BY LIBERTY PARTNERS GROUP

Radiation Oncology

POLICY UPDATE

APRIL 2012

House of Representatives Passes House Budget Resolution

On March 29, the House of Representatives passed the House Budget Resolution by a 228-191 vote. No Democrats backed the measure and it is not expected to pass the Senate.

The House Budget Resolution contains two provisions of interest:

- A "deficit-neutral" reserve fund to fix the SGR.
    - This is simply a non-funded policy placeholder to accomplish an SGR fix.
- "Reconciliation instructions" to various House committees, including Ways and Means and Energy and Commerce, to find offsets ($53 billion and $97 billion over 10 years respectively) to replace portions of the 2013 sequester established by the Budget Control Act of 2011.
    - Committees are required to report back to the House Budget Committee with offsets by April 27, 2012. While Medicare is not specifically listed as an offset, it is within the jurisdiction of both the Ways and Means and Energy and Commerce Committees.

An accompanying report to the Chairman's Mark for the House Budget Resolution noted, "Ultimately, the committees will be responsible for determining how to meet their reconciliation instructions. But savings could be achieved in the areas of making pensions for federal workers more like those for workers in the private sector, repealing recent expansions of the federal role in financial services, saving money in health care, means-testing entitlements, and reforming the medical liability system."

MedPAC Annual Report Released to Congress

On March 15, the Medicare Payment Advisory Commission (MedPAC) released its annual report and related fact sheet to Congress. Although non-binding on the Congress, MedPAC's recommendations receive serious consideration; the annual March report provides recommendations on payment updates for the various Medicare subsectors.

- *Physicians*. MedPAC reiterated previous recommendations from an October 2011 letter to Congress for "moving forward from the sustainable growth rate (SGR) system" including:
    - Repealing the sustainable growth rate (SGR) system and replacing it with (1) a freeze in current payment levels for primary care and (2) for all other services, annual payment reductions of 5.9 percent for three years, followed by a freeze. Related options included:
        - A list of options for the Congress to consider if it decides to offset the cost of repealing the SGR system within the Medicare program, including prior authorization for imaging by outlier physicians.
        - Computing benchmarks for ACOs (and bundled payment initiatives) at 2011 fee-schedule rates.
    - Regularly collecting alternative sources of data for work and practice expense costs from a cohort of practitioner offices and other settings recruited through a process that would require participation in data reporting.
    - Identifying overpriced fee-schedule services and reducing their relative value units (RVUs) accordingly.
- *Hospital Outpatient*. MedPAC recommendations for the hospital outpatient setting included:
    - Increasing payment rates for the outpatient prospective payment system in 2013 by 1.0 percent.
    - Over the course of three years, reducing payment rates for evaluation and management office visits provided in hospital outpatient departments so that total payment rates for these visits are the same whether the service is provided in an outpatient department or a physician office.

As part of the report, MedPAC also estimated the use of services by physicians according to "type of service." For radiation therapy, the average annual growth rate in volume per beneficiary from 2005-2009 was 5.3%, but from 2009 — 2010 it was —1.9%.

MedPAC Commission Meetings

Bundling Post-Acute Care Services

On March 8, MedPAC met to discuss bundling post-acute care (PAC) services in the Medicare program. MedPAC noted that "bundling provides another FFS strategy apart

from ACOs to manage spending while increasing value." Much of the discussion involved bundling design issues relating to an initial hospital stay including (1) whether the scope of services should be separate or combined with a hospital bundle, (2) how to deal with readmissions, (3) the time period for the bundle (e.g. 30 or 90 days post-discharge), and (4) how to pay for the bundle. MedPAC staff indicated, while a bundle that combined acute and post-acute care was more likely to incentivize coordinated care, separate bundles were likely to be more accurate.

MedPAC's presentation can be found here.

Reforming Medicare's Benefit Design

On March 8, MedPAC met to discuss options to reform Medicare's benefit design through such means as (1) combining the Part A and Part B deductible, (2) protecting against high out-of-pocket costs and (3) varying copayments according to the type of service. MedPAC presented an "illustrative" reform package whereby per-visit copays for primary care would be $20 and specialty care would be $40. The commission may include related recommendations on this issue in its June report to Congress

MedPAC's presentation can be found here.

House Passes Bill to Repeal the Independent Payment Advisory Board (IPAB)

On March 22, the House of Representatives passed H.R. 5, the "Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011" by a vote of 223-181.

This legislation included a provision to repeal the IPAB and related processes by which that Board or HHS would be required under certain circumstances to reduce payments in the Medicare program to achieve spending targets. These provisions were included in the Affordable Care Act (ACA). Because CBO estimated IPAB repeal would cost $3 billion, the bill also included a medical malpractice reform offset. This provision, which CBO estimates would reduce the deficit by $49 billion, would impose limits on medical malpractice litigation in state and federal courts by capping awards and attorney fees, modifying the statute of limitations, and eliminating joint and several liability.

The bill is not expected to pass the Senate.

CMS Hosts Bundled Payment Webinars

- ***Contractual and Governance Issues among Providers in Bundled Payment***

  On March 22, CMS held an Accelerated Development Learning Session on the BCPI. The presentation covered (1) examples of BCPI structures, (2) governance issues, (3) contract issues and (4) dispute resolution/appeals.

- *Examples of BCPI structures*. The presenter listed the following examples of possible BCPI structures including: (1) single physician group, (2) IPA of physicians, (3) co-management entity, (4) PHO (Physician-Hospital Organization), and (5) new entities (e.g. post-acute networks in Model 3).

- *Governance Issues*. Governance issues included: (1) the number of directors on a board, (2) voting structures (e.g. one person, one vote), (3) issues requiring supermajority votes, and (4) classes of providers involved in governance.

- *Contractual Issues*. Contractual issues included: (1) allocation of upside distributions and downside risk and (2) grounds for voluntary and involuntary termination.

- *Dispute/Resolution Appeals*. The presenter emphasized the need to address dispute resolution in contracts, otherwise, BCPI participants could end up in court over disputes. In the opinion of the presenter, the following items should not be subject to appeal: (1) the definition of the episode, (2) the part of the episode the provider contracted to provide, (3) rules pertaining to when an episode is triggered, and (4) Medicare's direct payment to the provider.

- ***What to Pack in Your Bundle: Episode Selection, Definition and Clinical Management for Care Improvement***

  On March 13, CMS held an Accelerated Development Learning Session on the BCPI. Presenters discussed issues relating to (1) Episode Construction and (2) Preparing for Episode Payment.

  - *Episode Construction*. The Episode Construction presentation involved, among other things, pricing and sources of risk.

    - *Pricing*. With respect to pricing, the presenter explained that Medicare payments under the BCPI would start with an applicant defining an "episode." Then an applicant would use 2008-2009 data to develop a cost per episode. For a BCPI pilot beginning in 2013, CMS would use a methodology to update 2008-2009 cost data to 2013. Importantly, the presenter indicated that CMS had not yet announced a method for adjusting between historical costs and performance year costs. The presenter noted that CMS also could require some discount from the 2013 cost to arrive at a target price.

    - *Sources of Risk*. The presenter listed the following potential sources of risk in the BCPI including (1) low case volume, (2) catastrophic cases, (3) change in case mix over time, and (4) failure to follow the care-redesign protocols.

- *Preparing for Episode Payment*. This presentation involved, among other things, process redesign principles, including: (1) elimination of unnecessary care steps, (2) automation of work, (3) delegation of work to appropriately trained non-physician staff, (4) incorporation of consensus and evidence-based guidelines, (5) baseline performance measures, and (6) robust clinical informatics.

- ***Distinguishing Between Applicant Roles in BCPI***

  On March 8, CMS held a call to discuss the different applicant roles relevant to the BCPI. Currently, there are four bundled payment models under BCPI, each of which is linked to an MS-DRG. Due to the broad range of Letter of Intent (LOI) submissions, CMMI felt the need to distinguish between various applicant roles according to (1) Facilitator Convener, (2) Awardee Conveners, and (3) Awardee.

  - *Facilitator Convener*. Facilitator Conveners would not be risk-bearing or receive payment from CMS, but would apply with risk-bearing Awardee Conveners or Awardees. Facilitator Conveners would provide administrative and technical assistance functions. For example, a specialty society, association or venture capital company might choose to be a Facilitator Convener.

  - *Awardee Convener*. Awardee Conveners apply with partners and bear risk for BCPI beneficiaries of at least one of those partners. For example, a parent company would bear risk for episode-initiating partners.

  - *Awardee*. Awardees would be risk-bearing, but would only bear risk for their own bundled payment beneficiaries and regardless of other providers where the patient might receive care during an episode. Examples include an individual hospital or center.

- ***Technical Assistance with the BCPI***

  CMS hosted several data technical assistance conference calls in March to discuss questions from users relating to the BCPI. CMS's contractor, the Research Data Assistance Center (ResDAC), has posted an ongoing Q/A here relating to these calls.

CMS Call on the EHR Incentive Program Stage 2 Requirements

On March 12, CMS hosted a national provider call about Stage 2 requirements contained in a Proposed Rule for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program.

This newsletter previously reported on the overall changes between Stage 1 and Stage 2 requirements contained in the Proposed Rule. During the March 12 call, CMS provided additional information relating to the program, including details relating to "payment adjustments" (i.e. provider cuts) for eligible professionals and hospitals that are not "meaningful users" of certified EHR technology for certain reporting periods. Specifically, payment adjustment reporting periods for eligible professionals and hospitals would depend on the year in which these providers first demonstrate meaningful use as follows:

- *2011/2012 Demonstration of Meaningful Use*. Eligible professionals and hospitals that first demonstrate meaningful use in 2011 or 2012 would be subject to 2015 payment adjustments based on a full year EHR reporting period in 2013.

- *2013 Demonstration of Meaningful Use*. Eligible professionals and hospitals that first demonstrate meaningful use in 2013 would be subject to 2015 payment adjustments based on 90-day EHR reporting period in 2013 (2016 payment adjustments would then be based on a full year EHR reporting period in 2014).

- *2014 Demonstration of Meaningful Use*. Eligible professionals and hospitals that first demonstrate meaningful use in 2014 would be subject to 2015 payment adjustments based on 90-day EHR reporting period in 2014 (2016 payment adjustments would be based on a 90-day EHR reporting period in 2014 and 2017 payment adjustments would be based on a full year EHR reporting period in 2015). In order to avoid 2015 payment adjustments, eligible professionals must attest to meaningful use no later than October 1, 2014, which means they must begin their 90-day reporting period no later than July 2, 2014.

The American Medical Association also has provided summary highlights of the Stage 2 Proposed Rule as well as a summary table of proposed requirements for meeting meaningful use under Stage 2.

CMS Call on the Physician Value-Based Modifier Program

On March 14, CMS hosted a National Provider Call about the Physician Value-Based Modifier Program. Section 3007 of the Affordable Care Act requires CMS to apply a value modifier, which compares the quality of care furnished to the cost of that care, to physician payment rates under the Medicare Physician Fee Schedule starting with specific physicians and physician groups in 2015 and expanding to all physicians by 2017. Services provided in 2013 will be used to calculate the 2015 modifier. In 2012, CMS is planning to provide participants in the Physician Quality Reporting System (PQRS) information that will be used in calculating the value modifier.

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Supreme Court Hears Oral Arguments on Constitutionality of Affordable Care Act

Between March 26-28 the U.S. Supreme Court heard oral arguments over the Constitutionality of the Affordable Care Act.

- Day one of oral arguments focused on whether the Anti-Injunction Act prohibits the Court from ruling on the Constitutionality of the ACA's individual mandate. The Anti-Injunction Act prohibits taxpayers from seeking pre-enforcement relief from a tax that has not been collected. Under the ACA, people who are required to purchase insurance but do not will face a monetary penalty collected by the Internal Revenue Service.

- On day two, the Court heard testimony over the constitutionality of the ACA's individual mandate and whether Congress has the authority to require that most Americans obtain health insurance. The questions focused on what the explicit limit is to Congress' power if indeed it has such authority.

- The final day of oral arguments focused on the severability of the law. The arguments centered on whether the rest of the ACA would remain in effect, were the individual mandate provision ruled unconstitutional. Day three also featured arguments on a separate constitutional challenge to the law: the contention that the law's expansion of Medicaid coerces the states.

Now that oral arguments are complete, the Court must decide how they will rule on the case. Technically, the Court can issue a ruling at any time; however, decisions are usually handed down before the Court adjourns in late June.

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