Radiation Oncology

POLICY UPDATE

JULY 2011

BY LIBERTY PARTNERS GROUP

Senators Lieberman and Coburn Reveal Medicare Plan

The U.S. Treasury Department continues to estimate borrowing authority under the statutory debt limit will expire on August 2. Although Congress and the White House have been in discussions to enact legislation to lower the deficit in exchange for passage of an increase to the statutory debt limit, details from various groups (e.g. the "Biden Group," the "Gang of Six") have yet to emerge.

On June 28, however, Senators Joe Lieberman (I-CT) and Tom Coburn (R-OK) introduced a plan to reduce Medicare spending and the deficit. According to the plan's sponsors, the proposal would save more than $600 billion over 10 years.

Key provisions:

- Provides for a three year, $37.7 billion SGR extension to allow Congress to develop a new funding mechanism to reimburse Medicare providers.
- Increases Part B premiums.
- Increases the eligibility age for Medicare to 67.
- Restructures Medicare's cost-sharing requirements with a unified, annual deductible and a maximum out-of-pocket and limits Medigap coverage.

MedPAC's June Report to Congress

MedPAC released its June 2011 Report to Congress on June 15. MedPAC notes the following relating to radiation therapy:

- Radiation therapy services increased from 2004 to 2008 by 7.1 percent per FFS beneficiary per year and from 2008 to 2009 by 1.9 percent. By comparison, all physician services grew from 2004 to 2008 by 4.1 percent per FFS beneficiary per year and from 2008 to 2009 by 3.3 percent.

- Recommends that the Congress enact legislation directing CMS to implement prior authorization for advanced imaging and clarify that the agency has the authority to do so. The legislation should also allow CMS to expand prior authorization to other services that experience rapid spending growth, such as physical therapy and radiation therapy.

- Although the Commission examined options to narrow the types of services or physician groups covered by the IOAS exception, MedPAC is concerned that limiting the IOAS exception could have unintended consequences, such as inhibiting the development of organizations that integrate and coordinate care within the practice. Therefore, it is not currently recommend that the exception be changed. Instead, the Commission's recommendations are designed to improve payment accuracy for imaging and other diagnostic tests and ensure the appropriate use of advanced imaging studies. These recommendations recognize that mispricing and inappropriate use are problems that go beyond self-referral. Although the recommendations do not directly address self-referral of physical therapy, radiation therapy, and anatomic pathology tests, MedPAC will continue to track the growth of these services and may consider policy options to specifically address them in the future.

CARE in Medical Imaging and Radiation Therapy Act Introduced

The CARE Act was reintroduced this Congress on June 2 by Congressman Whitfield (R-KY). In general, the bill is very similar to the legislation from the 111th Congress and does the following:

- Amends the Public Health Service Act to require personnel who perform or plan the technical component of either medical imaging examinations or radiation therapy procedures for medical purposes to possess: (1) certification in each medical imaging or radiation therapy modality and service provided from a certification organization designated by the Secretary of Health and Human Services (HHS); or (2) state licensure or certification where such services and modalities are within the scope of practice as defined by the state for such profession and where the requirements for licensure, certification, or registration meet or exceed the standards established by the Secretary. The bill exempts physicians, nurse practitioners, and physician assistants.

- Amends the Social Security Act to allow Medicare payment for medical imaging and radiation therapy services only if the examination or procedure is planned or performed by an individual who meets the bill's requirements.

CBO Releases Medicare Payment Estimates Report

On June 14 the Congressional Budget Office released a report that estimates the cost of a range of different approaches to address the 29.4 percent cut scheduled to impact physicians in January 2012. The cost of various options over a ten year span range from $22 billion to freeze payments in 2012 at current levels and then impose a 34 percent cut in 2013, to $388 billion to increase payments two percent each year over the next ten years, beginning in 2012.

The report explores the cost of different SGR-reform "cliff" and "clawback" options. The cliff approach, which Congress has used since 2007, allows for a short-term increase in payment in a method that results in a large payment-rate reduction the following year. In contrast, the clawback approach limits future rate reductions to no more than 7 percent in any given year, although the SGR mechanism ultimately "claws back" the excess spending in subsequent years. This latter approach was used by Congress in the Medicare Modernization Act of 2003 and the Deficit Reduction Act of 2006.

CMS Announces Coverage of Prostate Cancer Drug

CMS announced June 30 that Medicare will cover Provenge for the treatment of patients with advanced prostate cancer. The decision memo can be found here. Numerous press reports have indicated that the cost of Provenge is $93,000 and extends overall survival by an average of four months.

American Cancer Society Statistics Show Cancer Deaths Decline

The American Cancer Society released new statistics on June 16 showing, while cancer death rates in the United States continue to decline, cancer deaths in the least educated portion of the population are more than twice those of the most educated. According to the report, the reduction in the overall cancer death rates since 1990/1991 translates to the avoidance of about 898,000 deaths from cancer.

CMS Issues First Incentive Payments

A total of $158.3 million has been awarded this year under both the Medicare and Medicaid EHR Incentive Programs. In May CMS awarded its first round of Medicare EHR Incentive payments in May totaling $75 million. As of April 30 over 42,600 eligible professionals and eligible hospitals had registered for the Medicare and Medicaid programs, and CMS expects that number to grow.

Eligible professionals can receive as much as $44,000 over a consecutive five-year period under the Medicare EHR Incentive Program. They can receive as much as $63,750 under the Medicaid HER Incentive Program over six years.

IOM Submits Report to Congress and HHS

On June 1, the IOM submitted the first of three reports to Congress and HHS making recommendations to improve the accuracy of the data sources and methods used in making geographic adjustments in Medicare payments to providers. The report included the following recommendations:

- Use the same labor market definitions for both the hospital wage index and the physician geographic adjustment factor;
- The data used to construct the hospital wage index and the physician geographic adjustment factor should come from all health care employers;
- Geographic practice cost indexes should include the full range of occupations employed in physicians' offices, each with a fixed national weight based on the hours of each occupation employed in physicians' offices nationwide.

A supplemental report further examining geographical practice cost indexes is expected this summer. Next spring, a final report will evaluate the effect of adjustment factors on the distribution of the healthcare workforce, quality of care, access to care and population health, as well as the effects of the adjustment factors on the ability of providers to provide high-value care.

Recommendation to Delay Stage 2 Meaningful Use

On June 8, the meaningful use working group under the Health IT Policy Committee sent a letter to Dr. Farzad Mostashari, head of the Office of the National Coordinator for Health Information Technology and chairman of the Health IT Policy Committee calling for a one-year delay in the scheduled implementation of Stage 2 meaningful use criteria. The work group states that sticking to the original timeline of implementing Stage 2 by 2013 "poses a nearly insurmountable timing challenge for those who attest to meaningful use in 2011." This proposed delay would only affect EPs who attest to stage 1 meaningful use (MU) in 2011.

Prostate Cancer Resolution Introduced

Representative Gregory Meeks (D-NY) introduced H.RES. 313 on June 16 recognizing, "the occurrence of prostate cancer in African-American men has reached epidemic proportions." The resolution urges Federal agencies to designate additional funds for (1) research to end the health crisis and (2) efforts relating to education, awareness and early detection.

*****