Radiation Oncology

POLICY UPDATE

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BY LIBERTY PARTNERS GROUP

House Budget Committee Approves Sequester Replacement Reconciliation Act

On May 10, the House passed H.R. 5652, the "Sequester Replacement Reconciliation Act of 2012." This bill contained a number of healthcare savings provisions reported to the House Budget Committee under "reconciliation instructions" and previously reported by this newsletter. Assuming enactment around October 1, 2012, the Congressional Budget Office (CBO) estimated the total savings contained in the legislation would reduce the deficit by $328 billion over 10 years.

Related legislation reported by the House Budget Committee on May 7, the "Sequester Replacement Act of 2012" (H.R. 4966) would eliminate the scheduled January 2013 reductions under the Budget Control Act in spending for discretionary programs and in mandatory defense spending, but the scheduled reductions in mandatory nondefense spending (e.g. Medicare) would remain in effect. CBO estimates enacting the legislation would increase the deficit by $72 billion over 10 years.

The House Budget Committee estimates total net deficit reduction under these two bills would be around $240 billion over 10 years.

As noted in the previous newsletter, although these provisions are unlikely to pass the Congress in the near-term, they may establish the House of Representatives' "starting position" for negotiations on spending bills expected after the November elections.

Senate Finance Committee Hearing on Physician Payments

On May 10, the Senate Finance Committee convened a group of former Centers for Medicare and Medicaid Services (CMS) and Health Care Financing Administration (HCFA) administrators to discuss their views on physician payments under Medicare. The roundtable discussion, titled "Medicare Physician Payments: Understanding the Past so We Can Envision the Future," is the first in a series of roundtables to be held by the Senate Finance Committee. Witnesses testified with respect to bundled payments for physicians. Testimony of interest included the following:

- Gail Wilensky
  [A] bundled payment should be developed for the high cost, high volume interventions. That would include all of the physicians' services involved in providing care to the patient for treating that procedure or DRG. The Innovation Center will include some pilots that bundle physician and hospital payments but it is important to develop payment systems that do not include payment to the hospital unless it is believed that all or almost all physicians will either be part of integrated delivery systems or employed by hospitals. Otherwise, this will be one more step that increases the power of hospitals at the expense of other providers and payers. It is urgent that CMS devote more time than appears it has to redesigning how physicians are paid. It was disappointing to me that so little attention was paid to physicians in the ACA and it is even more disappointing that the early pilot studies from the Innovation Center are so focused on the hospital or are relatively limited in their scope.

- Mark McClellan
  Several pilot payment reforms have been implemented, including bundled payments for chemotherapy episodes that are no longer tied to giving more intensive chemotherapy and increasing drug margins; instead, the bundled payment provides support for the treatment protocols that the physicians determine are most appropriate, and is tied to a set of quality measures that support oncologists in focusing more on getting their patients the care they most need.

- Thomas Scully
  It is evolving with CMS demos, and it is inevitable that global capitation, or a post-acute DRGs are coming in the near future. For doctors, this must include folding Part B reimbursement into these bundles. This will align their incentives with their post-acute provider partners. These costs are predictable, and CMS should move away from physician FFS in these settings and toward global post-acute capitation.

House Ways and Means Committee Republicans Ask for Advice re: SGR

As part of the efforts to change the SGR formula, House Ways and Means Committee Republicans sent a letter to nearly 70 physician groups to solicit comments relating to "value-based measures and practice arrangements that can improve health outcomes and efficiency in the Medicare program." Among other things, the letter requests descriptions of alternatives to fee-for-service models, such as bundling arrangements and shared savings programs.

The committee requested comments to the solicitation no later than May 25, 2012. The RTA's comment to Ways and Means is included here.

Medicare Evidence Development & Coverage Advisory Committee (MEDCAC) Meeting

On May 16, MEDCAC held a meeting titled, "Evidentiary Characteristics for Coverage with Evidence Development (CED)." According to CMS's issue brief for the meeting, while CED has produced some gains in innovation, there is still room to improve the CED process. CMS is expected to issue an updated draft guidance document on CED based on the input it received from the MEDCAC meeting.

Among the speakers at the meeting was Mark Perman, MD, President of the Registry for Prostate Cancer Radiosurgery. Dr. Perman noted that an April 21, 2010 MEDCAC meeting discussed clinical evidence for radiation therapies (e.g. EBRT, BT, SBRT), but data on comparative effectiveness was inconclusive. Due to clinical evidence gaps, CMS staff stated a national coverage decision for these therapies would be difficult. As such, coverage remains a decision for local contractors. Apparently in response to these evidence gaps, in July 2010, the Multi-Institutional Registry for Prostate Cancer (RPCR) was launched "[t]o address pertinent questions regarding the utilization of stereotactic Body Radiotherapy (SBRT) to treat prostate cancer."

AHRQ Releases Fact Sheet on Proton Beam Radiotherapy Growth

On May 7, the Agency for Healthcare Research and Quality (AHRQ) released a fact sheet on the growth in use of proton beam radiotherapy between 2006 and 2009. Key points from the fact sheet include the following:

- From 2001 to June 2011, the number of centers providing proton beam therapy grew from 3 to 10. Many more centers have been proposed or are under construction.
- From 2006 to 2009, the number of Medicare beneficiaries receiving proton beam therapy nearly doubled. The near doubling of Medicare beneficiaries receiving proton beam therapy from 2006 to 2009 was due to a 68% increase in use for "conditions of possible benefit," mostly prostate cancer, with no increase in use for commonly accepted indications.
- Medicare reimbursements for proton beam therapy peaked at $28 million in 2007 and dropped to $27 million in 2009, with the drop owing partly to payment decreases and the shift toward treating the majority of patients in freestanding centers instead of hospital outpatient settings.
- Medicare "has yet" to release a national coverage determination for proton beam radiotherapy. The first LCD for proton beam therapy went into effect in 2009.

Release of USPSTF Final Recommendation on Screening for Prostate Cancer

In November 2011, this newsletter reported that USPSTF released a draft recommendation against PSA testing and asked for public comments. On May 21, the U.S. Preventive Services Task Force (USPSTF) issued its final recommendation against prostate-specific-antigen (PSA) cancer screening test. The USPSTF grade "D" recommendation means:

- *The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.*

A fact sheet that explains the final recommendation can be found here.

Proposal to Replace SGR Bill

On May 9, Rep. Allyson Schwartz (D-PA) and cosponsor Rep. Joe Heck (R-NV) introduced H.R. 5707, the "Medicare Physician Payment Innovation Act of 2012." Overall, the bill would (1) repeal the SGR, (2) provide stable updates in the near-term and (3) encourage the transition of physician payments away from fee-for-service and towards alternative health care delivery models. Specifically, the bill would provide for the following timetable:

- In 2013, Medicare physician payment rates would remain at 2012 levels.
- From 2014 to 2017, Medicare would raise rates by an annual 2.5% for primary care services and 0.5% annually for other physician services.
- In 2018, Medicare physician payment rates would remain at 2017 levels. In addition, the Secretary of HHS will provide guidance and assistance to assist physicians in transitioning to alternative payment and delivery models.
- Beginning in 2019, physicians who do not transition to alternative payment and delivery models will receive payment reductions under Medicare of 2% in 2019, 3% in 2020, 4% in 2021, and 5% in 2022.
- In 2023 and beyond, fee-for-service rates will remain frozen at 2022 levels. Services under alternative payment and delivery models would not grow at less than 1%.

The bill would use savings from the so-called "overseas contingency operations" as an offset (this newsletter previously reported on this offset).

A summary of the legislation is available here.

CMS Releases an Alternative Report to 2012 Medicare Trustees Report

On May 18, CMS Office of the Actuary released a memorandum titled, "Projected Medicare Expenditures under Illustrative Scenarios with Alternative Payment Updates to Medicare Providers." The memorandum notes Medicare payment rates for physician services as determined by the Sustainable Growth Rate (SGR) system are scheduled to be reduced by roughly 31 percent in 2013 and notes the following with respect to such cuts:

- *Medicare payment levels in 2009 were about 80 percent of private health insurance payment rates, and Medicaid payment rates in 2008 were about 58 percent. Medicare physician payment rates [would] decline to 55 percent of private health insurance payment rates in 2013, due to the scheduled reduction in the Medicare physician fee schedule of more than 30 percent under the SGR formula in current law. (In practice, Congress is very likely to override this reduction, as it has consistently for 2003 through 2012.) Under current law, the Medicare rates would eventually fall to 26 percent of private health insurance levels by 2086 and to less than half of the projected Medicaid rates.*

CBO Reports on Economic Effects of "Reducing Fiscal Restraint" in 2013

On May 22, the CBO released a report on the economic impact of allowing certain current law policies to continue in 2013. Under current law, a number of revenue increases (e.g. certain income tax and payroll tax increases) and spending reductions (e.g. SGR cut, BCA sequester) will occur in 2013. While these policies will reduce the deficit by $560 billion between fiscal years 2012 and 2013, they also will reduce GDP in 2013 to 0.5 percent. Alternatively, if these deficit reduction policies were reversed, GDP would grow by 4.4 percent in 2013, but over the long run future output would be reduced and interest rates would be increased.

House Judiciary Committee Hearing on Health Care Consolidation

On May 18, the House Judiciary Committee held a hearing titled, "Health Care Consolidation and Competition under PPACA." Select findings from the witnesses included the following:

- Scott Gottlieb, MD. Dr. Gottlieb testified regarding the trend for independent physicians to be acquired by large groups and hospitals and, to a lesser extent private health plans. Key data from the report included the following:

- By next year, about two-thirds of American physicians will be working as salaried employees of large groups and hospitals.
- Over the last decade, the number of independent physicians was falling by about 2% a year, but starting in 2013, the number of independent physicians will start declining by 5% a year. The largest proportion of these newly salaried physicians are being directly employed by hospitals or hospital owned medical practices.
- Hospital physician employment rose 32% from 2000 to roughly 212,000 physicians in 2010. Hospitals directly employ about a quarter of all U.S. physicians.

- Thomas Greaney. Mr. Greaney testified regarding hospital consolidation and made the following arguments:

  - Hospital market concentration is the result of various "merger waves" over the last twenty years facilitated by erroneous court decisions and lax antitrust enforcement, and exacerbated by government policies limiting entry and competition.
  - Problematic concentration is largely caused by horizontal combinationsâ€”mergers and joint ventures among rivals. By contrast, vertical integration, such as combinations of hospitals with physicians, is generally procompetitive, because reducing fragmentation improves both the quality of care and the capacity of providers to eliminate wasteful services.

- Edmund Haislmaier. Mr. Haislmaier testified regarding the standardization of health benefits and regulation of health plans under the Affordable Care Act (ACA). According to Mr. Haislmaier, the ACA's policies will result in markets dominated by a few large insurers with characteristics similar to a public utility.

Medicare Payment Advisory Commission (MedPAC) Appoints New Members

On May 24, MedPAC announced the appointment of five new members and the reappointment of one existing member:

- Alice Coombs, MD, Critical Care Specialist and Anesthesiologist, South Shore Hospital, Weymouth, MA;
- Jack Hoadley, Ph.D., Research Professor, Health Policy Institute, Georgetown University, Washington, DC;
- David Nerenz, Ph.D., Director of the Center for Health Policy and Health Services Research, Henry Ford Health System, Detroit, MI;

- Rita Redberg, MD, Professor, Clinical Medicine, University of California at San Francisco Medical Center, San Francisco, CA; and
- Craig Samitt, MD, President and Chief Executive Officer, Dean Health System, Inc., Madison, WI.
- The reappointed member is Chair Glenn M. Hackbarth, JD.

Their terms will expire in April 2015.

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