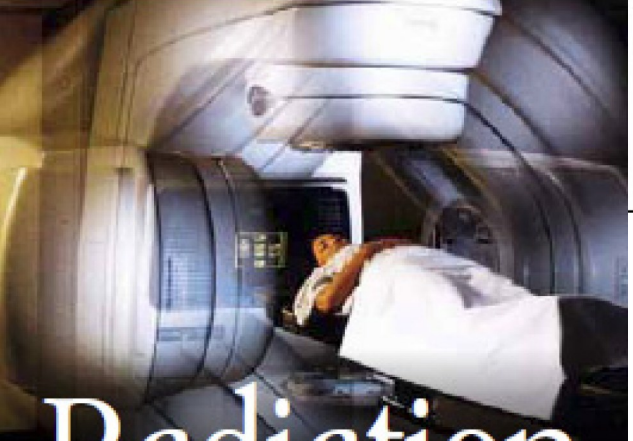

Radiation Oncology

POLICY UPDATE

FEBRUARY 2012

BY LIBERTY PARTNERS GROUP

AMA Urges Use of "War Funding" to Offset SGR Cuts

On January 23, the American Medical Association (AMA) and over 100 affiliated physician groups – including the American Society for Radiation Oncology (ASTRO) and the American College of Radiation Oncology (ACRO) – signed a letter to Ways and Means Chairman Dave Camp urging that Congress use so-called "War Funding" to offset 27 percent SGR cuts scheduled to occur on March 1, 2012. According to the AMA letter, "excess" baseline projections for funding related to the wars in Afghanistan and Iraq and similar activities (sometimes referred to as overseas contingency operations, or OCO) could be used to offset accumulated SGR "bad debt." In essence, the AMA argues that the use of the OCO funds would amount to "eliminating one flawed budget gimmick with another and allowing for a more accurate accounting of future government expenditures without increasing the federal deficit."

Conference Committee on Payroll Tax/SGR Bill Has First Meeting

On January 24, the conference committee on the payroll tax/ SGR bill (H.R. 3630, Temporary Payroll Tax Cut Continuation Act of 2011) had its first meeting. Conferees used the meeting time to make opening statements on the conference. As part of his opening statement, Ways and Means Chairman Camp indicated that the total cost of provisions under consideration for the legislation (e.g. SGR, payroll taxes, unemployment) would amount to roughly $160 billion.

CBO Review of Bundled Payment and Other Demonstrations

On January 18, the Congressional Budget Office (CBO) released an issue brief entitled, "Lessons from Medicare's Demonstration Projects on Disease Management, Care Coordination, and Value-Based Payment." According to CBO, over the past two decades CMS has conducted two broad kinds of demonstrations aimed at enhancing the efficiency of traditional Medicare: (1) Disease Management and Care Coordination and (2) Value-Based Payments. The issue brief is a review of 10 major demonstrations in these two categories with summary conclusions as follows:

>> **Disease Management and Care Coordination.** *In nearly every program involving disease management and care coordination, spending was either unchanged or increased relative to the spending that would have occurred in the absence of the program, when the fees paid to the participating organizations were considered.*

>> **Value-Based Payments.** *Results from demonstrations of value-based payment systems were mixed. In one of the four demonstrations examined, Medicare made bundled payments that covered all hospital and physician services for heart bypass surgeries; Medicare's spending for those services was reduced by about 10 percent under the demonstration. Other demonstrations of value-based payment appear to have produced little or no savings for Medicare.*

According to CBO, the bundled payment demonstration that yielded 10 percent savings was able to do so through the negotiation of bundled-payment rates that were lower than separate payments they otherwise would have received.

First Accelerated Development Learning Session on Bundled Payments

On January 18, the Center for Medicare & Medicaid Innovation (CMMI) held its first Accelerated Development Learning Session (ADLS) webinar for Bundled Payments. CMMI indicates it will be hosting a number of webinars particular to the topic of bundled payments. The January 18 webinar included two senior leaders from a hospital health system and large group practice of orthopedic surgeons, respectively, to outline the strategic and operational path each followed to implement bundled payment. Both presentations outlined the following broad steps in creating a bundle:

1. Convening the team (e.g. convening a team with the following characteristics: legal/ policy, clinical, quality improvement, data analysis, finance, leadership/administration, marketing).
2. Defining the episode (e.g. defining the appropriate services and timeframe).
3. Defining performance measures (e.g. defining process and outcome metrics).
4. Developing care models (e.g. utilizing existing clinical guidelines).
5. Cost reduction opportunities (e.g. reducing waste within the bundle).
6. Pricing the bundle (e.g. determining the "base cost" of each component in the bundle).
7. Gain-sharing (e.g. developing potential gainsharing strategies within the organization).
8. Continuous process improvements (e.g. utilizing a data registry).

Study on Comparative Effective Research for Prostate Cancer Radiation Therapy

On January 10, the journal Future Oncology released an article entitled "Comparative effectiveness research for prostate cancer radiation therapy: current status and future directions." The article distinguishes forms of comparative effectiveness research (CER) from randomized clinical trials (RCTs) by arguing that the former "seeks to use evidence to inform medical decision-making, based on measures of effectiveness of the various options in real-world scenarios," while the latter has several important limitations when applied to "real-life settings." First, RCTs typically exclude patients with a variety of comorbid conditions or potential inability to adhere to the treatment protocol. Second, RCTs often span many years and results may be obsolete by the time they are published. Third, RCTs do not exist for many clinically relevant comparisons due to the expense of conducting an RCT or challenges to accrual. As a result, the article argues "[t]o improve the effectiveness and efficiency of CER for PC and PC RT, a high priority must be placed on: developing, funding and conducting trials designed to compare effectiveness, such as pragmatic clinical trials and adaptive trials; creating high-quality PC registries designed to incorporate a wide-array of data types and sources; expanding the scope and quality of existing databases for observational studies; and improving the medical informatics system for PC CER."

2012 Cancer Facts and Figures Report

The American Cancer Society released its annual Cancer Facts and Figures report on January 4. The report concluded that cancer death rates continue to decline among the most commonly diagnosed cancers. Selected rates include:

>> **Prostate.** *Prostate cancer death rates have been decreasing since the early 1990s in both African Americans and whites. Prostate cancer death rates decreased 3.0% per year in white men and 3.5% per year in African American men from 2004 to 2008.*

>> **Breast.** *Death rates for breast cancer have steadily decreased in women since 1990, with larger decreases in younger women; from 2004 to 2008, rates decreased 3.1% per year in women younger than 50 and 2.1% per year in women 50 and older.*

>> **Lung.** *Death rates began declining in men in 1991; from 2004 to 2008, rates decreased 2.6% per year. Lung cancer death rates did not begin declining in women until 2003; from 2004 to 2008, rates decreased by 0.9% per year.*

CMS Actuaries Report on Health Spending

On January 9, CMS actuaries released a report on U.S. health spending in 2010. According to the report, health care spending overall experienced historically low rates in 2009 and 2010 due to the impact of the recession. High unemployment, loss of private health insurance coverage and increased cost sharing resulted in some individuals forgoing care or seeking lower cost alternatives. As such, growth in the use and intensity of health goods and services was a lower percentage of personal health spending than in previous years.

Physician and clinical services spending also grew at a historically low rate of 2.5 percent. In addition to the decline in private health insurance coverage, decreased spending on physician services was due to increased cost sharing requirements by employer-based health insurance plans. Decreased Medicare spending on physician and clinical services was due, in part, to a substantial slowdown in growth of the volume and intensity of services.

PCORI Outlines Research Priorities

On January 23, the Patient-Centered Outcomes Research Institute (PCORI) released a draft report on national priorities for research. Unlike the Institute of Medicine's 2009 report on priority topics for comparative effectiveness (CER), the recent PCORI report is a framework to identify the specific questions that are most important for PCORI to address. As part of this framework, PCORI proposed the following research agenda:

>> **Comparisons of Prevention, Diagnosis, and Treatment Options.** *Research should focus on 1) clinical options with emphasis on patient preferences and decision-making, 2) biological, clinical, social, economic, and geographic factors that may affect patient outcomes.*

>> **Improving Healthcare Systems.** *Research should focus on 1) ways to improve access to care, receipt of care, coordination of care, self-care, and decision-making, 2) use of non-physician healthcare providers, such as nurses and physician assistants, and the impact on patient outcomes, 3) system-level changes affecting all populations, diseases, and health conditions.*

>> **Communication and Dissemination.** *Research should focus on 1) strategies to improve patient and clinician knowledge about prevention, diagnosis and treatment options, 2) methods to increase patient participation in care and decision-making and the impact on health outcomes, 3) communication tools that enhance decision-making and achieve desired outcomes, 4) ways to use electronic data ("e-health records") to support decision-making, 5) best practices for sharing research results.*

>> ***Addressing Disparities.*** *Research should focus on 1) ways to reduce disparities in health outcomes, 2) benefits and risks of healthcare options across populations, 3) strategies to address healthcare barriers that can affect patient preferences and outcomes.*

>> **Accelerating Patient-Centered and Methodological Research.** *Research should focus on 1) ways to improve the quality and usefulness of clinical data in follow-up studies, 2) methods to combine and analyze clinical data that follow patients over time, 3) use of registries and clinical data networks to support research about patient-centered outcomes, including rare diseases, 4) strategies to train researchers and enable patients and caregivers to participate in patient-centered outcomes research.*

PCORI has opened a public comment on the report from January 23, 2012 through March 15, 2012.

Affordable Care Act/Supreme Court Update

On January 6, the Obama Administration submitted to the Supreme Court a brief defending the constitutionality of the individual mandate provision of the Affordable Care Act. The Administration is expected to file briefs addressing the other ACA issues before the court in February. The Supreme Court has scheduled oral arguments for March 26, 27, and 28 over the constitutionality of the ACA. A court ruling is expected before the end of the term in June.

On January 25, House Energy and Commerce Health Subcommittee Chairman Joe Pitts (R-PA) stated Republican lawmakers will offer an alternative to the Affordable Care Act (ACA) after the Supreme Court rules on the constitutionality of the law. Pitts suggested the following policy alternatives for a replacement package: (1) employee tax breaks for health insurance, (2) allowing insurance companies to sell across state lines and (3) medical malpractice reform.

MedPAC Meeting on Physician Services

On January 12, MedPAC held its January meeting to discuss, among other topics, payment adequacy for physician and other health services. The Commissioners repeatedly stressed the urgency of Congress to repeal the Sustainable Growth Rate (SGR) formula. The Commissioners reiterated the importance of their October letter to Congress which they resubmitted to Congress at their December meeting. The October letter called on Congress to replace the physician payment formula with a 10-year fee schedule that would freeze primary care payment rates and cut rates for specialist providers by 5.9 percent for three years before freezing the payments. Hackbarth emphasized the painful effect an SGR repeal would have on the health provider community if Congress chose to offset the repeal entirely through Medicare.

MedPAC Commissioners also expressed frustration with Congress over the most recent two month pay patch. Commissioners claimed short term fixes were extremely disruptive to physician practices, CMS, and beneficiaries.

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