HSCT in 2020
System Capacity Initiative

Financial Working Group

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Financial Disclosure – None

Learning Objectives

- At the conclusion of this session, attendees will be able to:
  - Describe financial infrastructure challenges to current and future HSCT therapy utilization.
  - Identify initiatives that will contribute to future concepts, methods, technology, treatment, and services that drive the field of HSCT.

Working Group Member Organizations

- Administrators
  - City of Hope
  - Northwest Marrow Transplant Program
  - Seattle Cancer Care Alliance
- Physicians
  - MD Anderson Cancer Center
  - Oregon Health & Science University
  - Roswell Park Cancer Institute
  - University of Miami Sylvester Cancer Center
  - University of Minnesota
- Payors and Transplant Networks
  - Aetna
  - Anthem WellPoint
  - Blue Cross Blue Shield of Texas
  - CIGNA
  - Kaiser Permanente
  - LifeTrac Network
  - OptumHealth

Key Issues within Scope

- Benefits and coverage for HSCT
- Authorization process – for transplants and participation in clinical trials
- Coding for reimbursement

Issue: Transplant Benefits

- Summary: Health insurance coverage and benefits for transplant are highly variable and often lack components important to transplant.

- Recommendations for Year II:
  1. Develop a model benefits set.
  2. Support HRSA ACBSCT's efforts to develop a standard coverage indications list.
  3. Advocate for transplant coverage during implementation of the Affordable Care Act.

Year II Activities

- *Model Benefits*: A benefits table was developed after survey and discussion.
- *Standard Coverage Indications*: *In development;* meeting on this issue tentatively scheduled for November 2011.
- *Health Reform*: The NMDP continues to monitor for opportunities to improve transplant coverage and care.

Model Benefits

August 5, 2011	Recommended Bone Marrow/Hematopoietic Cell Transplant Benefits						
	BMT/HSCT	Donor Search	Cell Procurement	Travel/Lodging	Clinical Trials	Prescription Medications	Length of Stay
Recommended	Coverage of BMT/HSCT and subsequent therapeutic infusions for all medically necessary indications.	Coverage of 1) full biological sibling typing; 2) Unrelated donor typing and testing through the NMDP or other approved registry. No limit on typing/testing costs if potential donors are from one of the covered categories.	Full coverage of cost of donor cell product procurement; no cost limit.	Full coverage for authorized travel and lodging expenses for member and 1 caregiver (adult) or member and two caregivers (if patient is under 18).	Coverage of clinical trials appropriate to the patient's care.	Coverage of all necessary medications throughout the transplant episode with $0 co-payment or co-insurance.	No limit on inpatient days or clinic visits.
Minimum	Coverage of BMT/HCT and subsequent therapeutic infusions for conditions listed on the HRSA ACBSCT Standard Coverage Indications list (pending).	Coverage of 1) full biological sibling typing; 2) Unrelated donor typing and testing through the NMDP or other approved registry. No limit on biological sibling typing; $30,000 minimum limit on unrelated donor typing/testing.	Full coverage of cost of donor cell product procurement; no cost limit.	$10,000 per transplant in coverage for authorized travel and lodging expenses for member and 1 caregiver (adult) or member and two caregivers (if patient is under 18).	Coverage of routine care for patients on clinical trials, per the requirements defined in the Affordable Care Act.	Coverage of all necessary medications throughout the transplant episode with an affordable co-payment or co-insurance limit.	No limit on inpatient days or clinic visits.
Impact of Minimum vs. Recommended	Limiting access to transplant as a treatment may result in increased costs and poor patient outcomes, including death.	Patients with limited search caps may face delay of transplant while attempting to raise additional funds for donor testing. Delay of transplantation can result in poor outcomes.	(N/A)	Patients with limited travel and lodging expenses may face difficulty in affording other necessary medical expenses and/or living expenses. The American Journal of Medicine found that 62% of bankruptcies in 2007 were due to medical bills.	Limiting access to clinical trials slows improvements in the standards of care. Payors often pay for identical care outside of a trial without gaining future benefit from the trial outcomes.	Necessary medications that are non-formulary or have a no-cap coinsurance amount may result in patient non-compliance, poor outcomes, graft failure and/or expensive hospital readmissions due to infection or complications.	(N/A)
Rationale	Transplant indications are expanding rapidly and improving the lives of patients with otherwise fatal conditions.	For BMT, donor cells cannot be obtained without typing and testing potential donors. The number of donor typings needed to find a match is based on the patient's genetics and family structure.	Obtaining cells for transplant is a necessary part of the process. Cost is dependent on where the donor is located and what type of cells are needed for the transplant (Cord blood vs. Marrow vs. PBSC).	There are limited transplant centers in the United States; patients may have to travel to access the center able to treat their condition and/or within their insurance network. Patients are often required to stay within a certain distance (time or mileage) of the transplant center for up to 90 days post-transplant, even after discharge from the hospital.	BMT is a rapidly evolving field. Results of clinical trials improve care for all patients.	Access to medications ensures the success of the transplant. Prohibitive co-payments or co-insurance on post-transplant medications can jeopardize the health of the patient.	Patients frequently need several inpatient visits for treatment of their primary disease, preparation for transplant and cell count recovery. The length of each of these stays varies by patient disease, condition, graft success and complications. Limitation of days in pre-transplant or transplant phase are counterproductive to treatment and may be life-threatening.
Administration	Include all transplant benefits under the general medical benefit spending. Do not implement a separate transplant-only benefit and spending limit.	Separate search and procurement benefits.	Separate search and procurement benefits.	Manage travel and lodging reimbursement through case management; can require use of transplant center provided or contracted housing. Offer different levels of coverage for autologous vs. allogeneic due to variation in expected length of stay. A reloadable debit card can be a good option and easy for patients to use. Tax Option 1: Adopt IRS reimbursement guidelines for taxable amounts. Tax Option 2: Allow for patient to spend allocation in more		1. Note that off-label use of medications is common for cancer care and transplant; they should be included in the definition of "necessary medications". 2. Review outpatient medication benefits to ensure that medically necessary medications are available on formulary and/or for a reasonable co-pay.	

Please see document in binder.

Model Benefits- examples

Minimum

- Coverage of routine care for patients on clinical trials, per the requirements defined in the Affordable Care Act.
- Coverage of all necessary medications throughout the transplant episode with an affordable co-payment or co-insurance limit.

Recommended

- Coverage of clinical trials appropriate to the patient's care.
- Coverage of all necessary medications throughout the transplant episode with $0 co-payment or co-insurance.

Issue: Authorization Process

- Summary: The process for patients to gain approval for transplant and/or participation in clinical trials is difficult and time consuming.

- Recommendation for Year II: Develop standard document that payors and transplant centers can use to request approvals.

Year II Activities

- Survey of payors: collected forms currently in use
- Reviewed common fields and identified areas at issue
- Drafted new form to promote consistency & efficiency of process

Prior Authorization for Transplant

Payor/Plan Name:
Case Manager Name:
Payor/Plan Phone:
Payor/Plan Fax:

☐ **Urgent Request**
Please only check this option if the provider believes that waiting for a decision could place the patient's life or health in danger.

Please attach pertinent supporting documentation to facilitate your request, for example, the history & physical, test results, letter of medical necessity, etc.

Prior Authorization Request Form for Transplant

PATIENT INFORMATION

Patient Name:	DOB:	Member ID:	Group ID:

Patient Address, City, State, Zip:

PROCEDURE INFORMATION:

☐ Search & Evaluation Only

Transplant Type: ☐ Autologous ☐ Cord Blood ☐ Allogeneic-Matched Unrelated ☐ Allogeneic Related ☐ Donor Leukocyte Infusion (DLI) ☐ Other_____

ICD-9 Code(s):	CPT-Code(s):
Brief Medical History (staging, underlying condition, previous remission, response to other therapies, co-morbidities):	**Rationale for Procedure:**

Is treatment part of a protocol? ☐ Yes ☐ No
If yes, please explain.

Date of Procedure:	Date of Arrival for Pre-Transplant Treatment:
Requesting Provider:	Provider NPI:

Requesting Provider's Signature:

Facility:	Facility Tax ID:	Facility NPI:

See document in binder.

Issue: Coding

- Summary: The codes available for transplant are not clear and comprehensive.

- Recommendations: Clarify and expand coding as needed.

Year II Activities

Development of coding recommendations:

1. Promote consistency in coding of search and cell procurement.
2. Clarify the CPT code for Donor Lymphocyte Infusion (38242) – remove 'transplant' terminology.
3. Request ICD-10 procedure code for DLI.
4. Identify the need and request additional codes as HCST and cellular therapy field develops.
5. Evaluate & consider for adoption: CIBMTR Infusion Definitions for use in billing and coding.
6. Review need for a permanent multidisciplinary coding committee.

Year III Recommendation:
Outreach and Distribution of Resources

Summary of Recommendation:

1. Finalize Resources
   - Input from Symposium
   - Input from key external stakeholders
2. Review Target Audiences
   - Payor Societies (AHIP, SIIA)
   - Employer Groups (NBGH)
   - Transplant Centers
   - Professional Society of Benefit Administrators

Year III Recommendation:
Outreach and Distribution of Resources

Summary (continued)

3. Promote and Distribute Resources
   - Tailor messages: highlight how the resources will be useful for each group
   - Create discussion guides and starter slide sets
   - Utilize established communication channels:
     - Conferences/meetings – presentations, booth
     - Webinars
     - eBulletins/newsletters
   - Publish white paper on Financial Working Group process and resources developed

Year III Recommendation:
Outreach and Distribution of Resources

- *Benefits to System Capacity Initiative*: Widespread use of these resources could reduce financial barriers to transplant
- *Resources*:
  - Distribution channels – access to Web Sites, e-mail lists,
  - Time and networks of group members
- *Metrics:* Number of organizations 1) engaged and 2) utilizing resources.
- *Challenges*: Gaining the attention of decision-makers in a very busy health care environment

Working Group Membership

- Chair
  - Richard Maziarz, MD
- Vice Chair
  - Richard Champlin, MD
- Members
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  - Peggy Appel, MHA
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Questions or Comments

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