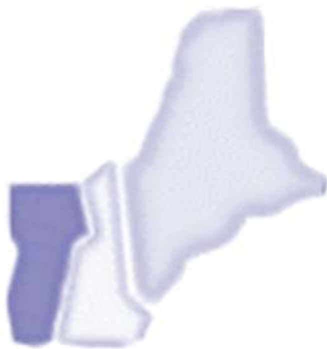


# NNECOS News

*an email publication of Northern New England Clinical Oncology Society*

*Spring 2007*
*Volume 3 Issue 1*


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## *IMPORTANT MEDICARE COVERAGE NEWS*
## *ERYTHROPOIETIN STIMULATING AGENTS*

**There have been several significant changes in Medicare coverage for erythropoietin stimulating agents (ESAs) – darbepoetin alfa (Aranesp) and epoetin alfa (Epogen, Procrit). Follow the links provided below for up to date information on this important topic.**

On March 9, 2007 ASCO reported **pending changes in Medicare coverage policy** for erythropoietin stimulating agents (ESAs).

**Also on March 9, NHIC issued a Part B New England update Revised LCD for Erythropoietin Analogs Unrelated to ESRD (Epoetin Alfa and Darbepoetin Alfa) effective immediately.**

CMS provided an update on March 14, 2007: **Medicare Reviewing Erythropoiesis Stimulating Agents (ESAS) Policies In Response To FDA's Recent Black Box Warning And Public Health Advisories**

ASCO provided a **Frequently Asked Questions** update on March 13, 2007 to provide additional clarification and responses to the most frequently asked questions since the changes in Medicare Coverage policy.

**On March 15, 2007 NHIC Part B New England issued a coding update as follows:**

**Coding for Darbepoetin Alfa (J0881) or Epoetin Alfa (J0885) for "anemia secondary to chemotherapy"**

Please submit claims for Darbepoetin Alfa (J0881) or Epoetin Alfa (J0885) for "anemia secondary to chemotherapy" with the following coding:

- **285.22 Anemia in neoplastic disease, AND one of the following:**
- **V58.11 Encounter for antineoplastic chemotherapy, or V67.2 Following chemotherapy**

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## *2007 EDUCATIONAL MEETINGS UPDATE*

### 4th Annual Spring Practice Management Seminar ~ Tuesday May 22, 2007

NNECOS' fourth annual spring practice management meeting will be held Tuesday May 22, 2007 at the Grappone Center in Concord, NH. Join us for a full day program for your entire team! Tentative topics include: Satellite Clinic How To's

- Payers Panel ~ new & improved!
- Reimbursement Breakouts
- Radiation oncology
- Medical oncology
- Networking with colleagues

### Annual Meeting ~ October 12-13, 2007

Join us in picturesque Burlington, Vermont near the shores of Lake Champlain at the height of peak foliage season October 12-13, 2007 at the beautiful Sheraton Burlington Hotel & Conference Center for NNECOS Annual Meeting, a two-day program for the multi-disciplinary care team. The planning committee is putting the finishing touches on the program, with the following topics tentatively scheduled:

- Biologics
- Breast Cancer
- Palliative Care
- Washington Update
- Nursing Breakouts
- Pain Management
- Safe Handling
- Reimbursement/Practice Management

Save the date for these two great events! We hope to see you there.

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## *AMERICAN SOCIETY OF HEMATOLOGY (ASH) UPDATE*

### Dr. Christian Thomas Represents NNECOS at ASH Practice Forum

Dr. Christian Thomas from the Vermont Center for Cancer Medicine represented NNECOS at the ASH Practice Forum and Reception last December. We thank Dr. Thomas for representing us so well, and appreciate his notes from the meeting to be shared with our members.

#### 2006 Clinical Practice Forum: Pay for Performance (P4P)

A session of experts in the field, chaired by Robert Weinstein, M.D.
Introduction by ASH President Dr. K Rai

**Keynote speaker: Rodger Winn, M.D. (past chair NCCN, editor-in-chief JNCCN)**
"National perspectives on Pay-for-Performance"

Dr. Winn began by defining that value = quality ÷ cost and that effective care requires effective, timely, safe, patient-centered, and efficient care. Studies have shown high medical error rates and only 56% adherence to medical guidelines. The reasons for these deficiencies are not known but may include rising expenditures, consumerism, and regulation/accreditation issues. Solutions for the low adherence to guidelines could include better transparency, payment alignment, and consumer engagement. Options can be provided by improving transparency and quality. One example he mentioned was cardiac surgery. There has been a significant impact

of public reporting of physician performance. He pointed out that patients typically do not select providers based on the publicly available data, at least not yet. Dr. Winn feels that this may play more and more of a role in the future, though. There is data, however, to suggest that public reporting of physician performance data in cardiac surgery influences referral patterns and that this has improved physician performance per se. The result has been a decrease in cardiac surgery mortality, likely as a result that some of the very low level providers have dropped out.

Dr. Winn pointed out that some 50% of HMO's use some P4P measure to evaluate how to reimburse services. The aim is to align incentives according to clinical relevance, promote fairness and professional trust, monitor the effectiveness of incentives, and to prevent unintended consequences (which ones are left to the imagination). The clinical relevance of this process is not totally clear as it is mostly applied to the primary care setting and measures structure and process over outcomes. It is typically simple and not complex. The question is how good is the evidence on which guidelines and outcome measures are based? How about the "incentives"? There are several, such as decreased administrative burden, improved reputation, and financial incentives. Financial incentives will be determined by the market share of the particular insurance, level of incentives (typically not more than 10%), and the type of incentive model: 1) competitive – tiered, 2) threshold – structural, and 3) revenue neutral (i.e. winners and losers balance out). One such revenue neutral model is a private 270 non-for-profit hospital system launched in '03 (PREMIER) rewarding top 10% performers (+ 2%) and penalizing bottom 10% performers (- 2%) (Nahare, Med Care Res Rev, 2004). Another example is PACIFICARE, a 172 hospital system (MB Rosenthal, JAMA, 2005 and 2007). The CMS Demonstration and Pilot Project included physician specialty reporting with a quality measure (CPT II codes). Recent legislation requires CMS to adopt a P4P approach for Medicare. AMA has committed to Congress to develop more than 100 P4P measure by the end of 2006.
The major question is: Will P4P raise standards?

**Paul Adams, M.D. President, Michigan Society of Hematology/Oncology**
Dr. Adams presented the recent discussion between State Society and BC/BS in regards to pharmacy trends and concerns. Issue: rapidly rising drug costs, expected to increase by 125% within next five years. First issue reviewed was introduction of specialty pharmacy for selected drugs (epo, neupogen). Practices were allowed to compete. The State society refused to participate in the program because of additional administrative burden and liability issues. The State Society's counter proposal was an anti-emetic drug and hematopoietic growth factor guideline compliance program. However, BC/BS was not willing to change the insurance forms to accommodate such a program. Currently, a gain sharing pilot program to increase generic drug use is introduced. The savings will be shared, up to $10,000 per MD/year.

**Gerald Robbins, M.D. private practice in Florida for the Florida State Society**
Dr. Robbins is in private practice in Florida. The group has 11 MD's (5 Heme/Onc, 3 Onc, 3 Rad/Onc). The payer mix for this practice: 70% Medicare, 10% HMO, 15% private insurance. Patient mix: 40-45% hematology patients. P4P has centered around clinical pathway development and introduction. Goals are to ensure quality, control and manage cost expectantly, and marketing. Clinical pathways help in negotiating managed care contracts and provide feedback to providers. The "Denver project" using similar methods was successful for teachers. He also cited the CMS demonstration project as an example to adopt, implement, and monitor clinical pathways.

**Samuel Silver, M.D. University of Michigan, former practice committee chairman**
Dr. Silver feels that P4P is the "right thing to do" ("icing on the cake") as it rewards financial performance and achieves (better) quality. He mentioned the Park Nicollet Health Service, a program used to prevent repeated CHF admissions. It worked well to decrease CHF admissions but was financially a loser (6.25% lost revenue).

**Lawrence Solberg M.D. Mayo Clinic, Vice chairman, practice committee**
Discussed quality measures in hematology, in particular ABIM recertification program and use of practice improvement modules for management of MDS, multiple myeloma, and ITP.

ASH has formed a pay for performance task force which recommended AMA reimbursement guidelines (Kenneth Adler, Steven Allen, Timothy Miley, Lawrence Solberg). Drs. Allen and Miley are also members of the ASH committee on practice task force for quality measures.

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## *CALL FOR ABSTRACTS FOR NNECOS 2007 ANNUAL MEETING*

**Submission Deadline: August 1, 2007**
**NNECOS 2007 Annual Meeting, the Sheraton Burlington, VT, October 12-13, 2007**
**Submit Your Abstract Online at www.nnecos.org**

NNECOS seeks abstracts on hematology/oncology topics to share knowledge during the Annual Meeting. Fellows, physicians, nurses, mid-level providers, administrators and pharmacists are invited to submit. Abstracts previously submitted to ASCO, ASH, etc. are acceptable. NNECOS reserves the right to review and accept submissions.

- **Authors of accepted abstracts will be invited to attend the poster session on the evening of Friday October 12, 2007, and offered a discounted meeting registration of $25.00.**
- **The four best abstracts will be presented orally on Saturday October 13, 2007. The responsible first author will have travel, registration, and lodging covered by NNECOS. The submission deadline is 5pm August 1, 2007.**

**Selected Areas/Topics may include:**

- Novel Clinical Trials/Interventions
- Nursing Care
- Palliative Care
- Business/Administrative issues
- Pilot Studies
- Best Clinical Practices
- Patient and Survivor Issues

**Abstracts should be:**

- 250 words or less
- 10-12 point font
- Affiliations clearly listed
- Submitted electronically via email to nnecos@comcast.net, following the enclosed template.
- **Submitted no later than the deadline of 5pm on August 1, 2007**

**For complete information, visit http://www.nnecos.org/NNECOS_Website/General_Members/.**

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## *YOUR FEEDBACK IS IMPORTANT TO US*

We are interested in your feedback and suggestions. Please send your comments and suggestions for future issues to nnecos@comcast.net.

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**Feel free to forward this issue of NNECOS News to your colleagues who may not be current members of Northern New England Clinical Oncology Society.** *If you would prefer not to receive future email correspondence from NNECOS, please reply to this message and type "remove" in the subject line.*

## NEWS FROM OUR SUPPORTERS

*"News from our Supporters" will be included in NNECOS News on a space available basis, with preference being given to supporters who have not shared news in the previous two issues. Send your submissions to nnecos@comcast.net.*

### PHARMION CORPORATION

#### FDA approves new route of administration to Vidaza

The FDA approved the new drug application (NDA) supplement to add intravenous (IV) use as a new route of administration to Vidaza (azacitidine for injectable suspension) on 1/29/07. Vidaza is indicated for all 5 subtypes of Myelodysplastic Syndrome (including low and high risk). With this approval, Vidaza may now be administered intravenously over a period of 10 to 40 minutes in a clinic or hospital setting, providing an additional convenient delivery route for physicians to meet their MDS treatment goals.

### GENENTECH ONCOLOGY

#### Avastin Patient Assistance Program

Genentech's Avastin Patient Assistance Program is an expenditure cap program designed to limit the overall annual cost of Avastin for eligible patients receiving treatment for FDA-approved indications This program was developed in response to concerns about increased costs associated with the higher doses of the new indications FDA approved in 2006. By limiting the overall annual cost of Avastin, the program can help oncologists and patients pursue clinically appropriate treatment without concern about additional costs.

**How the Avastin Patient Assistance program works**

Participation in the program provides a voluntary opportunity for physicians and eligible patients who reach an annual dosage of 10,000 mg to receive free Avastin from Genentech for the remainder of the 12-month period.

**Patient eligibility:** The program is open to all patients receiving Avastin (regardless of insurance coverage) with a household adjusted gross income of up to $100,000. Patients must be receiving Avastin for an FDA-approved indication. Patients must reach the annual dosage of 10,000 mg of Avastin from a single provider or provider organization. Patients and physicians must complete a program application.

If you have questions about the Avastin Patient Assistance program or these other programs, please visit www.SPOConline.com or www.avastin.com, or call SPOC at 888-249-4918.

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***NNECOS wishes to thank all of our Supporters for their contributions in support of the mission of the society, to ensure the availability of and access to high quality oncology care in our region.***