic or other controlled substance (G8446).
- To simplify reporting of the measure for 2010, CMS proposes to modify the first G-code (G8443) to indicate that at least 1 prescription in connection with the visit billed was electronically prescribed. In addition, CMS proposes to eliminate the 2 remaining G-codes from the measure's numerator.
- You can not get both the E-Prescribing and HIT bonus (beginning in 2011)

Final Updates to Hospital Outpatient Payment Rule for 2010

- Payments for drugs below \$65 are bundled into the drug administration payment
- Drugs remain at ASP+4%; further reductions to ASP-3% for 2010 were averted
 - CMS finally recognizes Charge Compression
- Pharmacy services and overhead costs inadequately reimbursed, but moving in right direction
 - CMS recognizes need for pharmacy overhead payment
 - Recognizes that some pharmacy overhead for separately paid drugs is being included in packaged drugs
 - \$395 million pool, of which, CMS proposed to move \$150 (+\$50 million) million to cover pharmacy, thus bringing overall reimbursement to ASP+4%

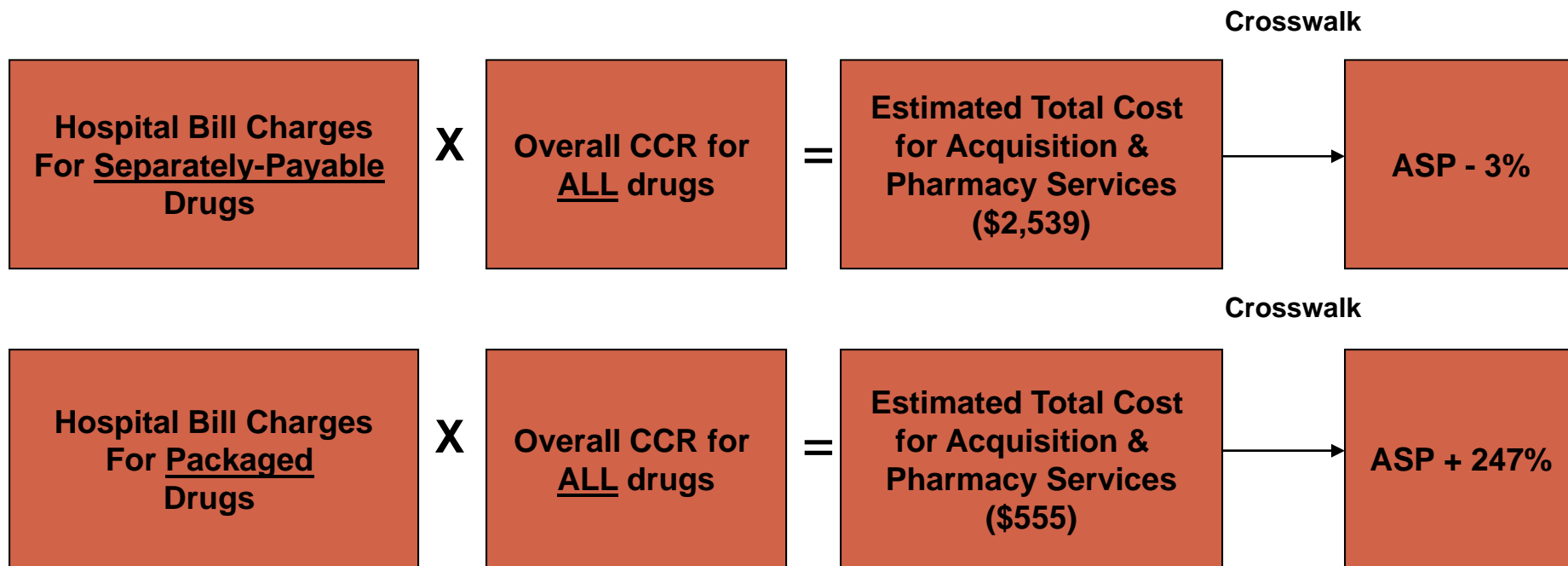
2010 Final Rule



- *In the 2010 Final OPPS Rule, CMS:*
- Assumes that 1/3 to 1/2 of the total pharmacy overhead cost currently associated with packaged drugs is appropriate to reallocate to separately paid drugs
- Proposes to reallocate \$150 million in pharmacy overhead cost from packaged drugs to separately payable drugs
 - **Listened to comments from ACCC that more needs to be moved due to mis-reported codes; added \$50 million**
 - **However, base line dropped from ASP-2% to -3%, thus keeping us at ASP+4%**
- Calculates a payment rate for separately payable drugs at ASP + 4%
- The claims data for 340B hospitals will remain in the drug payment calculation and that 340B hospitals be paid the same amounts for separately payable drugs as non-340B hospitals

CMS's Payment Formula

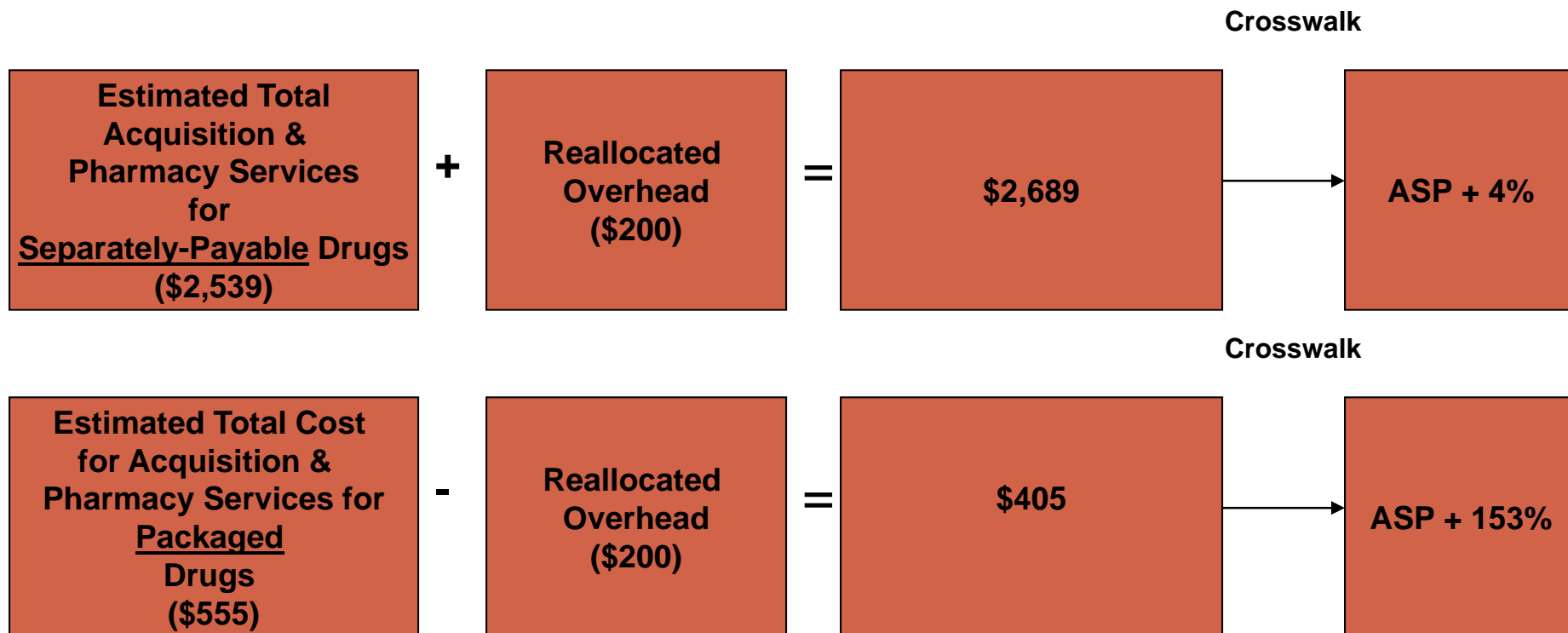
Before adjustment (\$s in millions)



Estimated pharmacy overhead attributed to packaged drugs = \$395 million, or 12.7% of total estimated pharmacy costs

CMS's Proposed Payment Formula

After reallocation of \$150 million in overhead cost from packaged drugs to separately-payable drugs (\$s in millions)



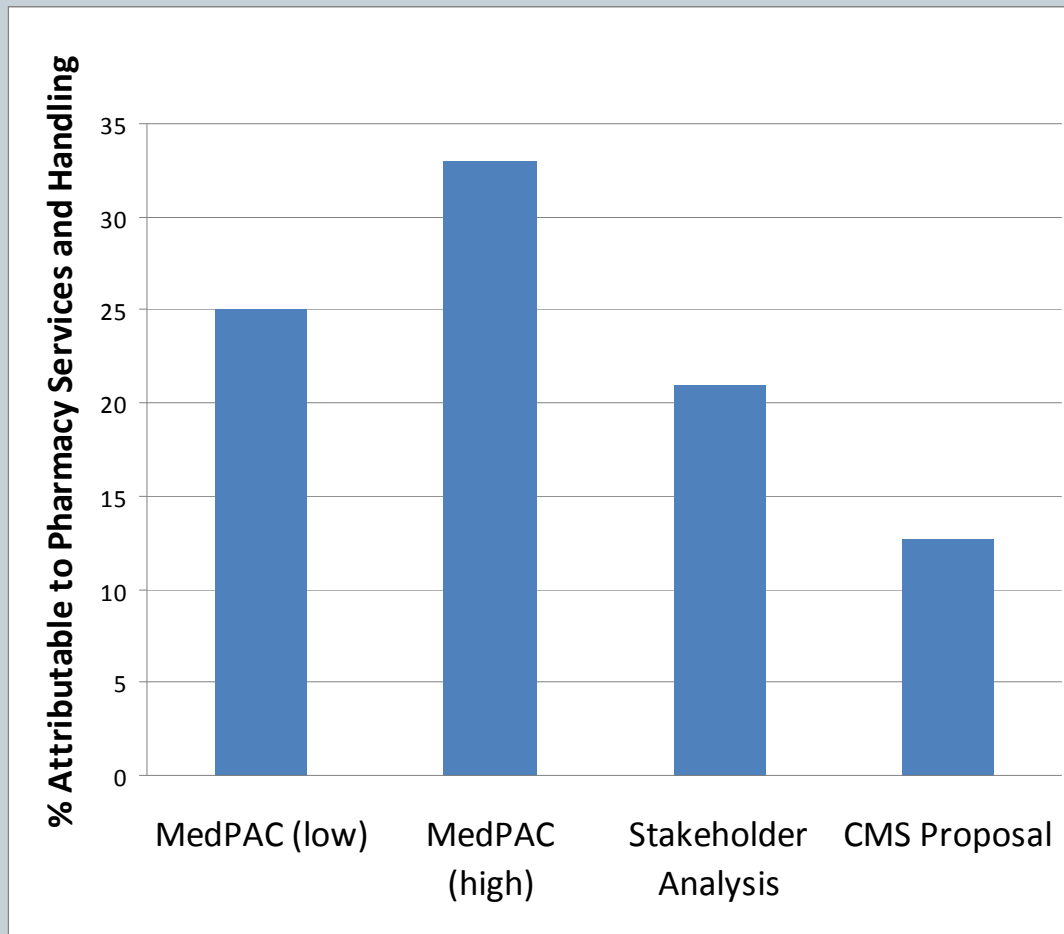
Key Points: Drug Payment Methodology



- Numerous analyses show that CMS's current methodology for estimating total costs produces drug payment rates that do not represent hospital acquisition cost and pharmacy services and handling costs
- CMS acknowledges that it does not have ASP data specific to sales to hospitals, and it is not clear that the reallocation of \$150 million, or \$200 million is sufficient to cover hospitals' costs
- Neither the GAO nor CMS have conducted surveys of hospital acquisition cost since 2004, so payment at ASP + 6% complies with the statute and establishes parity for drug acquisition across sites of service
- This rate also is reasonable given calculation of rates when data from 340B hospitals are excluded from CMS's rate-setting methodology

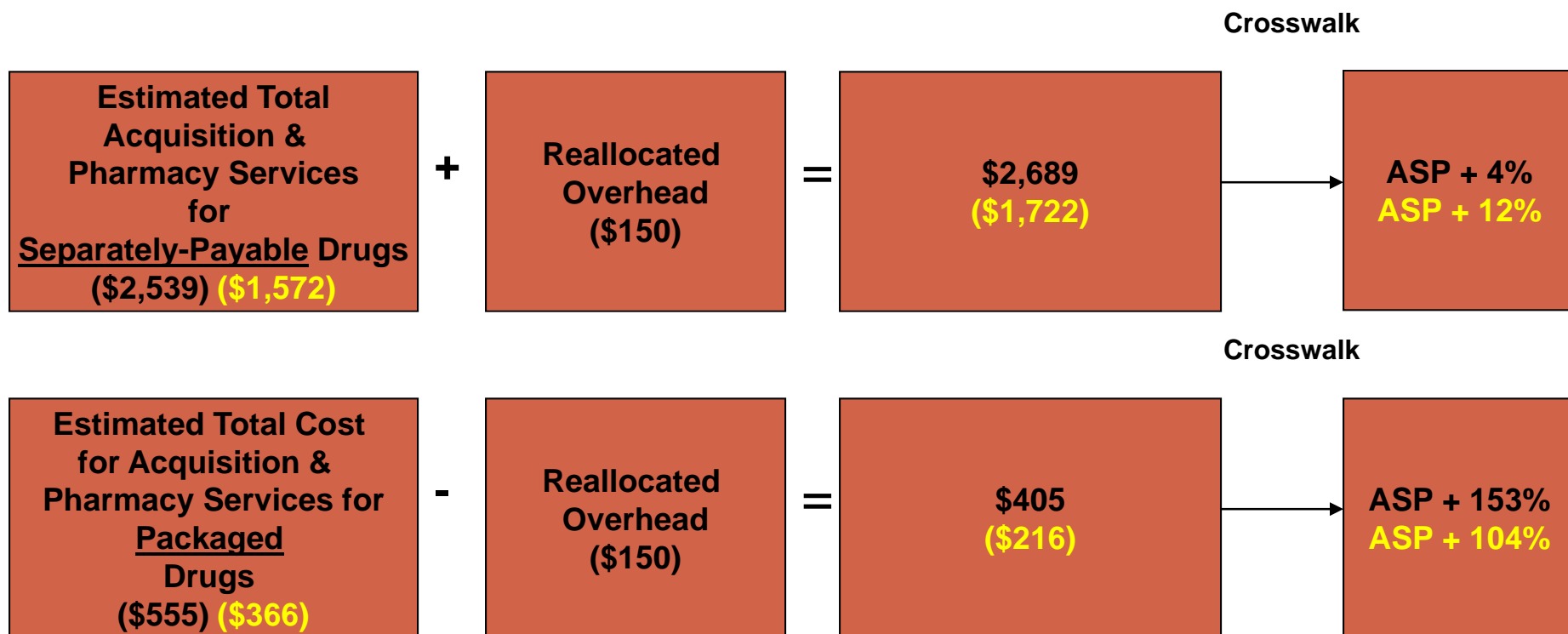
CMS Underestimates Overhead Pool

28

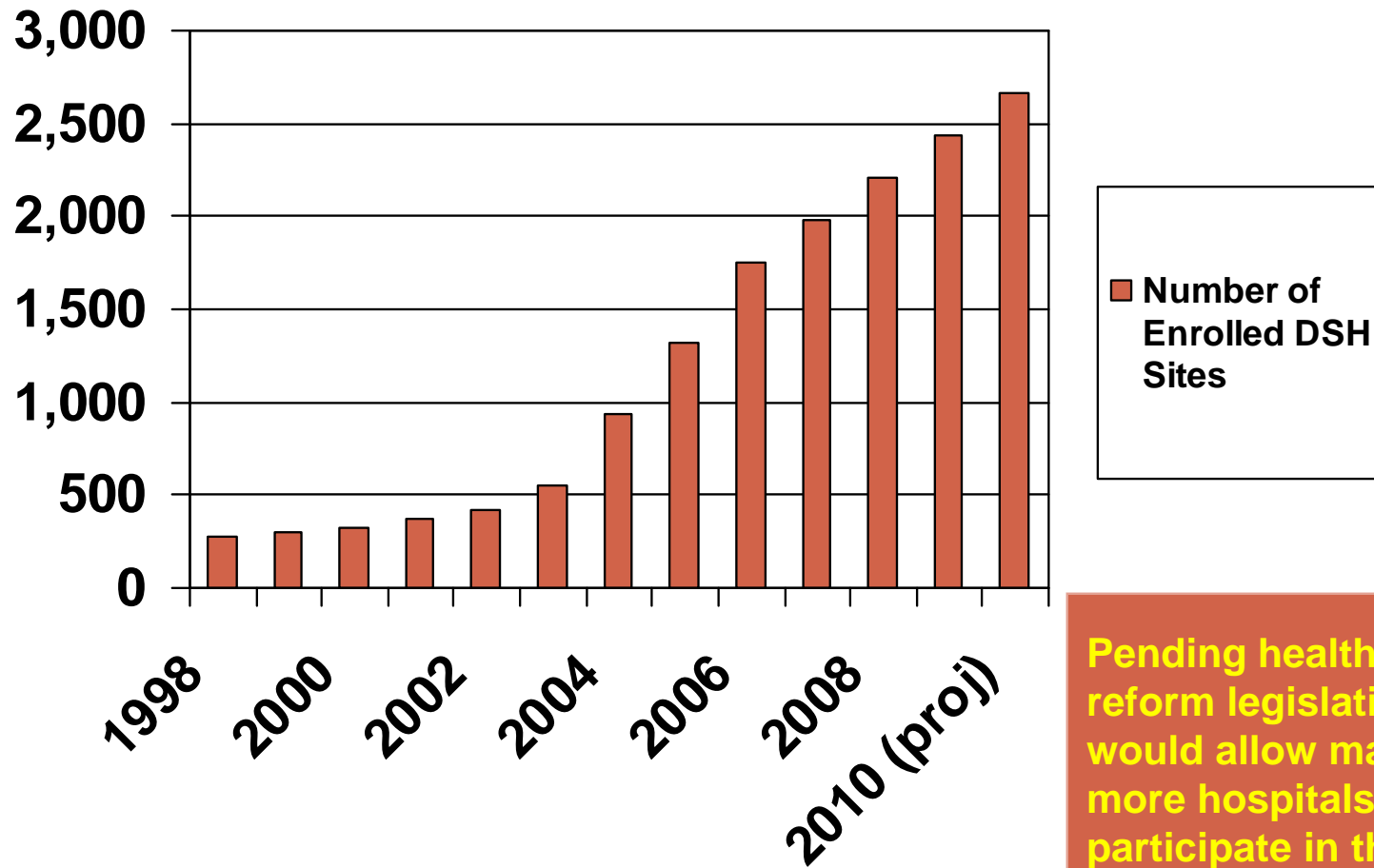


CMS's Proposed Payment Formula

After reallocation of \$150 million in overhead cost from packaged drugs to separately-payable drugs (\$s in millions) (**\$s from analysis excluding 340B hospitals**):



DSH Hospital Site Participation Growth in 340B Program



Pending health reform legislation would allow many more hospitals to participate in the 340B program

Code	Description	2009	2010
96360	Hydration iv infusion, init	\$73.67	\$75.69
96361	Hydrate iv infusion, add-on	\$24.89	\$25.67
96365	Ther/proph/diag iv inf, init	\$128.62	\$126.78
96366	Ther/proph/dg iv inf, add-on	\$24.89	\$25.67
96367	Tx/proph/dg addl seq iv inf	\$36.13	\$37.44
96369	Sc ther infusion, up to 1 hr	\$73.67	\$126.78
96370	Sc ther infusion, addl hr	\$36.13	\$37.44
96371	Sc ther infusion, reset pump	\$24.89	\$25.67

96372	Ther/proph/diag inj, sc/im	\$24.89	\$25.67
96373	Ther/proph/diag inj, ia	\$36.13	\$37.44
96374	Ther/proph/diag inj, iv push	\$36.13	\$37.44
96375	Ther/proph/diag inj add-on	\$36.13	\$37.44
96376	Tx/pro/dx inj new drug adon		
96379	Ther/prop/diag inj/inf proc	\$24.89	\$25.67
96401	Chemo, anti-neopl, sq/im	\$36.13	\$37.44
96402	Chemo hormon antineopl sq/im	\$36.13	\$37.44
96405	Chemo intralesional, up to 7	\$36.13	\$37.44
96406	Chemo intralesional over 7	\$73.67	\$126.78

96409	Chemo, iv push, sngl drug	\$128.62	\$126.78
96411	Chemo, iv push, addl drug	\$73.67	\$75.69
96413	Chemo, iv infusion, 1 hr	\$187.96	\$219.96
96415	Chemo, iv infusion, addl hr	\$36.13	\$37.31
96416	Chemo prolong infuse w/pump	\$187.96	\$219.96
96417	Chemo iv infus each addl seq	\$73.67	\$75.69
96420	Chemo, ia, push technique	\$128.62	\$75.69
96422	Chemo ia infusion up to 1 hr	\$187.96	\$219.96
96423	Chemo ia infuse each addl hr	\$73.67	\$75.69
96425	Chemotherapy,infusion method	\$187.96	\$219.96

96440	Chemotherapy, intracavitary	\$187.96	\$126.78
96445	Chemotherapy, intracavitary	\$187.96	\$219.96
96450	Chemotherapy, into CNS	\$187.96	\$219.96
96521	Refill/maint, portable pump	\$187.96	\$126.78
96522	Refill/maint pump/resvr syst	\$128.62	\$126.78
96523	Irrig drug delivery device	\$39.92	\$41.33
96542	Chemotherapy injection	\$128.62	\$75.69
96549	Chemotherapy, unspecified	\$24.89	\$25.67

APC	Description	2009 Rate	Final 2010 Rate	% Change 2009-2010
300	Level I Rad. Therapy	\$93.88	\$92.78	-1%
301	Level II Rad. Therapy	\$152.05	\$155.24	2%
303	Treatment Device Construction	\$188.16	\$190.62	1%
304	Level I Therapeutic Rad. Treatment Prep	\$114.70	\$102.94	-10%
305	Level II Therapeutic Rad. Treatment Prep	\$255.69	\$266.32	4%
310	Level III Therapeutic Rad. Treatment Prep	\$892.90	\$927.34	4%
312	Radioelement Applications	\$430.66	\$302.29	-29%

Supervision



- **CMS finalized:**
 - Non-physician practitioners, specifically physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse-midwives, & social workers may directly supervise all hospital outpatient therapeutic services that they may perform themselves in accordance with their State law and scope of practice and hospital-granted privileges, provided that they continue to meet all additional requirements, including any collaboration or supervision requirements as specified in the regulations

Supervision cont.



- **This was the result of combined effort:**
 - Began with ACCC and ONS
 - Expanded to include major hospital groups like AHA, AAMC, etc.
- **CMS also further clarified immediately available and direct supervision**
 - Less onerous on some, more so for others
- **CMS will not stop auditors from ensuring providers abided by rules for 2009**

CMS CR on Compendia



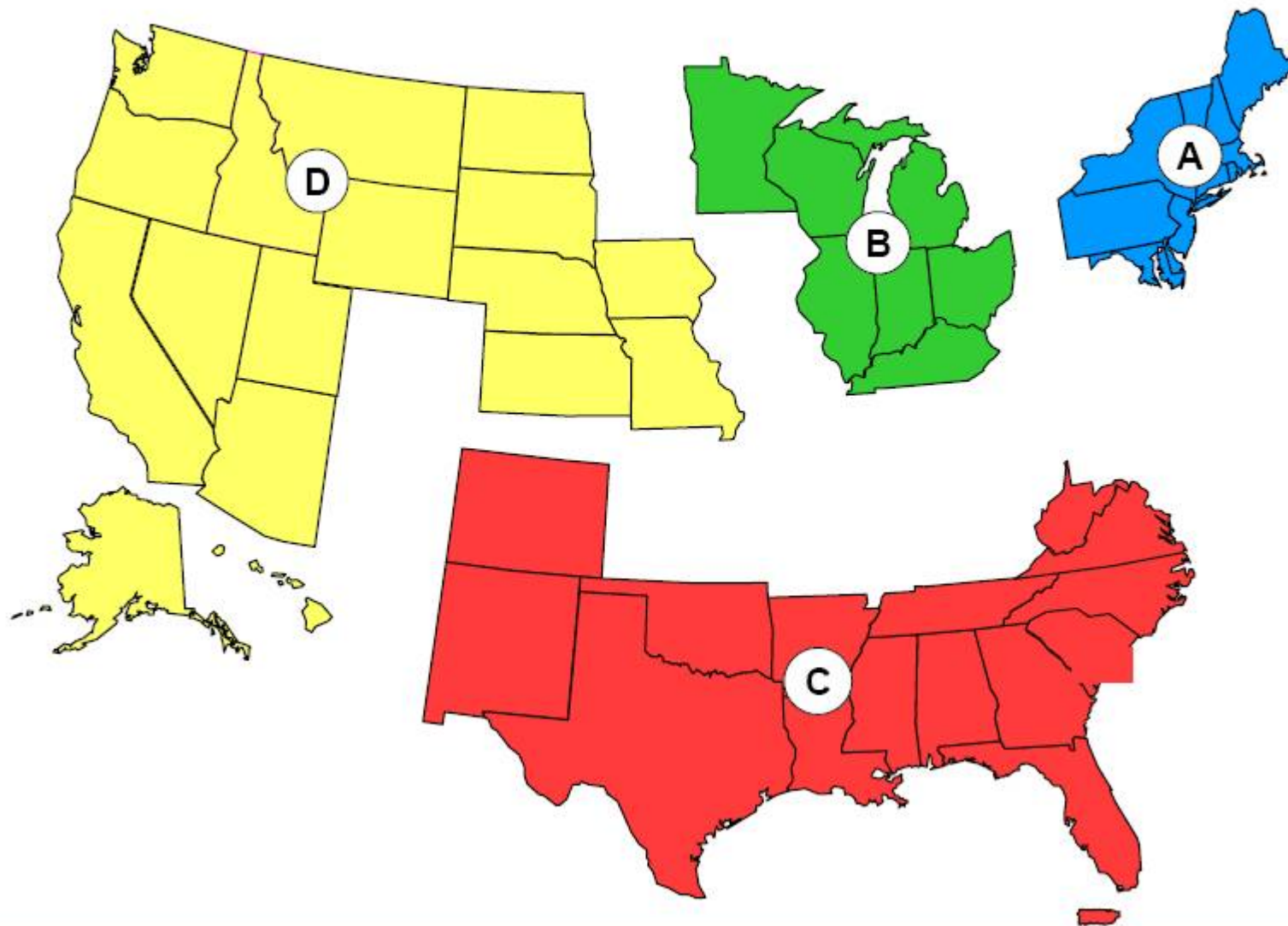
- Last year, CMS released a Change Request (CR) to address coverage of compendia listings
- Indications of 1, 2A in NCCN; 1, 2A, 2B in DrugDex accepted; positive narratives in AHFS and Clinical Pharmacology also accepted
- Indications of 3 in NCCN, DrugDex not accepted; negative narratives in AFHS, CP not accepted
- 2B listings of NCCN not in either category
- One negative listing will trump any positive listing
- We are hearing that MACs are using this as a guidance, not as a policy

Recovery Audit Contractors (RACs)



- CMS is using RACs to identify under and overpayments in CA, FL, NY
- RAC program has been started with all contractors in place
- Complex reviews will not begin until 2010
 - Gives hospitals and other providers more time to prepare to audits

Proposed 2008 RAC Jurisdictions



RAC Contractors

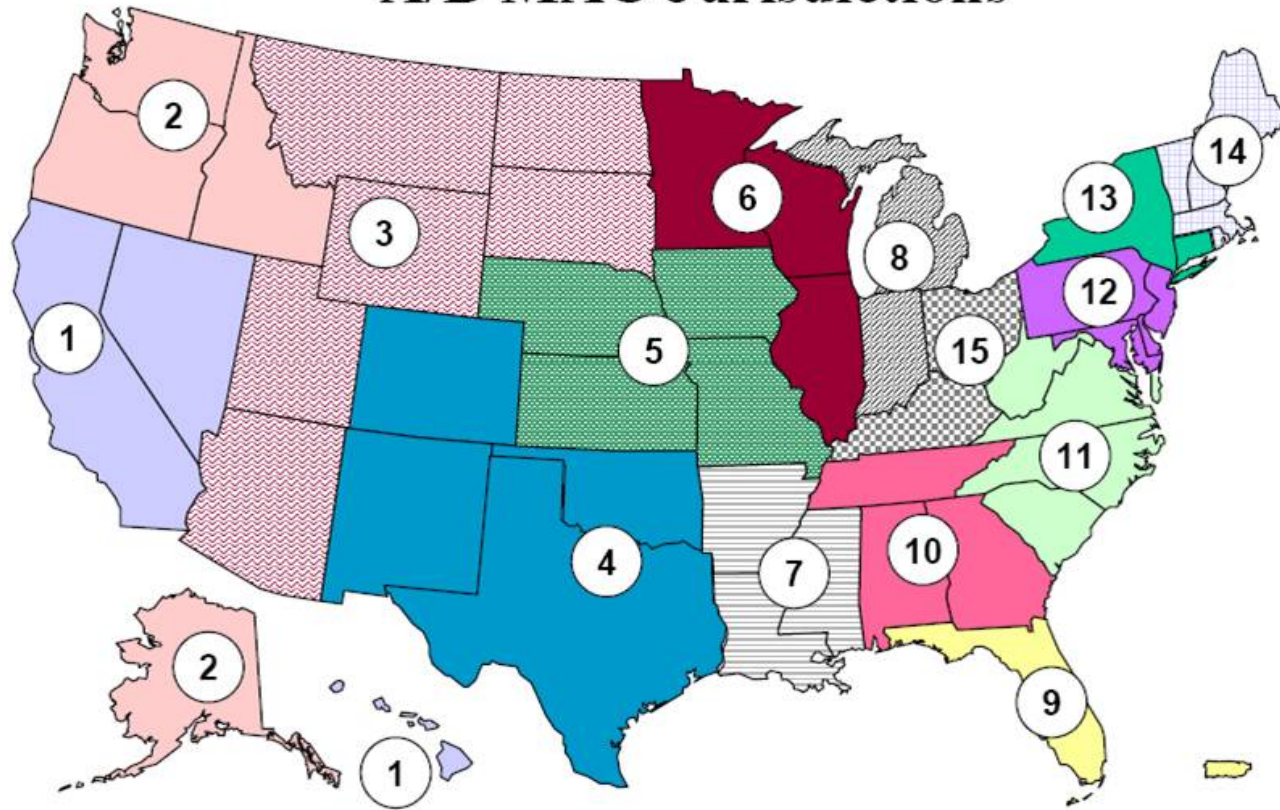


- **Diversified Collection Services, Inc. of Livermore, California, in Region A**
- **CGI Technologies and Solutions, Inc. of Fairfax, Virginia, in Region B**
- **Connolly Consulting Associates, Inc. of Wilton, Connecticut, in Region C**
- **HealthDataInsights, Inc. of Las Vegas, Nevada, in Region D**

MACs



A/B MAC Jurisdictions



Jurisdiction	Award Date	MAC	States
1	10/25/2007	Palmetto GBA	American Samoa, Guam, Northern Mariana Islands, CA, HI, & NV
2	5/5/2008	National Heritage Ins. Co. (NHIC)	AK, ID, OR, WA
3	7/31/2006	Noridian Administrative Services	AZ, MT, ND, SD, UT, WY
4	8/3/2007	Trailblazer Health Enterprises	CO, NM, OK, TX
5	9/4/2007	Wisconsin Physician Services (WPS)	IA, KS, MO, NE
6	1/9/2009	Noridian Administrative Services	IL, WI, MN
7	6/11/2008	Pinnacle Business Solutions	AR, LA, MS
9	9/12/08	First Coast Service Options (FCSO)	FL
8	1/9/2009	National Government Services (NGS)	IN, MI
10	1/9/2009	Cahaba Government Benefit Administrators	AL, GA, TN
11	1/9/2009	Palmetto GBA	NC, SC, VA, WV
12	10/24/2007	Highmark Government Services (HGS)	DE, DC, MD, NJ, PA
13	3/18/2008	National Government Services (NGS)	CT, NY
14	11/19/2008	National Heritage Ins. Co. (NHIC)	ME, NH, VT, MA, RI
15	1/09/2009	Highmark Government Services (HGS)	KY, OH

ICD-10



- CMS has called for a 5 year time frame to transition to ICD-10 codes (Oct. 2013)
- 65,000 codes, about 5 times more than ICD-9
- Physicians and hospitals will have to update their electronic systems to comply, most likely at a cost to them
- CMS says the move will be better for pay-for-performance
- There had been concern over the original 3 year time frame

ACCC Upcoming Meetings



- ACCC hosts regional meetings throughout the year
- Upcoming meetings:
 - Stamford, CT on November 19
 - Milwaukee, WI on December 1
 - Greensboro, NC on December 17
- ACCC 36th Annual National Meeting
 - March 17-20, 2010 in Baltimore, MD

Grassroots

http://www.accc-cancer.org/PUBPOL/pubpol_conwash.asp

Live Search

ACCC Public Policy: Legislative Action Center

[ACCC Home](#) | [Membership](#) | [Meetings](#) | [Public Policy](#) | [Publications](#) | [Education](#) | [Careers](#) | [Members Only](#) | [Media Room](#) | [Site Map](#)

ACCC Public Policy

Legislative Action Center



ACCC Works for You and Your Patients in Washington and Around the Country.

A major policy focus of the Association is to lead efforts aimed at assuring that cancer programs are adequately funded, thereby allowing our members to focus on what they do best: providing quality cancer care.

ACCC has been working tirelessly to ensure that future ambulatory payment classification (APC) payment rates appropriately reflect the cost of cancer care in the outpatient setting. We are working with the Centers for Medicare and Medicaid (CMS) and Congress to ensure continued patient access in both the outpatient and physician office settings.

The "Contact Washington" section of this web site is designed to alert ACCC members about upcoming legislation that may affect patient access to cancer care in. From time to time we may call on you to send an e-mail directly to your Senators and Representatives from the "Contact Washington" section of our web site.

IN THIS SECTION:

- ACCC Public Policy
- Hospital Outpatient Issues
- Physician Office Issues
- Coverage Issues
- Other Payment Issues
- ACCC Alerts and Updates

[Bookmark this site](#)

[Print this page](#)

[Email this page](#)

[Contact ACCC](#)

[Home](#)

[Elected Officials](#)

[Issues & Legislation](#)

[Elections & Candidates](#)

[Media Guide](#)

Legislative Action Center

The Association of Community Cancer Centers (ACCC) continues to work closely with Congress, government agencies, and cancer care advocacy organizations to help assure patient access to quality cancer care.



ELECTED OFFICIALS

Enter your ZIP Code and click "Go" or [click here](#) for other searches.

GO



ISSUES & LEGISLATION

Important issues, recent votes, current legislation, and more. [Click here](#)

GO

Questions



Go to ACCC's website at
<http://www.accc-cancer.org/>

Matthew Farber

mfarber@accc-cancer.org

(301) 984-9496 ext. 221



ACCC

Association of Community Cancer Centers

*The premier education and advocacy
organization for the oncology team*

Thank you

*The premier education and advocacy
organization for the oncology team*

ACCC

Association of Community Cancer Centers