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CMS Stonewalls GAO On Some Prescription Drug Data

The quest by Congress' investigative arm to scrutinize the Part D program hit another snag after Medicare officials in August backtracked on promises to provide 2006 prescription drug data, including the amount that dual-eligible patients paid out-of-pocket and the drugs most often prescribed to them, according to documents obtained by *Inside CMS*.

Former Acting CMS Administrator Leslie Norwalk said earlier this year that while she wouldn't turn over the prescription drug data to lawmakers, she may provide it to the Government Accountability Office (GAO) (see *Inside CMS*, March 8). But CMS hasn't done so, the documents show.

House Government oversight committee Chair Henry Waxman (D-CA) and ranking Republican Tom Davis (VA) requested GAO seek the information from CMS. Waxman also went to the Part D plans directly and requested some of the same data. While Waxman was successful with his request for data from the private companies that administer Part D benefits, CMS officials told GAO attorneys in an Aug. 27, 2007, letter that the law doesn't require them to provide prescription drug price trends, prices that dual-eligible patients pay and price concessions and rebates that manufacturers pass on to plan sponsors.

However, the agency agreed to give GAO data about Part D grievances and the low-income subsidy program.

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Seeking balance between safety and clinical judgment FACING CRITICS, CMS DEFENDS ESA-FOR-CANCER PAY POLICY

Medicare's top clinician on Tuesday defended a controversial new CMS policy that limits payments for popular anemia-fighting drugs in cancer patients, contending the guidelines are consistent with FDA labeling and will not lead to an increased number of blood transfusions. But Chief Medical Officer Barry Straube also indicated that the agency remains very much open to input from cancer-care stakeholders, some of whom are set to submit a second round of reconsideration requests as soon as this week.

Furthermore, Straube stressed, CMS has yet to make a determination surrounding a first round of reconsideration requests industry stakeholders submitted last month.

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GRASSLEY WANTS MEDICARE BILL MARKED UP BY FINANCE, 1-YEAR DOC FIX

Most Senate Finance Committee Republicans are pushing Committee Chair Max Baucus (D-MT) to follow regular order and mark up the Medicare bill that lawmakers have been negotiating since early September instead of taking it directly to the floor. Several GOP members also are quietly pushing for a one-year Medicare payment relief package for doctors instead of the two-year plan floated by some Democrats, a congressional staffer says.

All the Republicans on the committee, except Sen. Olympia Snowe (R-ME), signed an Oct. 30 letter urging Baucus to follow regular order, while acknowledging the process "will take valuable time."

"We request that you protect the Committee's jurisdiction by insisting that these issues not be brought to the floor without committee consideration

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DOMENICI ASKS FINANCE LEADERS TO CONSIDER HOSPICE CAP MORATORIUM

Hospice stakeholders seeking to stop CMS from collecting millions of dollars in overpayments for exceeding what they consider an outdated and unfair Medicare payment cap recently got a boost from a powerful GOP lawmaker. Sen. Pete Domenici (R-NM) on Oct. 17 sent a letter to Senate Finance leaders asking them to stave off what he views as impending financial disaster for some hospices by implementing a three-year moratorium on payment collection while Congress works to craft a long term solution.

Domenici asked Finance Chair Max Baucus (D-MT) and ranking GOP member Charles Grassley (IA) to include the moratorium in their upcoming Medicare package, expected to be unveiled shortly (see related story).

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2006 DME fee schedule, CMS cut reimbursement for power mobility devices (PMDs) “in excess of 25 percent on average.”

“The committee strongly encourages CMS not to alter further the PMD fee schedule in effect November 15, 2006, during fiscal year 2008,” the report states.

Further, the appropriators want CMS to expedite development of “realistic and workable admissibility criteria” for LTACHs.

Appropriators wrote that the LTACH regulations CMS issued earlier this year set “arbitrary quota limits for the number of patients which an LTACH can accept from any one hospital” and that LTACH patients often are the “most vulnerable of the sick.”

In previous reports, committee members have complained that “the decision as to which patients should go into a LTACH should be made by physicians based on well-defined patient and hospital admissions criteria — not on arbitrary quotas.” The report also mentions a March 2007 Medicare Payment Advisory Commission report that “warned that arbitrary criteria increase the risk of unintended consequences.”

In the House Appropriations Committee report

language, lawmakers noted “ongoing concerns” with beneficiary access to “lifesaving” intravenous immune globulin (IVIG) therapy and “encouraged CMS to continue to work with members of the IVIG community to address these challenges.” The committee commended CMS for establishing separate codes for each brand of IVIG introduced on the market after Oct. 1, 2003.

CMS officials continually remark that their overhead costs are dwarfed compared to those of private insurers. While many insurers see overhead costs that run to 11 percent or higher, CMS’ administrative operations continue to be below 3 percent. However, increases in funding for the administrative budget, which includes salaries for public servants, remain stagnant.

The administrative budget for Medicare has “been a priority for us” and “I’d agree that Medicare has low administrative” spending, a Harkin aide said. That said, the bill does nothing to directly increase spending on CMS overhead.

A recent analysis by the House Government and Oversight Committee found that CMS’s administrative costs, as a percentage of expense, were just 1.7 percent. This is compared to 9.8 percent of expenses incurred by privately run Part D plans.

DOMENICI WANTS MORATORIUM ON HOSPICE REPAYMENTS . . . begins on page one

“There are a number of local, independent hospice programs in New Mexico that are right to be somewhat panicked at repayments being demanded by CMS,” Domenici said in an Oct. 26 press release. “I believe Congress should put a hold on the repayment notices and find a solution that does not threaten the ability of the sick to access hospice care in rural and inner-city areas.”

In the early 1980s, when the benefit was first introduced, CMS implemented an aggregate payment cap as a method to control the costs of a then-experimental program. The agency has not altered the payment structure since. Originally \$6,500 per patient per year, the cap has risen with inflation and is now approximately \$21,400 per patient.

The hospice benefit, advocates explained, grew out of a pilot project serving cancer patients during their last six months of life. In the late 1990s, Congress enacted laws allowing eligible patients to receive hospice care for an unlimited amount of time. At the same time, CMS developed policy that encouraged physicians to declare non-cancer patients eligible for the benefit. The increased number of patients with diseases such as dementia or Alzheimer — which have a less predictable trajectory of illness and often live longer and therefore need services for longer periods of time — led to the current situation where many hospices hit or exceed their payment caps (see *Inside CMS*, July 5).

CMS officials have said they believe the cap has been doing its intended job of keeping Medicare payments to hospitals in check. Further, officials have noted that hospices with the most problems are centered in a handful

of states, but advocates say the numbers are growing. CMS also noted that hospice costs have increased tremendously, nearly \$1 billion over the past year and 641 percent over the past decade.

But industry advocates disagree.

According to the National Alliance for Hospice Access (NAHA), a recently formed coalition of more than 100 independent hospices and other stakeholders, the overpayments have been paid to hospices in only three states in 1999. By 2005, the cap had impacted hundreds of hospices throughout 25 states, with facilities owing CMS a total of nearly \$200 million. The amount seems to be doubling every year, NAHA sources say.

Domenici asked his senatorial colleagues to require CMS to hold off on the repayments for fiscal years 2005, 2006 and 2007. The request is not retroactive, he points out in the letter, because CMS just finished sending out the fiscal 2005 demand letters. In addition, Domenici wrote, the agency is still in the process of calculating the 2006 overpayments and notices demanding repayments will most likely be sent to the same hospices — and many more — soon.

An NAHA source said the organization is thrilled that Domenici has taken action to protect his constituents who are both hospice patients and providers. Domenici’s support is especially important, that source noted, since data from CMS fiscal intermediary Palmetto GBA show that 29 percent of New Mexico’s hospices were affected by the cap in 2005.

According to estimates, in Mississippi that figure could be as high as 62 percent. The number is 41 percent in Oklahoma and 47 percent of Alabama hospices could

exceed the cap.

A source with the National Hospice and Palliative Care Organization (NHPCO) confirmed that they have also been working with Senate Finance staff and members to find an interim solution. Meanwhile, the Medicare Payment Advisory Commission (MedPAC) has been actively engaged on the subject.

The source said NHPCO is having ongoing conversations with MedPAC commissioners and senior staff members in an effort to find reasonable ways to adjust the policies for “what everyone acknowledges is a flawed

payment methodology.”

There is little justification for a cost-containment policy to deny reimbursements to hospice programs when they have provided appropriate care for eligible patients at the end of life, the source said. “We’re looking at anything that would provide interim relief, [but remain] cognizant that the Medicare package itself is going to be limited in cost and scope.”

An aide to Baucus (D-MT) said the lawmaker is “currently reviewing Sen. Domenici’s letter and the important issue it raises.” Grassley’s office did not respond by press time.

Funding level, tobacco taxes remain sticking point . . . **BUSH VOWS TO VETO REVISED SCHIP BILL**

President Bush warned lawmakers Oct. 25 he would veto the revised SCHIP package, but the House proceeded to pass the bill hours later and the Senate reached cloture Wednesday (Oct. 31).

In a letter to lawmakers, the White House complained the bill is too expensive, relies on tobacco taxes, and doesn’t target coverage of poor kids first, among other things.

HHS Secretary Michael Leavitt signaled Oct. 24 areas where the White House was willing to compromise. Democrats moved ahead with their own plan, but failed to garner enough House GOP votes to override a likely second White House veto (see related story).

The Democrats’ revised bill to reauthorize the State Children’s Health Insurance Program tightens income eligibility levels, speeds termination of coverage of childless adults, does more to prevent substitution of SCHIP coverage for private coverage, and strengthens requirements for verification of citizenship. The bill withholds federal funds for children who live in families with incomes above 300 percent of the poverty level.

House Democrats, who were unable to gather enough votes to override the president’s veto of their earlier bill, hoped to gain more GOP support this time around.

The White House may have swayed some GOP members by circulating a Statement of Administration Policy on Capitol Hill Oct. 25 morning saying the president “will veto this legislation if it is presented to him without significant changes.”

The White House complains that the Democrats’ new bill continues to:

- “[A]llow states to expand coverage without assuring that poor children have coverage first.”
- “[P]rovide coverage for some adults through 2012.”
- “[A]llow the use of income disregards to increase eligibility levels.”
- “[M]ove children from private health insurance to government programs.

- “[Provide]insufficient safeguards to assure that funds will not be spent on ineligible individuals.”

- “[R]emarkably, actually costs more than the earlier bill, notwithstanding supposed improvements in policy.”

A day earlier, Leavitt said the president had some ground rules for reauthorization. First, states must meet “rigorous criteria” for enrolling those below 200 percent of poverty and “we’re prepared to talk about the definition of ‘rigorous.’” Up until now the president has been unwilling to back off an Aug. 17 letter that required states to enroll 95 percent of the lowest income children before they could expand coverage to those above 200 percent of poverty.

Second, he said, the language regarding SCHIP non-coverage of “non-citizens” needs to be “tightened up.”

Third, the administration would like to see the time frame to move adults currently covered by the program off SCHIP rolls “accelerated,” he said.

Finally, there is a potential consensus on limiting coverage for those with “fairly high incomes,” he said. Where the administration and Congress are diverging, however, is the \$60 billion price tag, including baseline funding, of the bill.

“What we’re seeing is this administration willing to put more money on the table,” Leavitt told reporters Oct. 24 at an afternoon

briefing about what he characterizes as the beginnings of a compromise on SCHIP reauthorization legislation. “There is obviously some more exactness that needs to be developed. We’re prepared to meet on policy. If we can find common ground on policy, we have to seek changes in the budget number. We’re not prepared to fund the bill with \$15 billion more than is necessary for the policy on which we agree,” Leavitt said.

The administration’s newfound willingness to compromise, which has not actually manifested itself into face-to-face meetings between congressional Democrats and administration officials, Leavitt confirmed, came after 38 Republicans, in a letter to the president, outlined a number of changes — very similar to what Leavitt described during the briefing with reporters — that could result in their

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**— HHS Secretary
Michael Leavitt**
