Radiation Oncology

POLICY UPDATE

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BY LIBERTY PARTNERS GROUP

President Signs 10 Month SGR Freeze

On February 22, President Obama signed into law H.R. 3630, the "Temporary Payroll Tax Cut Continuation Act of 2011." The legislation includes the following provisions of note:

- Physician Payment Rates – This provision prevents a 27.4 percent cut in Medicare physician payment rates slated to begin on March 1, 2012, and instead freezes payment rates at their current level though December 31, 2012.
- Physician Work Geographic Adjustment – This provision extends the floor on the adjustment to the work portion of payments for physician services that accounts for the geographic area where a physician practices.
- Study on Bundled/Episode-Based Payments for Cancer – This provision would require the Secretary of Health and Human Services to conduct a study on bundled/episode-based payments under the physician fee schedule for cancer and other chronic conditions. As part of the study, the Secretary is required to (1) consult with medical professional societies and other relevant stakeholders and (2) report to Congress no later than January 1, 2013 on suitable alternative payment options.

President Releases FY 2013 Budget

President Obama released his FY 2013 Budget on February 13. The budget proposes approximately $360 billion in reforms to Medicare, Medicaid, and other health programs over 10 years. Among the provisions included the President's Budget are the following:

- Permanent Fix to the SGR. The President's Budget includes $429 billion over 10 years to permanently replace the SGR. The budget notes that the adjustment does not signal a specific policy, but rather "a willingness to work with Congress to achieve permanent, fiscally responsible reform."
- Change in Equipment Utilization Rate for Advanced Imaging Equipment. This provision would institute a payment reduction for certain advanced imaging equipment to account for higher levels of utilization. The budget attributes $820 million in savings from the provision.
- Require Prior Authorization for Advanced Imaging. This provision would adopt prior authorization for certain advanced imaging services. The budget attributes no savings from this provision.

The Department of Health and Human Services (HHS) "Budget-in-Brief" provides a department level summary of the changes in the President's Budget.

Senate Finance Committee Hearing on President's FY 2013 Budget

HHS Secretary Kathleen Sebelius appeared before the Senate Finance Committee at a hearing on February 15. Senator Orrin Hatch (R-Utah) provided a contrast to the President's Budget by highlighting that "mandatory health spending under the President's budget actually increases by $72 billion, since the modest $366 billion in savings over 10 years are wiped away by an undefined $438 billion proposal to fix the physician payment formula."

CMS Hosts Bundled Payment Webinars

As we reported in a previous newsletter, on August 25, 2011, CMS announced a request for applications (RFA) for organizations to participate in one of four models under the Bundled Payments for Care Improvement (BPCI) Initiative. Each of the models is organized around a patient's hospitalization. Throughout the month of February, CMS hosted several webinars to help applicants better understand the various models and the applications process.

Model 3 Deep Dive

On February 9, CMS presented a "deep dive" into Model 3, a retrospective bundled payment model for post-acute care (PAC) for selected diagnostic related groups (DRGs). The slides and transcript are available on the CMS Innovations website. The following lessons may be informative for further CMS PAC bundling initiatives:

- *Strategic and Financial Opportunities*. CMS states that the Model 3 bundling demonstration offers PAC providers an opportunity to:
  - Play a leadership role in the redesign of PAC delivery models.
  - Share in the savings achieved as a result of adopting more efficient and effective care processes.
  - Position themselves as attractive partners in a value driven market.
  - Manage and enhance referral networks.

- *What CMS Expects from Applicants*. CMS states it is looking for:
  - Strong beneficiary protections (e.g. awardees may not restrict access to necessary care and CMS will routinely evaluate the care provided by participants).
  - Comprehensive quality assurance and quality improvement strategies.
  - Gain sharing methodology that rewards improved care.
  - Episode definitions that include broad categories of conditions.
  - Large number of beneficiaries served.
  - Highly competitive discounts.

- *How Awardees Will be Paid*. CMS states Model 3 participants will be paid as follows:
  - Applicants will propose a discounted target price and episode definition for each DRG; Applicants and CMS will determine the final price.
  - There is no change in payment method. Medicare will pay under current fee-for-service payment systems and after a patient's episode ends, expenditures for the episode will be compared to the target price.
    - If actual expenditures exceed the target price, the awardee will pay the difference to Medicare.
    - If actual expenditures are less than the target price, Medicare will pay the difference to the awardee.
  - All physician services provided during the episode are included:
    - Unless an excluded ICD-9 code has been approved under the application.
    - Regardless of whether the physician has a partnership relationship with the awardee.

Technical Aspects of Data Delivery and File Processing

On February 13-17, CMS hosted a learning series on data for the BCPI Initiative, which included the following four webinars:

- Technical Aspects of Data Delivery and File Processing. This webinar reviewed the technical aspects of the data that will be delivered to approved requesters from the Bundled Payments for Care Improvement Program. Project contacts listed in BCPI applications will receive one or more 500 gigabyte USB hard drives along with a password for the files. Included on the USB hard drives are the hospital referral clusters (HRCs) requested by the applicant as well as associated claims-level data and the Limited Data Set (LDS) Denominator File. The slides and transcript are available here.

- Understanding the LDS Denominator File. This webinar described the BPCI Limited Data Set (LDS) Denominator File and how to use it in defining BPCI populations. Specifically, the LDS Denominator File includes detailed Medicare beneficiary information for a particular HRC, including but not limited to age, sex, race/ethnicity, state/county of residence, mortality, and enrollment status in Parts A-D. The slides and transcript are available here.

- Understanding the LDS Utilization File. This webinar described the LDS Utilization File for further defining BPCI populations and measuring use of services. The presentation notes, for example, that it is incumbent on an applicant to define what would be meant by "physician services" (e.g. physician only or physicians plus nurse practitioners, etc.; only in a freestanding setting; limited to certain specialists; only certain types of patient visits or range of procedures). The slides and transcript are available here.

- Payment Variables Useful for Costing Bundled Payment Initiative Services. This webinar reviewed the various Medicare payment systems (hospital inpatient, critical access hospital, long-term care hospital, inpatient rehabilitation hospital, hospital outpatient, skilled nursing facility, home health) for determining the cost of services under a bundle. The slides and transcript are available here.

Strategies and Tactics Across the Continuum

On February 14, CMS hosted a webinar entitled, "Transform Care Today: Strategies and Tactics Across the Continuum." This webinar focused on post-acute care bundling models and the potential to (1) decrease fragmentation, (2) identify appropriate settings for services, (3) improve information sharing and care-transitions, and (4) reduce potentially avoidable readmissions.

Data-Driven Continuous Quality and Efficiency Improvement

On February 21, CMS hosted a webinar entitled, "Data-Driven Continuous Quality and Efficiency Improvement." This webinar focused on (1) data considerations within a bundle, (2) measuring and sharing clinical data, and (3) improving care transitions and reducing hospitalizations.

Electronic Health Record Incentive Program Stage 2 Proposed Rule Released

On February 23, CMS released its proposed rule for Stage 2 of the Electronic Health Record Incentive Program. Under the Health Information Technology for Economic and Clinical Health (HITECH) Act, eligible health care professionals (e.g. physicians) can qualify for Medicare and Medicaid incentive payments when they adopt certified EHR technology and use it to demonstrate "meaningful use" of that technology by achieving objectives set by CMS. In the graduated payment schedule provided under the HITECH Act, total annual bonus payments within the program can be up to $63,000 per physician. Medicare payment reductions for physician non-participation begin in 2015.

Program objectives are made gradually more difficult according to a given "stage." Under current regulations, 2011 and 2012 reflect stage 1 requirements. Pursuant to the November 30, 2011 announcement, this proposed rule would delay the onset of stage 2 from 2013 until 2014 for any provider who entered the program in 2011 (and maintain the 2014 stage 2 requirement for providers entering the program in 2012). While the proposed rule lays out stage 2 objectives, the proposed rule also would make certain changes to Stage 1 requirements which would take effect for 2013 (although "most would be optional until 2014").

Under the program, physicians are required to report on "core" and "menu" objectives as well as "clinical quality measures." For stage 2, CMS proposes that physicians would have to meet or qualify for an exclusion for 17 core objectives (up from 15 under stage

1); meet or qualify for an exclusion for 3 of 5 menu objectives (narrowed from a menu of 5 out of 10); and report on 12 clinical quality measures (up from 6).

Notably, CMS proposes a new stage 2 objective for physicians to have the capability "to identify and report cancer cases to a State cancer registry, except where prohibited, and in accordance with applicable law and practice." CMS notes:

- "Reporting to cancer registries by EPs would address current underreporting of cancer, especially certain types. In the past most cancers were diagnosed and/or treated in a hospital setting and data were primarily collected from this source. However, medical practice is changing rapidly and an increasing number of cancer cases are never seen in a hospital. Data collection from EPs presents new challenges since the infrastructure for reporting is less mature than it is in hospitals. Certified EHR technology can address this barrier by identifying reportable cancer cases and treatments to the EP and facilitating electronic reporting either automatically or upon verification by the EP. We have included this objective to provide more flexibility in the menu objectives that EPs can choose. We believe that cancer reporting could provide many EPs with a meaningful use public health reporting option that is more aligned with their scope of practice."

The proposed rule is scheduled for publication in the Federal Register on March 7, 2012. Interested parties will have 60 days after publication to comment.

Ways and Means Hearing Examines Private Payer Reward Systems

On February 7, the House Ways and Means Subcommittee on Health held a hearing entitled *Programs that Reward Physicians Who Deliver High Quality and Efficient Care*. The hearing examined how private sector payers reward physicians for providing high quality and efficient care. For example, witness testimony from Blue Cross Blue Shield of Michigan specifically discussed the Physician Group Incentive Program ("PGIP"). Certain PGIP initiatives include the following:

- **Michigan Oncology Clinical Treatment Pathways**. Description: Establish and define evidence-based oncology treatment pathways for lung, breast and colon cancer, via a partnership between Blue Cross, the Michigan oncology community and P4Healthcare.
- **Oncology/ASCO Quality Oncology Practice Initiative**. Description: Promote high-quality, cost-effective care for cancer patients, facilitated by participation in the American Society for Clinical Oncology's Quality Oncology Practice Initiative Health Plan Program.

American Cancer Society Comment on Essential Health Benefits

As mentioned in the January 2012 newsletter, HHS accepted comments through January 31, 2012 regarding the bulletin released on December 16, 2011 that outlined the department's intended approach in future rulemaking to define "essential health benefits." Prior to the deadline, the American Cancer Society Cancer Action Network (ACS CAN) sent a comment letter to HHS. Among other concerns, ACS CAN noted that HHS has not clearly indicated whether the ACA's prohibition on annual and lifetime limits would apply to service-based limits. ASC CAN's comment letter indicated such service-based limits could result in significant cost-sharing for certain cancer patients. ASC CAN also suggested HHS should:

- Advance national uniformity in developing a standardized definition of "medical necessity."
- Consider circumstances in which a benchmark plan chosen by the state contains a condition-based exclusion or other type of restriction that would conflict with the requirement to ensure at least the ten specified categories of services are covered.
- Precisely define the scope and services within each of the 10 benefit categories.
- Provide further clarification on how it plans to ensure that plan benefit design does not discriminate against individuals with complex health care needs, such as cancer.

ICD-10 Implementation Delayed

The final rule adopting ICD-10 as a standard was published by the Department of Health and Human Services (HHS) in January 2009 and set a compliance date of October 1, 2013 to replace ICD-9 code sets used to report medical diagnoses and inpatient procedures. On February 2, the American Medical Association (AMA) sent a letter to Secretary Sebelius advocating for the need to remove the required use of ICD-10 due to (1) the financial burden on office-based physicians and (2) concurrent requirements associated with Medicare reporting programs including the e-prescribing program, the EHR meaningful use program, and the PQRS program. As a result of this concern and opposition to the implementation date, HHS announced on February 16 its intent to delay the implementation of ICD-10.

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