State Affiliate News

Responding to the Impending Realignment of Medicare Administrative Contractors

In accordance with the Medicare Modernization Act of 2003, the Centers for Medicare & Medicaid Services (CMS) is restructuring the administration of the fee-for-service Medicare program. The new system replaces multiple local fiscal intermediaries (Part A) and carriers (Part B) with Medicare Administrative Contractors (MACs) chosen through bidding and open competition. Central to the reform is the creation of 15 new MAC-administered jurisdictions that CMS expects to be fully operational by October 2009.

CMS expects that the MACs will focus on three areas: customer service, operations, and financial management. To fulfill contractual obligations, MACs will be required to have staff with expertise in all aspects of the fee-for-service program. CMS states that the result should be simplified processing, improved customer service, and accurate and consistent claims payments. In addition, CMS believes that by serving as a primary point-of-contact for enrollment, training on Medicare coverage, and billing requirements, and the receipt, processing, and payment of Medicare fee-for-service claims within its jurisdiction, the integrated MAC system promises certain advantages to providers. For an expanded discussion of the MAC, see *Journal of Oncology Practice* 2:283-284, 2006.

Major transitions tend to bring unknown conditions. Therese M. Mulvey, MD, Chair, American Society of Clinical Oncology (ASCO) Clinical Practice Committee (CPC), who recently presided over the Carrier Advisory Committee (CAC) Network meeting, acknowledges that the role of the CACs is in a state of flux. Historically, CACs have assisted in developing local medical review policies (LMRPs) and local coverage determinations (LCDs). For a more detailed description of this process, see *JOP* 3:256, 2007. CACs also have provided a mechanism for improving administrative policies under the carrier's authority, and they have served as an information exchange between carriers and physicians. "MACs that have already formed are using the CAC reps for advice in the same way as before," she says. "It would be in our best interests for the CACs to remain active and report to the MACs."

CAC representatives are reviewing LCDs in their new jurisdiction in order to present the least restrictive policy to the MAC medical director. "Whether or not these folks' services are utilized is likely to be at the individual medical director's discretion," Mulvey says. "By remaining proactive and responsible, we hope that our concerns will be heard, and we will maintain our roles as advisors."

The CPC is forming a MAC advisory committee to consist of an appointed CAC representative from each new MAC jurisdiction, along with the CPC chair, past chair, and chair-elect. By validating this group, ASCO hopes to position its members as leaders and enhance communication between the CAC and MACs.

On the local and regional level, ASCO affiliates are demonstrating the value of collaboration. For example, the Texas Society of Medical Oncology and the Oklahoma Society of Clinical Oncology jointly applied for and received a 2005 to 2006 state affiliate ASCO grant to convene a meeting of the ASCO affiliates whose states comprise the

jurisdiction J4 MAC. In November 2006, representatives from Texas, Oklahoma, New Mexico, and Colorado met to consider how the MAC may affect treatment decisions and access to care, and to develop partnerships to protect their own and their patients' interests. "By meeting early in the process we anticipated that the four state societies would be in an optimal position to move forward when the contract was awarded," says Christopher Ruud, MD, president, Texas Society of Medical Oncology. "And that is exactly what happened."

As a result of that meeting, another in conjunction with the 2007 CAC network meeting, and an active electronic mailing list, representatives from the affiliates were ready to work immediately with TrailBlazer Health Enterprises, LLC, a MAC based in Dallas, Texas. "Our members, along with their patients, will benefit from the seamless transition we anticipate," says Alan Langerak, MD, president, Oklahoma Society of Clinical Oncology. "Our state societies can feel proud of their diligence."

The South Carolina Oncology Society and the North Carolina Oncology Association (NCOA) applied for and were awarded 2006 to 2007 ASCO grants for a similarly focused joint meeting, which convened in August 2007. James D. Bearden III, MD, president, South Carolina Oncology Society, believes the well-received meeting should encourage future collaborative efforts. "State societies can best prepare their members for the changeover to MACs through ongoing communication among their members, joint meetings and reports from CAC representatives," he says. "Establishing a coordinated, fully representative CAC will be the most formidable challenge for the J11 affiliates."

At the meeting, Richard Krumdieck, MD, immediate past president, NCOA, moderated a panel including CAC members from North Carolina, South Carolina, and Virginia, to discuss creating a single J11 CAC that will be fully functional on completion of the transition.

"If a new vendor wins the contract, we will likely face uncertainty surrounding the mechanism for making local coverage decisions and the new medical director's accessibility, attitude and style," says T. Flint Gray, MD, president NCOA. "One of our goals is to make sure our membership is aware of the upcoming changes, so we will continue to address this at our meetings and in our communications with state society members."

Although MAC jurisdictions were created to balance workload allocation, assigning Ohio and West Virginia to separate jurisdictions imposes a burden on the Ohio/West Virginia Hematology Oncology Society (OHVWHOS). "The original impetus for Ohio and West Virginia to join together was their sharing the same local carrier," says Larry Stallings, MD, president, OHVWHOS. "Once we learned of the changes under MAC, we began reviewing options for the continued operation of our society and concluded that a separation was necessary."

Of the 211 members of OHVWHOS, 18 practice in West Virginia. The affiliate is working with a group of those physicians to establish a West Virginia society prepared to collaborate with the other states in

Oncologist Perspectives on Medicare Administrative Carriers (MACs)

The announcement of upcoming changes to Medicare Part A and B administration under the new arrangement of Medicare Administrative Carriers (MACs) has been met with uncertainty, and some concern, by many practicing oncologists. Among the areas of most interest are jurisdictional realignment; the transition from familiar local carriers to a larger, potentially unknown entity; and what the reform will mean for local coverage decisions.

Former Blue Cross Blue Shield of Alabama Carrier Medical Director and current ASCO member Stan Forston, MD, MPH, of Oncology Hematology Care, Cincinnati, OH, recognizes potential cost savings and elimination of redundant efforts under the new system. Additional advantages may include better coordination of payment policies for similar clinical issues and better direct communication about coverage issues.

“The MAC organization seems to be reasonable from my perspective, as long as each state or small region still has its voice in policy development. One of the strengths of the present carrier system is its accessibility to providers,” Forston says. “Potential cons could be that the MAC is so large that it loses its local relations with physicians who can provide valuable policy input [and that] it includes states with few or no common issues, thereby trying to manage a large array of unrelated policies.”

ASCO member Jeffery Ward, MD, of Puget Sound Cancer Centers, Edmonds, WA, agrees that the reorganization of jurisdictions can bring some advantages. “If there is an upside to the MAC, it is [that] it affords an opportunity for state societies that are geographically in proximity to each other to collaborate and unify in an attempt to influence policy for the good of patients with cancer,” Ward says.

As Medicare Contractor Management Group Deputy Director Alan R. Constantian pointed out at the July 2007 meeting of the Carrier Advisory Committee Network in Washington, DC, there is no Centers for Medicare & Medicaid Services (CMS) restriction that would prevent representatives from different states from working together on coverage policy. However, whether different states can work together despite differing priorities and politics, especially among what Forston referred to as states with few common issues, is a different question entirely. And, Constantian said at the meeting, “There can be only one local coverage decision for a jurisdiction.”

In addition, Ward has concerns about what might be characterized as excessive streamlining within the new arrangement. “One of my fears is that one cost cutting measure will be to decrease the number of carrier medical directors to one per jurisdiction,” he says. “Take one person and ask them to cover multiple states and to know Medicare A and B, [and that] translates into an inaccessible and unresponsive medical director—[it] doesn’t matter who they are.”

Another facet of the MAC reform that has raised eyebrows is the 5-year contract period for MACs. “On the one hand, if the MAC is good, providers will want to continue to do business with it and not have to make more frequent transitions to another entity,” says Forston. “On the other hand, a MAC with operational problems and/or difficult medical policy staff means the region is stuck with it for the 5-year duration [of the contract].”

Ward sees the 5-year contract period as a way for CMS to exert more control and have a more active role in what carriers do, which may not be to patients’ benefit. “. . . The current carrier will have 5 years to get into the good graces of CMS so that they can maintain the infrastructure they have built that would be key, over the long run, to make the business worthwhile to the carrier. Talk about pressure to perform,” Ward says. “However, fewer carriers and fewer medical directors will presumably make it easier for CMS to exert influence as well. I think that the further you move control from the patients, the more likely that the patient will suffer.”

On the technical side of things, Forston worries that information technology (IT) in the early stages of the MAC arrangement may not be ready to support the jurisdictions. “I assume that any entity chosen as a MAC will have the necessary IT capability,” he says, “but we have witnessed some real problems at the carrier level when transitioning IT systems, [such as] payment delays, incorrect claims adjudication, and so on.”

Whether these concerns will come to fruition and cause temporary or lasting challenges for practicing oncologists is something that only time will tell, but Ward offers a final concern that may be more immediate and long-lasting than any procedural or organizational changes that come out of the MAC reform. The potential positives to come from the new system, including opportunities to have an impact on policy for patients’ benefit, are “a tall order in an environment where we feel buried by the myriad and continuing changes to Medicare,” Ward says. “I fear that most oncologists have been so buffeted by the changes in reimbursement that they have developed a bunker mentality of resignation and will have no energy for this new task.”

J11, North Carolina, South Carolina, and Virginia, before January 1, 2009, the anticipated launch date for the new Ohio society.

As ASCO continues making recommendations to help CMS identify meaningful and outcome-oriented performance standards on behalf of Medicare beneficiaries with cancer, ASCO affiliates will work together to establish a unified voice for oncology within their new

MAC jurisdictions and to learn from state societies in regions where the transition to a MAC has already taken place.

Marci Cali, Managing Director, ACCC, and Dave Dillahun, Executive Director, OHVHOS, contributed to this article.

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