Radiation Oncology

POLICY UPDATE

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BY LIBERTY PARTNERS GROUP

The President's Framework for Shared Prosperity and Shared Fiscal Responsibility

On April 13, President Obama delivered a speech and a related "fact sheet" on deficit reduction. In the fact sheet, the President sets a goal of reducing the federal deficit by $4 trillion over 12 years or less. As part of this goal, the framework proposes to save $340 billion over 10 years from Medicare and Medicaid stating the amount is "sufficient to fully pay to reform the Medicare Sustainable Growth Rate (SGR) physician payment formula, while still reducing the deficit." While certain proposals in the framework already were included in the President's FY 2012 Budget, others are new. For example, the framework would require the Independent Payment Advisory Board established by the Affordable Care Act to limit Medicare spending to GDP+0.5 percent rather than GDP+1 percent.

Congressional Budget Resolution Passes the House

House Budget Chairman Paul Ryan (R-WI) introduced the Chairman's mark for the House Budget Resolution as well as an accompanying full report on April 5. The budget resolution sets the broad parameters for Congressional spending, but does not contain enacting legislation. According to Budget Committee documents, the budget resolution would provide $3.5 trillion in spending for FY 2012, but cut $5.8 trillion in spending and $4.2 trillion in revenues over the next 10 years. As such, the budget assumes about $1.6 trillion in deficit reduction over the next 10 years.

Major Medicare and Medicaid Proposals include:

- PPACA. Repeals the Patient Protection and Affordable Care Act and maintains current law Medicare savings.
- Premium Support. Assumes a new "premium-support" model will be enacted in 2022 for Medicare beneficiaries whereby the Federal Government would provide premium support payments to new beneficiaries to choose from a list of guaranteed coverage options.
- Medicaid Block Grant. Converts the federal share of Medicaid spending into a block grant to States.
- Medical Liability Reform. Assumes a cap on non-economic damages in medical liability lawsuits.
- SGR. Contains a "deficit neutral" reserve fund to fix the SGR system.
- IPAB. Eliminates the Independent Payment Advisory Board (IPAB).

The FY 2012 Budget Resolution, H. Con. Res. 34, passed the House of Representatives on April 15, 2011 by a vote of 235-193.

CMS Releases Proposed Rule on Accountable Care Organizations

On April 7, CMS released a Proposed Rule on the Medicare Shared Savings Program, also known as the "Accountable Care Organization" (ACO) program. Under the Proposed Rule, physicians, hospitals and other providers may join together as ACOs to manage and coordinate care under a shared savings and shared governance structure. Eligible ACOs must be assigned at least 5,000 beneficiaries and enter into 3-year agreements with Medicare. In general, ACOs that are able to save money for assigned beneficiaries relative to a historical benchmark would share such savings with the Federal Government. However, ACOs must also meet minimum quality thresholds to be eligible for any savings derived in a performance year.

Of importance to oncology, it appears many cancer patients and other high-cost beneficiaries will be assigned to another physician (i.e. internal medicine, general practice, family practice, or geriatric medicine) even if the plurality of a patient's primary care treatments is provided by an oncologist or other specialist. In addition, while some of the quality measures in the Proposed Rule might be considered generally applicable to an oncology patient, other quality measures are not. There are no measures directly applicable to the treatment of cancer.

U.S. Supreme Court Denies Expedited Review of Health Care Law

On April 25, the U.S. Supreme Court turned down the early opportunity to review the constitutionality of the federal health care law. The rejection was not unexpected as the Supreme Court rarely decides a case before the appellate courts have weighed in. Federal appeals courts are scheduled to hear challenges to the health care law in the coming months. Some observers are predicting the Supreme Court will hear some form of the case next term with a ruling expected by June 2012.

The order denying review of *Virginia v. Sebelius*, had the participation of all nine justices. This likely confirms that all nine justices would participate if and when the Supreme Court hears the case. Over the past year, five federal judges have ruled on the constitutionality of the law. Two Republican appointees, in Florida and Virginia, have declared it unconstitutional in whole or in part.

MedPAC Meeting on Ancillary Services

On April 7, MedPAC voted on updated draft recommendations on ancillary services. All recommendations were adopted unanimously, except for the recommendation on prior authorization, which was approved with a single dissenting vote. These recommendations will be included in MedPAC's June Report to Congress.

- Draft Recommendation 1: The Secretary of HHS should accelerate and expand efforts to package discrete services in the PFS into larger units of payment.

- Draft Recommendation 2: Congress should require the Secretary to reduce payment rates for the professional component for multiple imaging services performed by the same practitioner during the same session.
- Draft Recommendation 3: Congress should require the Secretary to reduce the work component for imaging and other diagnostic tests ordered and performed by same physician.
- Draft Recommendation 4: Congress should direct the Secretary to establish a prior authorization program for physicians that perform significantly more imaging than their peers.

During the meeting, Chairman Hackbarth reiterated that his concern over ancillary services was not simply with self-referral, but the combination of self-referral and mispricing. He indicated that a broad ban on self-referral could negatively impact integrated practices in the market today and, as such, MedPAC took a more narrow approach to the issue for this cycle. Hackbarth stated that, in the future, a widespread and robust ACO program could offer a means to more directly address the issue. MedPAC staff indicated that the commission continues to be concerned with therapeutic services such as radiation oncology (including IMRT), and may revisit IOAE options in the future.

MedPAC Meeting on the Sustainable Growth Rate (SGR)

On April 7, MedPAC held a public meeting on reforming the SGR. MedPAC staff noted the many problems with the SGR, including a lack of ability to distinguish by providers as well as the large, "unrealistic" cuts looming at the end of the 2011. Broad policy considerations relating to a new "expenditure target system" included the scope of such a system, the growth targets, variation in targets (e.g. by type-of-service, geography), and an allowance for certain entities (e.g. ACOs, medical homes) to be exempt from the new targets. As part of the reform, MedPAC also discussed a "major realignment of the fee-schedule" to "balance per-hour compensation across specialties" and making "service-specific fee changes to increase price accuracy." Regarding the issue of how to offset the estimated $300 billion cost of eliminating the SGR, certain commissioners recommended simply not offsetting it.

AMA Sends Letter to House Committee on SGR

The American Medical Association (AMA) sent a letter to the Energy and Commerce Committee on April 26 regarding suggestions to reform the Medicare physician payment system. In the letter the AMA proposes that the Committee (1) repeal the SGR, (2) implement a five-year period of stable payments and (3) transition to new payment models over the five-year period.

Senate Bill Would Make Medicare Claims Data Public

On April 7, Senate Finance members Grassley (R-IA) and Wyden (D-OR) introduced legislation (S. 756) aimed at making Medicare claims data available to the public. The Medicare DATA Act would require the HHS Secretary to issue regulations by December 31, 2012, to make available a searchable Medicare payment database at no cost to the public. The data repository would be organized based on the specialty or the type of the provider. The bill clarifies that data

on Medicare payments to physicians do not fall under one of the Freedom of Information Act exemptions.

According to reports, the American Medical Association opposes the legislation and released the following statement *"Medicare claims data alone cannot identify quality care, and the public release of Medicare claims data, without the complete medical record and due process, would often be misleading, inaccurate and disruptive to patients' longstanding relationships with their physicians."*

President Signs CR Funding Federal Programs Through FY 2011

On April 15, President Obama signed the fiscal 2011 spending bill (H.R. 1473) into law. The House voted 260-167 to approve the measure and the Senate passed the measure by a vote of 81-19. An amendment to defund the health reform bill, which passed the House, failed to pass the Senate. The bill provides $157.7 billion for Labor, HHS, Education and Related Agencies programs, about $5.5 billion or 3.36% less than in fiscal year 2010. The bill funds the federal government for the remaining 24 weeks of the fiscal year and expires on September 30, 2011.

MedPAC Discusses Payment Accuracy in the Medicare PFS

On April 7, the Medicare Payment Advisory Commission met to discuss ways to improve the accuracy of payments to physicians under the Medicare physician fee schedule. Although the current fee schedule is intended to account for the relative costliness of inputs, commissioners have raised concern regarding the fee schedule's vulnerability to mispricing and its indifference to clinical outcomes. MedPAC staff noted that relative values for services are based in large part on the estimates of time practitioners spend furnishing services and that some of these estimates are likely to be too high. As such, MedPAC discussed way of collecting objective time data noting that such data may be captured in EHR and patient scheduling systems. Concerns were raised regarding surveys as a data collection tool (given low response rates) and mandatory reporting of time data (given administrative burden concerns). While the commission did not make any recommendations at the April 7 meeting, a discussion relating to the presentation and meeting is expected to be incorporated in MedPAC's June Report to Congress.

CMS Proposes to Cover Costly Prostate Cancer Drug

Medicare officials announced March 30 that they are proposing to cover Provenge, a $93,000 drug that extends the lives of prostate cancer patients for about 4.1 months. Provenge was approved by the FDA in 2010 for late-stage cancer sufferers who do not have significant symptoms. Medicare officials are not proposing to cover the drug's use for men with early-stage prostate cancer or those who have serious symptoms. CMS will make a final decision after considering public comments; it is speculated that this announcement could come as early as June.

HHS Announces New Partnership

HHS announced on April 12 that it would invest up to $1 billion in federal funding, made

available under the Affordable Care Act, to launch the Partnership for Patients. According to a news release by HHS this new partnership will help save 60,000 lives by stopping millions of preventable injuries and complications in patient care over the next three years. It is also estimated that the partnership has the potential to save up to $35 billion in health care costs, including up to $10 billion for Medicare. The two major goals of the Partnership for Patients are to keep hospital patients from getting injured or sicker, and help patients heal without complication.

Legislation to Repeal IPAB Gains Democratic Support

In January of this year Representative David Roe (R-TN) introduced H.R. 452, legislation that would repeal the Independent Payment Advisory Board (IPAB), a panel created in the health care law to curb Medicare spending. In April this legislation gained its fourth Democratic supporter, Representative Allyson Schwartz (D-PA).

The IPAB is charged with making cost-cutting recommendations if Medicare expenditures grow faster than GDP+1 percent. These recommendations would become law unless the House and Senate each adopt, by three-fifths majority, a resolution to block the IPAB. Many provider groups fear the IPAB could seek to reduce Medicare payments over the long term. Representative Pete Stark (D-CA), the Ranking Member of the Ways and Means Health Subcommittee, said he "[intends] to work tirelessly to mitigate the damage that will be caused by IPAB." In April this legislation gained its fourth Democrat supporter, Representative Allyson Schwartz (D-PA).

Senator Boxer Focuses on Disease Clusters

As Chairman of the Senate Environment and Public Works Committee, Senator Barbara Boxer (CA-D), convened a hearing to assess the potential environmental health effects related to cancer and disease clusters. During her opening statement she said that "when the same disease impacts a family, neighborhood or community, people are rightly concerned a common factor is the cause." Senator Boxer introduced legislation, S. 76, the Strengthening Protections for Children and Communities from Disease Clusters Act, designed to:

- Strengthen federal agency coordination and accountability when investigating these potential certain "clusters" of disease;
- Increase assistance to areas impacted by potential disease clusters; and
- Authorize federal agencies to form partnerships with states and academic institutions to investigate and help address disease clusters.

CMS Report Shows Significant Trends in PQRS and eRx

On April 19, CMS announced that in 2009 nearly 120,000 eligible professionals earned $235 million in incentive payments through the Physician Quality Reporting System (PQRS). The

average incentive amount for individual professionals who satisfactorily reported was nearly $2,000 for the PQRS.

In addition, over 48,000 eligible professionals earned $148 million through the ePrescribing Incentive (eRx) Program. The average incentive amount for individual professionals who satisfactorily reported was over $3,000 for successful electronic prescribers under the eRx Program.

CMS Announces Meaningful Use Attestation Calculator

On April 22, CMS announced the Meaningful Use Attestation Calculator to help physicians and other eligible professionals determine if they have met the objectives and measures required under Electronic Health Record Incentive Program. Additional information about the program is available here.

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