



# Radiation Oncology

## POLICY UPDATE

JULY 2012

## Supreme Court Decision on the Affordable Care Act

On June 28, the Supreme Court rendered a decision in the case of *National Federation of Independent Business v. Sebelius*. The case reached the Supreme Court as a result of the National Federation of Independent Business and others bringing suit in Federal District Court to challenge the constitutionality of the individual mandate and the Medicaid expansion provisions included in the Affordable Care Act.

- *Individual Mandate*. Although the Court ruled that the individual mandate was not a valid exercise of Congress's power under the Commerce Clause and the Necessary and Proper Clause, the Court did rule that the individual mandate could be upheld within Congress's power under the Taxing Clause.
- *Medicaid*. The Court concluded that the Medicaid expansion of the health reform bill violates the Constitution by threatening States with the loss of their existing Medicaid funding if they decline to comply with the expansion. The Court further noted that (1) the constitutional violation is remedied by precluding the Secretary from withdrawing existing Medicaid funds for failure to comply with the requirements set out in the expansion and (2) Congress' extension of Medicaid remains available to any State that affirms its willingness to participate.

In sum, while the ruling upholds the majority of the health reform law, it appears to limit the federal government's ability to penalize states for not expanding their Medicaid populations and, as such, could reduce the total number of new Medicaid beneficiaries under the law.

The court's decision is available [here](#).

## Senators Urge CMS to Reverse Radiation Therapy Services Pay Cuts Relating to Technical Error

On June 6, Senators Debbie Stabenow (D-MI), Ben Cardin (D-MD), and Bill Nelson (D-FL), key Senate Finance Committee members, sent a letter to the Centers for Medicare & Medicaid Services (CMS) requesting that the agency fix an error relating to intensity-modulated radiation therapy (IMRT) payments



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under the CY 2012 Physician Fee Schedule (PFS) Final Rule. As noted in the letter, the American Medical Association (AMA) and radiation oncology specialty societies (i.e. the American Society for Radiation Oncology and the American College of Radiation Oncology) previously acknowledged the error to CMS at the end of 2011. The error related to seven equipment direct cost inputs inadvertently dropped between the CY 2012 Proposed and Final Rule. In the letter, the Senators request CMS to use its authority to correct the code during the current 2012 Physician Fee Schedule or as soon as possible.

The letter is available [here](#).

## Joint Former Medicare Administrator Letter on Physician Payment Reform

This newsletter previously [reported](#) on a May 2012 Senate Finance Committee hearing on Medicare physician payment issues. As a follow-up to that hearing, Chairman Baucus asked the four former Centers for Medicare and Medicaid Services (CMS) and Health Care Financing Administration (HCFA) administrators who testified to provide solutions to the SGR problem. In response, the administrators sent a joint letter with several recommendations, including the following:

- *No later than five years from now, CMS should implement alternatives to fee-for-service payment for physicians, with the costs of these reforms offset by overall (not just Part B) Medicare cost savings. Physician participation in these alternative payment systems should be voluntary. Physicians who choose to remain in the traditional fee for service payment system will be subject to a reformed spending limit. CMS, with assistance from MedPAC, should articulate a strategy for achieving this reform in a timely manner.*
- *In order to meet this five-year target, CMS should begin immediately to experiment with and then implement the bundling of appropriate fee-for-service CPT codes into bundled payments to appropriate physicians or groups of physicians. Physician organizations should be encouraged to lead the development of these reforms, which must also include robust quality measures. Unlike current CMS demonstrations and pilots, these payment bundles should include only physician and related services, but the accounting for savings should include reduction in Part A and Part D utilization.*

## Energy & Commerce Hearing on Radiation Therapy

On June 8, the House Energy and Commerce Subcommittee on Health held a [hearing](#) entitled, "Examining the Appropriateness of Standards for Medical Imaging and Radiation Therapy Technologists." According to the staff briefing [memorandum](#), the purpose of the June 8 hearing was to address issues relating to the "provision of



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medical imaging and radiation therapy services by unqualified and/or untrained medical personnel." The briefing memorandum notes that other legislation, such as the Mammography Quality Standards Act (MQSA) and the Medicare Improvements for Patients and Providers Act (MIPPA), set standards for the provision of mammography and diagnostic imaging (although MIPPA only accredits the facility). As such, staff noted that the House version of the "Consistency, Accuracy, Responsibility, and Excellence in Medical Imaging and Radiation Therapy Act (the "CARE" Act) would establish minimum standards for personnel who provide medical imaging or radiation therapy services. The Congressional Research Service (CRS) has provided a summary of the legislation:

- 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, effective January 1, 2014: (1) certification in each medical imaging or radiation therapy modality and service they plan or perform 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. Exempts physicians, nurse practitioners, and physician assistants from the requirements of this Act.

Directs the Secretary to: (1) establish minimum standards for personnel who perform, plan, evaluate, or verify patient dose for medical imaging examinations or radiation therapy procedures; (2) establish a program for designating certification organizations after consideration of specified criteria; (3) provide a process for the certification of individuals whose training or experience are determined to be equal to, or in excess of, those of a graduate of an accredited educational program; and (4) publish a list of approved accrediting bodies for such certification organizations. Authorizes the Secretary to develop alternative standards for rural or health professional shortage areas as appropriate to ensure access to quality medical imaging.

Amends title XVIII (Medicare) of 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 this Act's requirements.

Witnesses representing radiation oncology, diagnostic imaging, and radiologic technologists were in attendance. Each of these witnesses expressed support for the CARE Act. On June 2, 2011, the CARE Act ([H.R. 2104](#)) was introduced in the House of Representatives by Rep. Ed Whitfield (R-1st KY). On June 26, 2012, Sens. Tom Harkin (D-IA) and Mike Enzi (R-WY) introduced similar legislation ([S. 3338](#)) in the Senate.



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### USPSTF Transparency and Accountability Act of 2012 Introduced

On June 21, the USPSTF Transparency and Accountability Act of 2012 ([H.R. 5998](#)) was introduced by Reps. Marsha Blackburn (R-7th TN) and John Barrow (D-12th GA) calling for significant changes to the U.S. Preventive Services Task Force (USPSTF) and the process by which formal recommendations are made regarding preventive care services. The bill strikes the language added by the 2010 Affordable Care Act (ACA) that directly ties Medicare coverage of a particular preventive service to the USPSTF grade.

This legislation calls for a mandate to ensure a "balanced representation of primary and specialty care providers" and other key stakeholders are involved in the development and review of recommendations. It also establishes a Preventive Services Task Force Board comprised of providers, patient groups and federal agency representatives to provide recommendations to the USPSTF, suggest evidence for consideration when a service is reviewed, and provide feedback on recommendations.

On June 25, ten members of the Prostate Cancer Roundtable offered [their support](#) of the proposed legislation.

### Senate Finance Committee Roundtable Discussion on Physician Payments

On June 14, the Senate Finance Committee held the second in a series of roundtable discussions, entitled "[Medicare Physician Payment Policy: Lessons from the Private Sector.](#)" Five witnesses testified with respect to various alternative payment systems to reimburse physicians in the private insurance market. One witness, Mr. Darryl Cardoza, the CEO of Hill Physicians Medicare Group, [testified](#) regarding a case rate pilot program in which its largest medical oncology practice volunteered to participate. Under the program, payments are based on nine distinct cancer diagnostic groups (e.g. breast, lung, colon cancer). Predetermined amounts are paid to participating providers for each patient over a 36-month period. The program utilizes the American Society of Clinical Oncology (ASCO) metrics to evaluate and maintain quality. Mr. Cardoza indicated that Hill Physicians Medicare Group intends to expand the program in the future.

### MedPAC June Report

In its [June 2012 report](#) to Congress, the Medicare Payment Advisory Commission (MedPAC) made recommendations relating to the design of the Medicare fee-for-service (FFS) benefit package for beneficiaries and noted that the design has remained



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essentially unchanged since 1965. As such, MedPAC recommended that Congress direct the Secretary to develop and implement a FFS benefit design that would include:

- Copayments, rather than coinsurance, that may vary by type of service and provider;
- An Out-of-Pocket maximum;
- Deductible(s) for Part A and Part B services that may be combined or separate;
- Secretarial authority to alter or eliminate cost sharing based on the evidence of the value of services;
- No change in beneficiaries' aggregate cost-sharing liability; and
- An additional charge on supplemental insurance to recoup at least some of the added costs imposed on Medicare.

With respect to copayments that vary by type of service and provider, MedPAC's illustrative benefit package includes copays of \$20 for primary care and \$40 for specialists.

## American Cancer Society (ACS) Publishes Report of Estimated 13.7M Cancer Survivors in U.S.

In collaboration with the U.S. National Cancer Institute, the American Cancer Society published its first [report](#) surveying cancer survivors in the United States. The report states that an estimated 13.7 million Americans with a history of cancer were alive on January 1, 2012. As of January 1, 2022, it is estimated that the population of cancer survivors will increase to almost 18 million (8.8 million males and 9.2 million females). The report states that the three most common cancers among male survivors are prostate cancer (43%), colorectal cancer (9%), and melanoma (7%). Among female survivors, the three most common cancers are breast (41%), uterine (8%), and colorectal (8%) cancers.

Among other things, the report also shows treatment patterns for selected cancers. For example, the report notes that radiation therapy is the initial treatment for prostate cancer in 25 percent of men aged 18 — 64, 42 percent of men aged 65 — 74, and 37 percent of men aged 75 — 85.

## CBO Predicts Long-Term Budget Outlook

On June 5, the Congressional Budget Office (CBO) released its [long-term budget outlook](#), projecting the federal debt will reach 73 percent of GDP at the end of this fiscal year. The report also presented two economic scenarios and the long-term impact of each:

- **The Extended Baseline Scenario:** This scenario assumes current laws remain unchanged. Under the extended baseline scenario, federal debt held by the public would fall from an estimated 73 percent of GDP this year to 61 percent by 2022 and



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53 percent by 2037. That outcome would be the result of increasing revenue and decreasing spending.

- *Revenues.* Revenues would rise, among other things, due to (1) the scheduled expiration of cuts in individual income taxes, (2) the alternative minimum tax (AMT), (3) the tax provisions of the Affordable Care Act, and (4) other factors. Revenues would reach 24 percent of GDP by 2037 — much higher than recent decades — and would grow to larger percentages thereafter.
- *Spending.* Spending would decrease, among other things, due to (1) scheduled cuts in Medicare physician payments and (2) automatic reductions in spending required by the Budget Control Act.
- **The Extended Alternative Fiscal Scenario:** This scenario assumes certain policies that have been in place for a number of years will be continued. Under those policies, federal debt would exceed 90 percent of GDP in 2022 and approach 200 percent of GDP in 2037. This outcome would be the result of lower revenue and higher spending than the extended baseline scenario.
  - *Revenues.* Under this scenario, among other things, expiring tax provisions would be extended through 2022 and remain at those levels thereafter. Those levels of revenue — 18.5 percent of GDP — are just above the average of the past 40 years.
  - *Spending.* Under this scenario, among other things, Congress would stop scheduled cuts to Medicare physician payments and automatic reductions in spending under the Budget Control Act. CBO estimates Medicare physician payment cuts would drop by 27 percent at the end of this year under current law. CBO also estimates that automatic reductions in spending under the Budget Control Act would reduce net Medicare spending by \$88 billion between fiscal years 2013 and 2022.

## Senate Finance Committee Hearing on Rivlin-Domenici Proposal

On June 19, the Senate Finance Committee held a [hearing](#) titled, "Confronting The Looming Fiscal Crisis." [Joint testimony](#) was received from Alice Rivlin (former CBO Director) and former Senator Pete Domenici (R-NM), who are co-chairs of the Debt Reduction Task Force at the Bipartisan Policy Center.

Key points from the testimony included the following:

- Recent Congressional deficit reduction efforts have imposed virtually 100 percent of deficit reduction on less than 37 percent of the federal budget.
- The main drivers of future deficits and debt remain (a) Medicare, Medicaid, Social Security and (b) revenues.



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Key health-related proposals from the testimony included the following:

- Capping and phasing-out the tax exclusion of employer-sponsored health insurance benefits.
- Modernizing patient cost-sharing in the Medicare program.
- Moving away from fee-for-service and towards broader payment units.
- A Dominici-Rivlin "Protect Medicare Act" proposal to transition Medicare to a "defined support" plan in 2016 through which beneficiaries would choose among private healthcare plans and traditional Medicare in federally-run Medicare exchanges.

## CMS Announces Data and Information Initiative

On June 5, CMS launched an initiative to transform the agency's approach to data and analytics. To lead the initiative, CMS created a new [Office of Information Products and Data Analysis](#) (OIPDA). A CMS fact sheet about OIPDA may be viewed [here](#).

New data and information resources available under CMS' initiative include:

**[Medicare Geographic Variation Trend Data](#)**: A data set that leverages nearly 5 billion Medicare claims to provide metrics at the state and hospital referral region levels. The data expands upon data currently available through the [Health Indicators Warehouse](#).

**[Medicare Enrollment Dashboard](#)**: An online dashboard that provides a single location with comprehensive statistics on Medicare enrollment (Parts A, B, and D and Medicare Advantage).

**[Medicare & Medicaid Research Review](#)**: A peer-reviewed online journal on current and future directions of the Medicare, Medicaid and Children's Health Insurance.

**CMS Data Navigator**: A web-based search tool that rapidly connects researchers, policy makers, and the general public to the CMS data resources they need. The Data Navigator is scheduled to be in operation by mid-summer 2012 and will be located on the CMS.gov website.

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