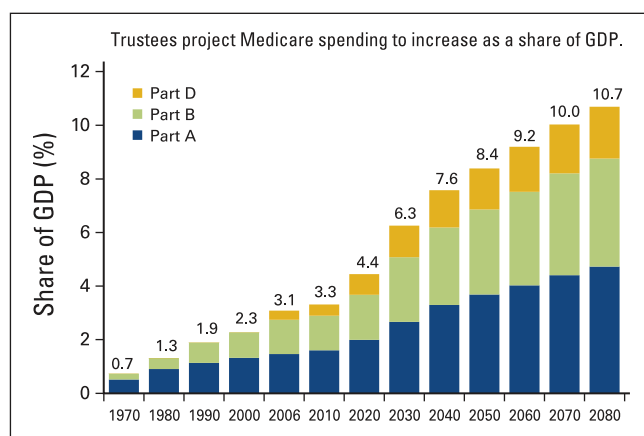


Overview of Medicare Parts A-D

As Medicare spending continues to climb, policymakers are calling for major reforms to ensure that Medicare beneficiaries continue to have access to care without bankrupting the Medicare Trust Fund (Fig 1). It's hard to know what the future holds for health care and how potential changes to the system would affect cancer care delivery. In the following pages, we'll present a primer on Medicare Parts A-D to provide oncologists context for the substantive Medicare reform debates that are anticipated to begin during the coming months.

Figure 1. These projections are based on the trustees' intermediate set of assumptions. Source: 2008 Annual Report of the Boards of Trustees of the Medicare Trust Funds. GDP, gross domestic product.



Medicare in a Nutshell

In its current iteration, Medicare provides health insurance for Americans age 65 and up, and for individuals of any age with a permanent disability or end-stage renal disease (ESRD). Medicare is made up of four parts:

- Part A provides hospital insurance;
- Part B provides medical insurance;
- Part C comprises Medicare Advantage Plans; and
- Part D provides prescription drug coverage.

Since its signing into law in 1965 by President Lyndon B. Johnson, Medicare has undergone numerous revisions. The Centers for Medicare and Medicaid Services (CMS) offers a timeline of key legislative milestones affecting Medicare and other health programs from 1965 to 2003.¹

Medicare Part A

Medicare Part A is dedicated to covering beneficiaries' inpatient hospital costs. These include costs incurred at hospitals and critical-access hospitals, and a limited skilled nursing facilities benefit—but not long-term or custodial care. Also covered are some elements of home health care and

hospice support. Part A pays only for the institutional fees, not for physician professional services. Medicare requires no monthly premium for most beneficiaries because the individual or spouse paid Medicare employment taxes while working. Employment taxes paid by both employees and their employers fund the Medicare Hospital Insurance Trust Fund and therefore fund Part A. For those who never worked or who are otherwise unable to receive premium-free Medicare Part A coverage, there is a purchase option. States also offer assistance for eligible individuals who lack the income and financial resources to pay for Part A. For 2009, the Part A premium for those who purchase Part A coverage is \$443 per month.⁴

Medicare Part A covers only services deemed medically necessary. The following are examples, but not an exhaustive listing, of covered services under Part A:

- Inpatient hospital stay: semi-private room, meals, general nursing, drugs required by treatment, and mental health services.
- Skilled nursing facility care: semi-private room, meals, skilled nursing, and rehabilitative services.
- Home health services: part-time or intermittent skilled nursing care or physical therapy, speech-language pathology, and occupational therapy.
- Hospice care: drugs for management of pain and symptoms, short-term inpatient stays such as inpatient respite care, and medical, nursing, and social services.

Individuals must meet certain criteria for coverage for each episode of skilled nursing care, home health services, and hospice care. For hospice care, for instance, beneficiaries must be diagnosed with a terminal illness and certified by a physician to have a life expectancy of 6 months or less. For home health services, beneficiaries must be homebound, in which case Medicare will cover the first 100 home visits after a hospital stay. For skilled nursing or rehabilitative care, the beneficiary must first complete a 3-day or longer inpatient hospital stay for a related illness or injury, after which Medicare will cover the first 100 days of skilled care in a benefit period. (A benefit period is defined as beginning the day a patient enters a hospital or skilled nursing facility and ends when the patient has gone 60 days without requiring any inpatient care.) Additionally, each type of care may carry out-of-pocket cost to the beneficiary, such as either a flat rate or copayment for services. A deductible applies to some services, including a \$1,068 deductible for inpatient hospital care.⁴

Individuals can automatically get Part A if they are age 65 or older and receiving Social Security or Railroad Retirement

Medicare-Specific Highlights Drawn From the Centers for Medicare and Medicaid Services Timeline and Other Resources

- 1965: Medicare is enacted as Title XVIII of the Social Security Act. The initial premium for Part B is set at \$3 per month.²
- 1966: Medicare is implemented, and 19 million people enroll on July 1.
- 1972: Medicare benefits are extended to Americans younger than 65 with long-term disabilities and end-stage renal disease.
- 1980: Medigap, or Medicare supplemental insurance, comes under federal oversight. Coverage is broadened for home health services.
- 1982: The passage of the Tax Equity and Fiscal Responsibility Act simplifies the process for health maintenance organizations to contract with Medicare and increases quality oversight with peer review organizations.
- 1983: Cost-based payments are replaced by a diagnosis-based inpatient acute hospital prospective payment system (on the basis of diagnosis-related groups).
- 1985: Medicare hospitals with active emergency rooms must provide medical screenings and stabilizing treatments under the Emergency Medical Treatment & Labor Act.
- 1988: The Medicare Catastrophic Coverage Act improves a wide range of benefits, including added mammography coverage, outpatient prescription drug benefits, and a patient liability cap.
- 1989: The Medicare Catastrophic Coverage Act is repealed and a new physician fee schedule is introduced, replacing charge-based payments with a resource-based relative value scale. Each service is defined by a CPT code, valued on the basis of a reference relative value unit.
- 1996: The Health Insurance Portability & Accountability Act of 1996 (HIPAA) creates the Medicare Integrity Program, which funds integrity activities and empowers Centers for Medicare and Medicaid Services to seek competitive contracts for program integrity work.
- 1997: The Balanced Budget Act of 1997 brings seven big Medicare changes, including slowing spending to increase the fund's life span, introducing more managed care and private health plan choices for beneficiaries, and increasing beneficiary educational efforts. This act replaced the Medicare volume performance standard with a sustainable growth rate (SGR) provision to determine the conversion factor each year. The Act specifies the formula for establishing yearly SGR targets for physicians' services under Medicare. The use of SGR targets was intended to control the growth in aggregate Medicare expenditures for physicians' services.
- 1998: Medicare.gov goes live.
- 1999: 1-800-MEDICARE launches and every beneficiary receives a copy of the first *Medicare and You* handbook. The Balanced Budget Refinement Act of 1999 increases some provider payments.
- 2000: The Benefits Improvement and Protection Act increases payments to managed health care organizations and providers, and reduces some copayments while improving preventive services coverage. Medicare Part B premiums climb to \$45.50 per month.²
- 2003: The Medicare Modernization Act of 2003 introduces a prescription drug discount card, permits competition among health plan options, and increases coverage for preventive care, as well as previews the permanent voluntary Part D prescription drug benefit coming in 2006. It also considers Medicare beneficiary income for the first time in setting premiums. This Act establishes the use of the average sales price (ASP) methodology for office-based payment for Part B drugs and biologicals, replacing a system that paid providers on the basis of a published reference price of the drug (average wholesale price). This Act set payments at a rate established by the ASP methodology and generally equal to the ASP plus 6%.
- 2006: The voluntary Medicare Part D prescription drug benefit is opened to Medicare Advantage Plan and private drug plan enrollees.³

Board benefits; younger than age 65 but with certain disabilities and receiving Social Security or Railroad Retirement Board disability benefits; or younger than age 65 with a diagnosis of amyotrophic lateral sclerosis. Individuals must sign up for Part A if they are age 65 or older but not receiving Social Security benefits or if they have been diagnosed with ESRD. For those who are not eligible for premium-free Part A coverage, enrollment is permitted around the time an individual turns 65, from January 1 through March 31 each year and at certain other times, and there may be a 10% increase in the premium if an individual does not purchase Part A when first becoming eligible.

Medicare Part B

Medicare Part B is an optional insurance program that beneficiaries may choose to purchase. It is funded by beneficiary premiums and general revenues. Beneficiaries who do not begin paying a monthly Medicare premium on eligibility are subject to higher premiums unless they qualify for special enrollment (eg, if they continue to receive health insurance coverage through an employer).

Part B covers physicians' services, outpatient services, some preventive care, and other medically necessary services. Beneficiaries pay a portion of all costs (such as a 20%

copayment for the Medicare-approved service amount) or even the entire cost (such as a physician's visit) until they meet their deductibles. Under original Medicare (not Medicare Advantage Plans, which we'll discuss under Part C), the deductible is \$135 per year.⁴ The deductible does not apply to all services. The monthly premiums paid by beneficiaries do not cover the cost of the Part B program; the balance is paid out of governmental general revenues.

Examples of services covered by Medicare Part B include, but are not limited to:

- Physician services
- Chemotherapy drugs and biologics and their administration costs in the office
- Ambulance services
- Emergency room services
- Tests, including diagnostic tests, x-rays, magnetic resonance imaging, and computed tomography scans
- Clinical laboratory services
- Diabetes screening and supplies
- Mammograms
- Selected prescription drugs, including injections, some oral cancer drugs, and drugs administered with durable medical equipment (such as an infusion pump)

A comprehensive listing of covered services is available through Medicare.gov.

As with Part A, Medicare Part B has specified enrollment periods, with possible penalties if an individual fails to sign up when he or she initially becomes eligible. Part B enrollment is automatic, assuming that an individual meets the conditions outlined for Part A, or individuals can sign up under the same conditions as Part A. Part B benefits may be affected by employer or union group health coverage or TRICARE coverage. The 2009 standard monthly premium for Part B is \$96.40, but income and enrollment can affect the final cost to a beneficiary.⁴

Medicare Part C

Part C is another name for Medicare Advantage Plans, which offer Medicare beneficiaries multiple health plan options that cover all of the Part A and Part B services through Medicare-approved private providers. This is the new Medicare, as opposed to the original Medicare—Part A and Part B as separate entities.

Among Medicare Advantage Plan options are preferred provider organizations, health maintenance organizations, private fee-for-service plans, medical savings accounts, and special needs plans. Medicare Advantage Plans cover all of the services covered by Parts A and B and may cover additional services. Most, but not necessarily all, include prescription drug coverage (Medicare Part D). Out-of-pocket expenses will depend on the individual plan, but generally one can expect copayments and possible deductibles and coinsurance.

Some Medicare Advantage Plans have a provider network, so services provided by out-of-network physicians or others may not be covered. In some cases, a referral may be required.

Individuals are eligible for Medicare Advantage Plans if they already have Parts A and B, do not have a diagnosis of ESRD, and live in a plan's service area. Medicare Advantage Plans may or may not charge a monthly premium on top of the Part B premium. Employer or union group health coverage may affect Medicare Advantage Plan coverage, and vice versa. After the time at which an individual became eligible for Medicare, enrolling in, changing, or stopping Medicare Advantage Plan coverage is generally restricted to November 15-December 31 and January 1-March 31 each year (with some limitations in the latter period) and in the case of special situations such as moving out of a plan's service area.

Medicare Part D

Part D provides prescription drug coverage through Medicare-approved private companies. Part D typically carries a separate premium if added to Parts A and B coverage, but is usually rolled in with Medicare Advantage Plan premiums. However, not all Medicare Advantage Plans include prescription drug benefits. Individuals can enroll in Part D when they're first eligible for Medicare or between November 15 and December 31 annually. There may be late-enrollment penalties.

Restrictions vary by plan, but may include prior authorization, quantity limits, or a requirement to try certain lower-cost alternatives before a prescription is covered. As with most prescription drug plans, Part D divides drugs into tiers with varying copayments. Beneficiaries can request an exception and a lower copayment if a higher-tier drug is medically necessary, compared with a lower-tier alternative.

Part D covers all prescription drug costs (except for drugs already covered under Part B) up to a certain dollar amount per calendar year, after which the beneficiary is responsible for 100% of the cost of prescription medications up to a cap during this "coverage gap." Once an individual reaches the out-of-pocket spending cap, he or she will then be responsible for a copay or coinsurance for the remainder of the calendar year under catastrophic coverage. Actual costs vary by plan, and assistance is available for individuals unable to afford any or all Part D costs.

A Few Words on Medigap

Medigap is Medicare supplemental insurance that can ameliorate some of the costs that aren't covered by Medicare Parts A and B. This insurance is provided by private companies, and typically requires that a beneficiary already have Medicare Parts A and B to enroll. Premiums are generally paid monthly, and it's best to enroll as close as possible to enrollment in Parts A and B.

Changes

"In 2008, a friend and mentor retired from an administrative position with a Medicare contractor after a distinguished career that spanned almost the entire existence of the federal program," says Laurence Clark, MD, FACP, a former Medicare contractor medical director who currently serves as senior health advisor for Washington, DC–based government relations firm MARC Associates, Inc. "She stated that she had experienced more change in the last 2 years of her tenure than in the previous 30-plus years. Interpreting the evolving impact of those statutorily derived changes as they unfold, both in a new administration and a difficult economy, may be essential to maintaining a healthy practice in the coming year."

Susan Feigin Harris, partner in the Houston health industry team of Baker Hostetler, agrees, and identifies prescription drug coverage (Part D) and Medicare Advantage Plans (Part C) as the most significant changes to Medicare. "The prescription drug program, because it is new, and for the first time, seniors have access to coverage for much needed drugs, and the Medicare Advantage Plan program simply because it is a managed-care product overlay to the governmental program," says Harris. "Their relative infancy and the gray areas involved in their implementation make them both ripe for problems and for misinterpretation."

Another major Medicare shift is the entrée of Medicare administrative contractors (MACs), which came about when the Medicare Modernization Act authorized CMS to change the fee-for-service program's administrative structure to provide integrated Part A and Part B entities, says Clark. "With the existing program's coverage decision-making process called 'byzantine' and 'arcane' by some industry sources, and the Congressionally mandated PPAC [Practicing Physicians Advisory Council] and CMS's PRIT [Physician Regulatory Issues Team] citing coverage inconsistencies even within the same states, this seemed to be a welcome change to the Medicare landscape," he says. "With time, it well may prove to be so. In the interim, however, it is reasonable to expect confusion and implementation difficulties within the MAC regions. It was unrealistic to expect contractors, bidding for regional contracts that provide for hundreds of millions of dollars of claims processing revenue during the 5-year life of the contracts, not to look for recourse if they were perceived to be disadvantaged in the process." Clark described the result as "a spate of protests" that were generally refereed by the Government Accountability Office, which delayed implementation of the new MAC structure and added not only time but cost to the transition.

The effects of other legislation may not be as apparent but are clearly affecting oncology practice. Clark highlights a provision in the Health Insurance Portability and Accountability Act (HIPAA).⁵ This Act requires a new 10-position numeric identifier called the National Provider

Identifier (NPI).⁶ The NPI was implemented throughout the 2007 calendar year and is required for any transaction to comply with HIPAA regulations. Incorrect or legacy identifiers on a claim invalidate it and result in a denial of payment. Says Clark, "Both of these legislative initiatives [MACs and NPIs], taken as separate efforts to improve the fee-for-service program, would probably be considered seismic with any degree of reflection. To have both initiatives progress concurrently has unfortunately compromised the financial security of many practices, particularly in medical oncology, with its high practice overhead and prepurchased therapeutics."

And although recent changes are having substantial influence over Medicare, the oncology community is still feeling the effects of earlier legislation. The most dramatic change in oncology practice came with the Medicare Modernization Act's revision in payment for chemotherapy drugs provided in the office. The transition from average wholesale price pricing of these drugs to pricing on the basis of average sales price plus 6% has forced oncologists to adjust the services they offer in the office.

Pay-for-performance (P4P), a result of the 2006 Tax Relief and Health Care Act's requirement that a physician quality reporting system be implemented and include incentives for eligible providers,⁷ also caused waves in the Medicare waters. 2008's Medicare Improvement for Patients and Providers Act⁸ made P4P a permanent fixture but authorized incentives only through 2010. Clark identified the P4P efforts as a response to industry and consumer concerns about rising health care costs. "Again, a reasonable intent which includes clinical accountability measures that apply to the practice of hematology and oncology," says Clark. "However, the lack of easily reportable performance codes, and the implicit concerns of these coding conventions interfering with existing practice billing systems prevented many clinicians . . . from participating."

Looking Ahead

There have clearly been major changes to Medicare in recent years, and more changes are expected. "The financial crisis and the continuing deficits will continue to place extreme financial pressure on Congress relating to health care spending," says Harris. "In our history, the last time we went through a similar situation, we saw the BBA [Balanced Budget Act of 1997] and massive cuts in Medicare spending. I think we are in for the same type of cuts. However, our nation is more focused on health-care quality measurements . . . As a result, I think we will see attempts to tie the cuts to quality, or rather, tie incentive payments to higher quality."

The changes anticipated for the near future are more general than oncology specific, says Terry Coleman, Esq., of Ropes & Gray, LLP, a global law firm with offices in Washington, DC. "For the next year or more, I expect Congress to focus on broader health care reform issues—providing health insurance

to individuals who currently are uninsured or underinsured and instituting changes that could help control costs throughout the health care system. Broader insurance coverage may lead to insurance payments for cancer treatment that is currently being provided without reimbursement," he says. "In the area of cost control, I think there will be greater reliance on evidence-based coverage guidelines, but oncology already relies on such guidelines, so the impact should be less than on some other specialties."

However, oncology may not be completely immune. Coleman predicts a revision of physician fee schedules, including chemotherapy payments. "Also, Congress may revise the sustainable growth rate methodology for updating the conversion factor each year," he says. "One possibility being considered is a revision that would create different update amounts for various categories of services. If such an approach were adopted, chemotherapy administration services could be disadvantaged compared with some other types of services."

This possibility is a substantial driver for oncologist involvement in advocacy efforts. "Oncology practices are, by their nature, apt to interface with local policymakers more than some other types of practices. High-ticket chemotherapeutic agents . . . are likely to trigger the development of limited coverage in their applications," says

Clark. Decision makers will be scrutinizing the data that support the use of new drugs and technologies. As noted, evidence-based medicine will play an increasingly visible and critical role in health policy going forward.

Resources for Oncologists

Ensuring that their patients have access to the best available medical care is a key priority for practicing oncologists. Here are some resources to help oncologists stay abreast of critical Medicare information and educate their patients.

- Medicare.gov: The official Medicare Web site contains dozens of articles, downloads, and other resources running the gamut from coverage basics to appeals and billing issues. View the *Medicare & You 2009* PDF for specific information about what is and is not covered and costs for Medicare Parts A-D.
- MedPAC.gov: The MedPAC Web site provides easily digestible summaries and background documents to give any reader a working knowledge of Medicare. The site also offers reports and Congressional testimony.
- Detailed information about Medicare rules and regulations concerning oncology drugs and treatments, and information about local contractors, CAC representatives, and local coverage determinations organized by state and topic.

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