MEDICARE CODING AND PAYMENT: IMPROVING PATIENT ACCESS BY KEEPING PACE WITH INNOVATION

Serious problems in Medicare's coding and payment programs are making it hard for beneficiaries to gain access to innovative technologies and procedures, even if these therapies are covered by Medicare.

A new technology or procedure likely will not be widely available to beneficiaries unless a proper procedure code is assigned and an adequate payment level is set. Coronary stents and a breakthrough pre-term labor test are just two of the many examples of cost-saving technologies whose use has been discouraged by inadequate payment.

Congress must improve Medicare by ensuring that coding and payment decisions are made in an open and timely fashion and that policies are appropriate and frequently updated. Legislation introduced last year by Sen. Orrin Hatch (R-UT) and Rep. Jim Ramstad (R-MN) (HR 2030/S 1626) would write these principles into Medicare law. A similar bill is expected to be reintroduced in 2000.

HCFA should update policies annually to reflect changes in medical practice and technology.

- Medical technology changes rapidly, with new innovations appearing daily. The latest treatment options will be available to beneficiaries only if Medicare's coverage and payment systems are regularly adjusted and updated to accommodate them.
- HCFA should review and modify existing product and procedure codes and reimbursement levels at least annually to reflect changes in medical practice and technology. This policy should be applied consistently across Medicare's program areas, such as inpatient hospital, ambulatory surgery centers, and physician services.

HCFA should draw on external data to keep payment policy current with the latest medical advances.

- Traditionally, HCFA has used only its own internal data set – called the Medicare Provider Analysis and Review, or MedPAR, file – as the basis for changing payment amounts or categories. This can result in inadequate reimbursement rates and can significantly delay needed payment adjustments.
- Much valuable data on the costs and charges of new technologies and procedures is generated outside of HCFA in clinical trials and other areas. The agency could make better, quicker payment decisions by using this data, particularly when its own information is untimely, insufficient or inaccurate.

HCFA should encourage public participation in Medicare payment policy to make sure it is setting appropriate reimbursement levels.

- Public stakeholders should be encouraged to participate in important payment policy decisions, such as initial payment rates and annual adjustments.
- Medicare also needs mechanisms for requesting reconsideration of and appealing payment decisions. This will ensure that inappropriate payment amounts are corrected as quickly as possible.

- Medicare's coverage advisory committee procedures should be improved to encourage the active involvement of the committee's consumer and industry representatives. In addition, the Medicare Payment Advisory Commission (MedPAC), a group that gives Congress input on Medicare issues, should include one member with expertise in medical technology.

Timely assignment of new procedure codes will encourage timely patient access.

- Unless products and procedures have an appropriate identifying Medicare "code," they cannot be reimbursed properly by Medicare and providers will be unlikely to adopt them. HCFA, however, can take 18 months or more to issue new codes because it sets arbitrary annual deadlines for requesting and issuing them.

- HCFA can speed up the issuance of codes by accepting applications on a quarterly basis instead of only once a year and by updating codes so they take effect on a quarterly basis.

- HCFA should eliminate its current requirement that products be on the market for six months before they are eligible for a new code. This arbitrary requirement adds even more time to the code review process, unnecessarily delaying availability of innovative treatments.

- HCFA can make the coding process more responsive to new technology by allowing companies to immediately request a temporary code for an item or service reviewed by FDA.

HCFA should continue using local procedure codes to ensure availability of the most current medical technology.

- New technologies often are introduced into the health care system at the local level and then diffuse slowly into the broader, national market. The overwhelming majority of Medicare coverage decisions are made at the local level by HCFA contractors.

- These contractors use local codes known as "HCPCS Level III" codes to identify new technologies that have not yet been incorporated into the national coding process, which is much slower.

- HCFA should continue to use HCPCS Level III procedure codes, which are the most responsive to changes in technology. HCFA should withdraw its proposal to eliminate such codes and replace them with a strictly national coding process.

HCFA should closely monitor its Medicare coverage, coding and payment programs to make sure that they foster timely access to innovative technology.

- Because coverage, payment and coding are interconnected parts of the process of making new technologies available to beneficiaries, improvements in one area, such as coverage, can be thwarted by a continuing problem somewhere else, such as payment policy.

- HCFA should closely monitor all aspects of the Medicare review process – coverage, coding and payment – to make sure they are working together to provide timely access to innovative technology. The agency should report each year on the timeliness of its Medicare review procedures.

- HCFA's implementation of hospital outpatient reforms called for under the Balanced Budget Act could have dramatic and unintended effects on patient access. HCFA should monitor technology utilization to ensure that patients continue to have access to the full range of treatment options under the new hospital outpatient payment system.