NMDP Update to ACBSCT on Reimbursement for BMT

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May 29, 2014
Presentation Outline

• Provide an Affordable Care Act update
  – The role out
  – Impact on transplant
• Review Medicare coverage and reimbursement
• Describe current initiatives regarding reimbursement
• Review NMDP activity for 2014
Current Reimbursement Issues

• Commercial payers:
  – Definition of networks is concerning – will they include transplant centers?
  – Variation in private plans continues and may be expanding with many exceptions and phase in provisions under ACA
  – Continuing pressure to reduce costs generally

• Medicare
  – Payment for BMT is inadequate
    • Payment for cell source is below cost
    • Payment for inpatient services is inadequate
    • Payment for outpatient BMT is under cost

• Medicaid - Payment for BMT is inadequate
Overview of the ACA
Introduction to the ACA

• The Patient Protection and Affordable Care Act became law in March 2010. PPACA became the ACA.
• Designed with phased implementation for preparation
• Health insurance exchanges and most benefit provision changes went into effect on January 1, 2014

• 3 Major Tenets:
  – Increase access
  – Control costs
  – Improve quality
Essential Health Benefit Set

- Requires coverage of several high-level care categories
- BMT and other transplant types not specifically defined
- Components of BMT are covered in the categories
ACBSCT Recommendation 10

Recommendation regarding Essential Health Benefits

- ACBSCT recommends that the Secretary recognize hematopoietic transplantation for generally accepted indications as a covered benefit for all Federal programs for which the Secretary has appropriate responsibility and oversight.

November 15, 2010
ACBSCT Recommendation 10

Further elaboration:

- This includes autologous and allogeneic blood, marrow and cord blood transplantation. ACBSCT recommends hematopoietic transplantation be included as a required covered service for all federally-funded programs under the Secretary's purview, to the fullest extent allowed by law and that it be included as an "Essential Health Benefit" under provisions of the Patient Protection and Affordable Care Act.
Enrollment above 8 million
More still ‘in queue’
80-90% have paid premiums
Plans scrambling to understand their member mix.
Need to determine 2015 rates ASAP.
On average, 24% of each state’s population will have Medicaid after the expansion.
Substantial Gains in Medicaid

NEW MEDICAID ENROLLMENT, FEBRUARY 2014

NUMBER OF LIVES
- 100,000 or more (10)
- 20,000-99,999 (15)
- 1-19,999 (11 + DC)
- No growth (9)
- No Data Reported (5)
Increase Access through Clinical Trials Coverage

• Coverage of all routine costs associated with clinical trials – Labs, Imaging, Drugs, Professional Fees
  – Federally “approved or sponsored” trials
  – “For the treatment of cancer and other life-threatening diseases or conditions”

• Does not apply to the **actual device, treatment or drug** that would normally be given to the patient free of charge by the clinical trial sponsor

• **Emerging Issue:** For new indications, is the infusion (and associated costs) considered the investigational treatment?
Reduced Costs

- Limited networks
- Potentially limiting benefit coverage
- Changing reimbursement from discounted fee basis
Limited Networks

- To make exchange plans affordable, insurers may dramatically reduce network size
- May not include a transplant center in-network
- Minnesota:
  - Of 13 plans offered in Twin Cities area, only 9 have an Allo SCT program in network
Unknown: How will limited network issues be handled?

- When a patient is in a limited network plan and needs a transplant, what options will they have?
  - Single-case agreements with a local provider?
  - Will patients face out-of-network costs?
  - Will they have to go to the closest center?
- Major cancer organizations are challenging networks
- Network adequacy and out-of-network options will get more scrutiny from HHS in future
Benefit Coverage Concerns

• Different requirements and applicability of ACA provisions based health insurance type:
  – Grandfathered vs. non-Grandfathered
  – Individual (i.e. those available on the Exchanges)
  – Small Group Fully Insured (less than 50 lives)
  – Large Group Fully Insured
  – Self-Insured
  – Individual hold-over plans
  – Early renewal 2013 plans

• Benefits will change from state to state and plan to plan
Reimbursement Trends

• Provide population based reimbursement through ACOs
• Pay for a package of services, e.g. bundled payments
• Uses Medicare reimbursement rates as baseline
  – Gaining momentum – employers no longer willing to subsidize government payors using PPO rates
  – Patients often caught in the middle and balance-billed
Improve Quality
Medicare Focus on Quality

Focus on value and research:
- Required measurement of quality indicators
- Patient-Centered Outcomes Research Institute (PCORI)
- Innovation Center – innovation through payment bundling (Accountable Care Organizations, PCMH)

Promote adoption of electronic medical records:
- Capture patient care data
- Feed studies on effectiveness
- Integrate across providers
Cost Control = Effectiveness Research

What works?
- Clinical Effectiveness

What works best?
- Comparative Effectiveness

What has the best value?
- Cost Effectiveness
Value = Return on Investment

Transplant Community Issues:

- How do we demonstrate our value as a field?
- How do TCs demonstrate their value to a network?
- How do we integrate these questions into our research and our daily activities?
Medicare Coverage and Reimbursement
Coverage Updates

- MDS CED a success
  - Significant growth in access
  - Continuing to accrue patients

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplants, age 65+</td>
<td>5</td>
<td>158</td>
<td>216</td>
<td>274</td>
</tr>
</tbody>
</table>

- New indications:
  Frequent requests re: Tandem MM, Lymphomas
  Problematic due to data requirements
  CED is lengthy and expensive – MDS example
  Alternate mechanism?
ACBSCT Recommendation 11

Recommendation on Medicare reimbursement for graft sources

• ACBSCT recommends to the Secretary that Medicare reimburse for the acquisition of blood, marrow and cord blood products for hematopoietic transplantation on a cost basis similar to how reimbursement is made for graft acquisition in solid organ transplantation.

November 15, 2010
ACBSCT Recommendation 11

• Rationale: The current Medicare payment structure seriously under-reimburses the cost of performing hematopoietic transplantation. The cost of graft acquisition is bundled into the overall reimbursement under the current Medicare prospective payment systems for inpatient and outpatient hospital services. This is fundamentally different from how reimbursement is structured for solid organ transplantation. This recommendation is made to improve the alignment of Medicare reimbursements for these costly but life-saving services.
Reimbursement Update: Reasonable Cost Pass-Through Request

- December 2013 – NMDP and ASBMT partner on meeting with CMS staff to request pass-through of acquisition costs on a “Reasonable Cost Basis”
  - Model used by Solid Organ
  - DRG + Standard Acquisition Charge (SAC)
- Initial CMS indication that they would review and consider the request.
- Waiting for response.
- Can view submitted memos on Reimbursement web site.
Initial Proposal from NMDP/ASBMT

• Utilize solid organ methodology = DRG + SAC
• Likely to differ by care setting:
  – IPPS = DRG + Standard Acquisition Charge (SAC)
  – OPPS = Inclusive Comprehensive APC
    • OPPS would use all claims, not just single claims
    • Stand alone APC with its own payment rate
    • No model for SAC; no OPPS solid organ transplants
• Proposed 3 SAC groups for allo SCT:
  – Unrelated Donor
  – Related Donor
  – Cancellation
Purpose of the OIG:

*Protect the Integrity of HHS Programs*

**Bone marrow or stem cell transplants (new)**

*Billing and Payments.* We will review Medicare payments made to hospitals for bone marrow or stem cell transplants to determine whether Medicare payments were paid in accordance with Federal rules and regulations.

Context—Bone marrow or peripheral blood stem cell transplantation is a process that includes mobilization, harvesting, and transplant of bone marrow or peripheral blood stem cells and the administration of high dose chemotherapy or radiotherapy prior to the actual transplant. When bone marrow or peripheral blood stem cell transplantation is covered, all necessary steps are included in coverage. (CMS’s *Medicare Claims Processing Manual, Pub. No. 100-04, ch. 3, §90.3.)*

Transplantations are covered under Medicare only for specific diagnoses. Procedure codes must be accompanied with by the diagnosis codes that meet specified coverage criteria. **Prior OIG reviews have identified hospitals that have incorrectly billed for bone marrow or stem cell transplants.** (OAS; W-00-14-35723; expected issue date: FY 2014; new start)
2014 Access Priorities
Determining Priorities for 2014

• Review of key reimbursement issues and concerns
  – Legislative and policy changes
  – Issues raised by network transplant centers – emails, site visit feedback, Reimbursement Committee
  – Advisory Group on Financial Barriers to Transplant
  – Gaps in resources for TCs and/or payors
• Priority-setting discussions with NMDP, ASBMT and CIBMTR leadership
• Creation of annual goals and priorities
Advisory Group on Financial Barriers to Transplant (AGFBT)

- Permanent NMDP Advisory Group
- Created in October 2012
- Multi-disciplinary team: Payer Representatives, Physicians, Transplant Networks, Administrators
- Recent activities of the AGFBT:
  - Recommended Benefit Set
  - Infusion Definition Paper
  - Standard Authorization Form
  - Article on Recommended Benefits
  - Forums – 2013 and 2014
  - Key insights and planning
2013 Transplant Payor Forum

Blood and Marrow Stem Cell Transplant:
A Forum on Quality, Transparency, Cost and Value

• Defined priorities for 2014 – outreach, cost studies, quality and transparency initiatives.
• Keynote from Dr. John Santa of ConsumerReports Health
• Examination of the costs of transplant from several different data sources.
• Varied attendee group – gave a fresh perspective and helpful feedback on the information.
• Summary available on both websites.
2014 Forum: Defining Quality and Value in SCT

- Focus for the 2014 Forum: Quality and Value
  - How do we define value for SCT?
  - What outcome measures matter most to clinicians?
  - What quality metrics are most useful to purchasers?
  - How do we incentivize great care without penalizing?
  - Can payers align on quality and value measures?
- June 24-25, 2014, Minneapolis
NMDP Payor Policy Priorities

- Affordable Care Act Implementation
- Relationships & Resources
- Health Services Research
- Medicare Coverage & Reimbursement
Promote Recommended SCT Benefits

- Recommended benefits table available on both websites
- Adopted into NCCN & NBGH Employer’s Guide to Cancer Treatment & Prevention

### Benefit Design for Hematopoietic Cell Transplantation

**Recommendations for designing an effective benefits plan**

<table>
<thead>
<tr>
<th>Donor Search</th>
<th>Cell Procurement</th>
<th>Cell Infusion/HCT</th>
<th>Travel/Lodging</th>
<th>Length of Stay</th>
<th>Medications</th>
<th>Clinical Trials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unrelated donor: coverage of tissue typing; no limit. Related donors: full coverage of procurement, including travel and lodging of selected donor.</td>
<td>Unrelated donor: full coverage of procurement; no limit. Related donors: full coverage of procurement, including travel and lodging of selected donor.</td>
<td>Coverage of HCT and subsequent therapeutic interventions for all medically necessary indications.</td>
<td>Full coverage of travel and lodging costs for member and caregiver(s) for the transplant visit, in addition to necessary pre-and post-transplant evaluations.</td>
<td>No limit on inpatient days or clinic visits.</td>
<td>Coverage of all necessary medications throughout the HCT process, including post-transplant medications, without co-payment or co-insurance.</td>
<td>Coverage of clinical trials appropriate to patient’s age, indication and clinical condition. Minimum: coverage of routine care for patients on clinical trials, per the requirements in the Affordable Care Act.</td>
</tr>
</tbody>
</table>

- No limit on typing/testing costs if potential donors are in covered categories.
- Autologous collection: full coverage of preparation, harvest and storage of cells.
### Center Reporting to CMS
#### Cell Source Cost Reporting Focus

<table>
<thead>
<tr>
<th>Data Year</th>
<th>2007</th>
<th>2009</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Allogeneic Transplants (MS-DRG 014)</td>
<td>329</td>
<td>495</td>
<td>545</td>
<td>752 (600 from non-exempt)</td>
</tr>
<tr>
<td>% reporting 0819</td>
<td>38%</td>
<td>68%</td>
<td>72%</td>
<td>75%</td>
</tr>
<tr>
<td>Median 0819 charges reported (w/o $0 claims)</td>
<td>$8,000</td>
<td>$48,000</td>
<td>$51,800</td>
<td>$50,349</td>
</tr>
<tr>
<td>% reporting Donor Codes</td>
<td>N/A</td>
<td>69%</td>
<td>72%</td>
<td>75%</td>
</tr>
</tbody>
</table>
Cell Source Cost Reporting

- As part of our efforts to understand reporting issues, analyzed claims on a center level
  - Publicly available information from the annual CMS file
  - Can only see high-level information – number of cases, % of claims with donor-code and/or 0819 code attached, total dollar charges reported
  - Only for centers with more than 11 FFS Medicare SCTs
- Pursue activities to further inform centers that are not reporting well
  - Goal of 95% reporting by 2016
Pursue Health Services Research

- Payor Policy and HSR teams at NMDP partnering to produce resources that help decision-makers understand the cost, value and quality of transplant.
- Several publications in 2013-14.
- Studies currently underway:
  - Cost comparisons between SCT and non-SCT treatment pathways for patients age 60-70 with AML.
  - Cost of Medicare transplant patients – hospital stay, donor search and acquisition, year post-transplant.
ICD-10

• Delayed until Oct. 1, 2015 (or longer)
  – Potential to move straight to ICD-11 in 2017
• ICD-10 SCT Crosswalks developed; available soon
• Many national payers and EHR systems moving ahead
• Why non-coders should care:
  – Medicare NCD Conversion will be crucially important – non-converted codes will revert to local contractor decision.
  – Depending on your specialty, may impact reimbursement
Appendix
NMDP Resources
New Website, New Resources
http://network.bethematchclinical.org/reimbursement

Recent additions:

- CMS Donor Search Cost Memos
- 2014 CPT Code Crosswalk
- Impact of the ACA article
- CMS 2-Midnight webinar
- Medicare Billing Toolkit
- Standardization of Terminology article
- New CPT Assistant article with updated codes
- HCT Coding and Documentation webinar

Let us know what you need!
Monthly eBlast – Best Source for Updates

- Monthly email highlighting key information.
- Separate transplant center and payor lists and topics.
- This will be our primary method of communication with the transplant community.
Payer Resources

- Recommended SCT benefit summary
- Fact sheets
- Cost summaries
- Research and coding articles
- AGFBT information
- Standardized authorization form
- Much more coming in 2014

http://payor.bethematchclinical.org
Questions?

• Email – nmdppayorpolicy@nmdp.rg
• Website – www.network.bethematchclinical.org/reimbursement