

Helping Medicare Keep Pace With Medical Technology

HIMA Position

HIMA urges Congress to improve Medicare's ability to keep its payment systems current with advances in medical technology. This can be done through adjustments in the often technical methods and systems that Medicare uses to adopt and pay for new products. Unless the problems plaguing these systems are corrected, Medicare patients will be denied access to needed treatments and continued innovation will be threatened.

Impact on Patients

Though these problems might appear arcane and technical, they go to the heart of what beneficiaries expect Medicare to be — a program that offers appropriate access and the highest quality of care. Yet problems like those described below can delay introduction of — or limit the availability of — new treatments for Medicare patients; retard investment in new products, especially those that while perhaps cost-increasing greatly enhance quality of care; and threaten small companies that are often responsible for the most significant innovations.

Background

After medical technologies are cleared by the Food and Drug Administration, they must pass several critical hurdles in the Medicare program before they are integrated into the portfolio of services that Medicare makes available to its beneficiaries:

- ◆ ***Technologies must be covered.*** Medicare must decide whether they are “reasonable and necessary” and, thus, qualify for any level of payment.
- ◆ ***Technologies must have an identifying procedure code.*** Medicare insists that all procedures have a unique code that identifies the treatment.
- ◆ ***Technologies must be reimbursed through one of Medicare's payment systems.*** Once a product has a code and is covered, Medicare then sets a payment rate for the treatment through separate reimbursement systems that apply to physician care, inpatient care, outpatient care, and treatment in nursing homes, ambulatory surgery centers, and other facilities.

If a problem arises at any of these levels, the technology may not become available to Medicare patients.

Current Problems

In recent years, problems have plagued all of these Medicare systems — coding, coverage, and payment. Although HCFA is currently working hard to reform the *coverage* system, serious problems also abound for medical technology in Medicare's myriad *coding* and *payment systems*. Though the nature of these problems is as diverse as the mechanisms themselves, they share several common themes:

- ◆ Medicare is slow in adjusting these systems to reflect changes in technology and medical practice.
- ◆ Medicare's methods for deciding the appropriate payment codes and payment categories is cumbersome and lags dangerously behind the rapid pace of innovation in medical technology.
- ◆ Medicare's plan for a major new system for hospital outpatient departments – where seniors increasingly receive their care – is deeply flawed and will result in payment rates biased against new technologies.
- ◆ Medicare's data does not reflect the latest and most useful information about new technologies, either because data is not available or because HCFA is unwilling to look beyond its own limited data sources.

Summary of HIMA Recommendations

To address such problems, HIMA recommends that Congress require the Health Care Financing Administration to take steps to protect patients who need current technology:

- ◆ Adjust Medicare payment levels and payment categories at least annually to reflect changes in medical practice and technology.
- ◆ Use valid external sources of information to update payment categories if Medicare's data are limited or not yet available.
- ◆ Establish a process for collecting better data on technologies vulnerable to HCFA's flawed plan for paying hospital outpatient departments.
- ◆ Update national procedure codes (HCPCs Level II) more frequently to reduce delays and timelags.
- ◆ Continue to use local procedure codes to ensure availability of the most recent advances in medical technology.
- ◆ Require HCFA to utilize an advisory committee to help ensure that Medicare's coverage, coding and payment systems are open, prompt, and functioning properly.

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Explanation of HIMA Recommendations

Recommendation 1

Adjust Medicare payment levels and payment categories at least annually to reflect changes in medical practice and technology.

Background

Medical technology changes rapidly, with new innovations appearing daily. Institute of Medicine studies indicate that the life cycles of many medical technologies are extremely short — sometimes measured in months. Such innovations will be available to Medicare patients only if Medicare's coverage and payment systems are regularly adjusted and updated to accommodate them. For example, HCFA is required to adjust a new hospital outpatient payment system only *periodically* to account for changes in technology and medical care, and there is no guarantee that this will occur systematically or in a timely manner.

HIMA Proposal

HIMA recommends that HCFA review and revise payment categories and payment levels for all prospective payment systems *at least annually* to reflect changes in medical practice and technology. This includes prospective payment systems for hospital inpatient, hospital outpatient, skilled nursing facility, and ambulatory surgery facility services. In addition, the public should be permitted to participate in this process.

Recommendation 2

Use external sources of data to update payment categories if Medicare's data are limited or not yet available.

Background

In adjusting payment rates and categories, HCFA has traditionally taken a very narrow view toward information collected outside of the Medicare program. HCFA insists on collecting and using only its own data set — called the Medicare Provider Analysis and Review, or MedPAR, file. Unfortunately, MedPAR data are beset with time lags. New technologies can be tracked

through this system only if they have an appropriate code. But product developers often must wait 18 months or more before a new technology is assigned a new code. Beyond that, Medicare refuses to consider partial-year data that are then extrapolated to reflect full-year charges — thereby further limiting the power of its available data resources. Additionally, as prospective payment systems are developed in the outpatient and ambulatory care settings, it makes little sense to replicate these same problems.

HIMA Proposal

HIMA recommends that HCFA draw on external sources of data about the costs and charges of medical services when its own dataset is untimely, inadequate or insufficient. With respect to new drug therapies for example, the Balanced Budget Act of 1997 required the Secretary to consider reliable, validated data other than MEDPAR when it annually recalibrates and reclassifies DRGs. Medicare should consider, among other sources, data from private insurers, independent clinical research organizations, manufacturers, suppliers, and other non-Medicare entities. HIMA also recommends use of partial-year data when such data are reliable and representative.

Recommendation 3

Establish a data-collection process for technologies vulnerable to HCFA’s proposed new payment system for hospital outpatient departments.

Background

Remarkable advances in technology and medical practice over the past decade have supported the shift of many medical diagnostic and therapeutic procedures from the hospital inpatient setting to the more economical and clinically appropriate hospital outpatient department. HCFA’s plan for a major new payment system for outpatient departments contains serious flaws, among them the failure of the proposed system to sufficiently reflect data on many important items of medical technology.

HIMA Recommendation

HIMA recommends establishing a temporary data-collection period that would apply to devices for which HCFA’s database lacks adequate data. This “do-no-harm” provision would protect patients treated by vulnerable technologies until sufficient data are available to ensure that the new outpatient payment rates and payment categories are appropriate. HIMA’s provision is structured so as not to affect out-of-pocket costs to patients.

Recommendation 4

Remove payment-rate bias from the proposed new Medicare system for hospital outpatient departments.

Background

HCFA's planned new outpatient payment system uses a formula that would give undue weight to high-volume, low-cost medical procedures, thus undervaluing more expensive, quality-enhancing technologies. For example, HCFA wants to pay a little over \$325 for one group of procedures – “plasma and/or cell exchange” – even though this group includes technologies with costs that exceed \$1,600.

HIMA Recommendation

HIMA recommends that the payment groups be constructed based on genuine averages. HIMA also suggests that the highest average cost within a group be no more than two times greater the lowest cost within that group, thus preventing widely divergent medical procedures – requiring widely divergent levels of resources – from being lumped into the same category and paid the same rate.

Recommendation 5

Update national procedure codes (HCPCS Level II)¹ more frequently to reduce delays and timelags.

Background

Unless products have an appropriate identifying code, they cannot be reimbursed appropriately by Medicare. Yet it can take HCFA 18 months or more to approve a new code because of the way the agency structures its calendar for considering and making code changes. In the absence of an appropriate code, hospitals and providers who use the product must file claims using a catch-all or “miscellaneous” code, which is harder for Medicare to process and often results in denial of payment.

HIMA Proposal

HIMA recommends that HCFA eliminate its single annual deadline — currently on April 1 — for applications to change codes or create new codes and, instead, accept applications on a rolling quarterly basis. Further, HIMA urges the agency to update codes so that they become effective on a quarterly basis, rather than bundling them together and releasing them annually. HIMA also recommends that HCFA eliminate its current requirement that products be on the market for six months before they are eligible for a new code.

Recommendation 6

Continue to use local procedure codes to ensure availability of the most current advances in medical technology.

¹ The HCFA Common Procedure Coding System is the uniform system that health care providers use to report the medical services, and in some cases, products that they provide to patients. Level II of that system consists of national codes developed by HCFA and now used widely to report treatment and services for Medicare patients.

Background

New technologies usually are introduced into the health care system at the local level and then diffuse slowly into the broader, national market. For example, the overwhelming majority of coverage decisions are made at the local level by Medicare's contractors. These contractors often use what is known as the HCPCS Level III Local Code to describe new technologies that have not yet been incorporated into the much-slower national coding process. Without these local codes, providers would have to submit claims for many new products using the catch-all "miscellaneous" national code that is often rejected by payers.

HIMA Proposal

HIMA recommends that HCFA continue to maintain and use HCPCS level III procedure codes, which are most responsive to changes in technology. Further, HIMA is opposed to HCFA's proposal to eliminate such codes beginning in 2000 and replace them with a solely national process.

Recommendation 7

Require that HCFA utilize an advisory committee to address Medicare coverage, coding, and payment to ensure that these systems are open, prompt, and functioning properly.

Background

Though rarely recognized, the detailed, inner workings of Medicare's coverage, payment, and coding systems can often delay — or prevent entirely — appropriate patient access to new medical technologies. Because these systems are highly technical and not easily understood, their shortcomings are often overlooked, even by those policymakers trying to make Medicare more technology-friendly. Perhaps more troubling, flaws in payment, coding, and coverage mechanisms often interact with one another in such a way that an improvement in one area— coding, say— can be thwarted by a continuing problem elsewhere, such as in payment levels or categories.

HIMA Proposal

HIMA recommends that HCFA utilize an advisory committee to turn a spotlight onto coverage, coding, and payment issues to help make certain that payment and coding decisions are prompt, permit public participation, and are carried out in a way that ensures access of Medicare beneficiaries to high quality services. Advisory panel attention would be directed to how payment, coding, and coverage systems interact, to steps for correcting any problems that impede the smooth integration of medical technology into Medicare, and to an equitable method of deciding — and appealing — fee schedule payments for non-physician services under Medicare Part B. Finally, HIMA recommends that HCFA consult stakeholders before limiting delivery of Medicare-paid services to certain kinds of health care settings.

