Radiation Oncology

POLICY UPDATE

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BY LIBERTY PARTNERS GROUP

House Committees Report Reconciliation Savings

As this newsletter previously reported, the FY 2013 House Budget Resolution contained reconciliation instructions to various House committees to report savings to the House Budget Committee by April 27, 2012. In April, committees with jurisdiction over healthcare reported the following health savings provisions:

- **Ways and Means**.
  - *Exchange Subsidies*. This proposal would require those who receive Exchange subsidies to which they are not entitled to repay the full amount of overpayments. The Joint Committee on Taxation and the Congressional Budget Office (CBO) estimate this provision would reduce the deficit by $43.9 billion over ten years.
- **Energy and Commerce**.
  - *Prevention and Public Health Fund*. This proposal would repeal the Prevention and Public Health Fund. CBO estimates that this proposal will save approximately $11.9 billion over ten years.
  - *Health Insurance Exchange Funding*. This proposal would repeal funds to establish health insurance exchanges established by the Affordable Care Act. CBO estimates that this proposal will save approximately $14.5 billion over ten years.
  - *Consumer-Operated and Oriented Plan (CO-OP) Funding*. This proposal would repeal funds to provide government-subsidized loans to qualified non-profit health insurance plans established by the Affordable Care Act. CBO estimates this proposal will save $872 million over ten years.
  - *Rebasing Disproportionate Share Hospital (DSH) Payments*. This proposal would rebase FY 2022 DSH allotments to FY 2021 levels. CBO estimates this proposal will save $4.2 billion over ten years.
  - *Medicaid Provider Tax Threshold*. States are able to use revenues from health care provider taxes to help finance the state share of Medicaid expenditures and receive federal matching funds, but are limited to a provider tax threshold of no higher than 6 percent of the net patient service revenues. This proposal would reduce the provider tax threshold to 5.5 percent beginning in FY2013. CBO estimates this proposal would save $11.25 billion over ten years.

- *Medicaid Enrollment Bonus Payments*. This provision would repeal bonus payments to states that increase their Medicaid enrollment above a defined baseline from the prior year. CBO estimates this proposal would save $400 million over ten years.
- *Reforming the Medical Liability System*. This proposal, among other things, would establish a medical liability cap of $250,000 on non-economic damages. CBO has estimated these provisions would save between $40 billion and $64 billion over ten years.
- *Maintenance of Effort Requirements*. This provision would repeal the Maintenance of Effort (MOE) requirement whereby a state is prohibited from having eligibility standards, methodologies, or procedures under its state Medicaid or Children's Health Insurance Program (CHIP) plans that are more restrictive than those in effect on March 23, 2010. CBO has estimated that this proposal would save approximately $600 million over ten years.
- *Increased Federal Medicaid Funding Cap and Match Rate for Territories*. This provision would repeal the increased Medicaid Funding Cap and Match Rate for Territories. CBO has estimated that this policy would save $6.3 billion over ten years.

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.

A related memorandum from the Speaker of the House is available here.

Senate Budget Committee Released Budget Plan

On April 17, the Senate Budget Committee released the legislative text and a summary of the FY 2013 Budget Resolution. The plan encapsulated policies from the National Commission on Fiscal Responsibility and Reform, also known as the Bowles-Simpson plan. Included in the budget plan is a "Health Care Savings Policy Statement" reflecting the framework of the commission plan and including the policies below.

- Fully offsetting the cost of reforming the Sustainable Growth Rate by achieving savings within the budget window from a set of policies including options proposed by the bipartisan Fiscal Commission report, such as:
  - increasing government authority and funding to reduce Medicare fraud;
  - reforming Medicare cost-sharing rules;
  - restricting first-dollar coverage in Medicare supplemental insurance;
  - extending Medicaid drug rebate to dual eligibles in Medicare Part D;
  - reducing excess payments to hospitals for medical education;
  - cutting Medicare payments for bad debts;
  - accelerating home health savings in the Affordable Care Act;
  - eliminating State gaming of Medicaid tax gimmick;
  - placing dual eligibles in Medicaid managed care;

  - reducing funding for Medicaid administrative costs;
  - allowing expedited application for Medicaid waivers in well-qualified States;
  - medical malpractice reform; and
  - pilot premium support through FEHB Program.
- Reforming or repealing the CLASS Act.
- Aggressively implementing and expanding payment reform pilots by directing CMS to design and begin implementation of Medicare payment reform pilots, demonstrations, and programs as rapidly as possible and allow successful programs to be expanded without further Congressional action.
- Eliminating provider carve-outs from the Independent Payment Advisory Board (IPAB) by giving IPAB the authority to make recommendations regarding hospitals and other exempted providers.
- Establishing a long-term global budget for total health care spending by setting targets for the total federal budgetary commitment to health care and requiring the President and Congress to make recommendations for structural reforms to the health care system if per beneficiary cost growth exceeds the average growth in gross domestic product plus one percentage point over the prior five years, provided that this target shall be adjusted to take into account changes to any exclusion for health care insurance made as part of a reform of the tax code.

Although the Senate Budget Committee met on April 18 to discuss the plan, votes did not occur and it is unlikely that the plan will be voted on before the November elections, if at all.

JAMA Explores IMRT Quality

On April 17, the Agency for Healthcare Research and Quality (AHRQ) Effective Health Care (EHC) Program announced results from a study published in the Journal of the American Medical Association (JAMA) entitled, "Intensity-Modulated Radiation Therapy, Proton Therapy, or Conformal Radiation Therapy and Morbidity and Disease Control in Localized Prostate Cancer." The objective of the study was to determine the morbidity and disease control of IMRT, proton therapy, and conformal radiation therapy for primary prostate cancer treatment. The study used Surveillance, Epidemiology, and End Results (SEER) and Medicare-linked data from 2000 through 2009 for patients with nonmetastatic prostate cancer.

According to the study, among patients with nonmetastatic prostate cancer, the use of IMRT compared with conformal radiation therapy was associated with less gastrointestinal morbidity and fewer hip fractures but more erectile dysfunction. IMRT compared with proton therapy was associated with less gastrointestinal morbidity.

MedPAC Meeting on Data Collection under the Physician Fee Schedule

On April 5, the Medicare Payment Advisory Commission (MedPAC) met to discuss alternative forms of data collection to improve the accuracy of payments under the Physician Fee Schedule. MedPAC staff noted that there have been longstanding concerns regarding the accuracy of payments under the Physician Fee Schedule due to the fact that (1) services can change and (2) estimates are based on surveys by specialty societies with a financial stake in the results. In particular, MedPAC focused on the accuracy of time estimates for services. Currently, there are four practices and integrated delivery systems collecting data as part of a project to test methods for collecting time and service volume data. Although MedPAC indicated a next step would be to expand this project to additional practices, nothing on this issue is expected to be in the June MedPAC Report to Congress.

CMS Announces the Selection of the First Accountable Care Organizations (ACO) to Participate in Medicare Shared Savings Program

On April 10, CMS held a conference call to give a program update to the Medicare Shared Savings Program (MSSP) authorized through the Accountable Care Act (ACA). The first 27 Shared Savings Program ACOs, which include more than 10,000 physicians, 10 hospitals, and 13 smaller physician-driven organizations in both urban and rural areas, have entered into agreements with CMS for the opportunity to share in savings for assigned beneficiaries under the program. These ACOs will serve an estimated 375,000 beneficiaries in 18 States and bring the total number of organizations participating in Medicare shared savings initiatives to 65 (including the 32 Pioneer Model ACOs that were announced last December, and six Physician Group Practice Transition Demonstration organizations that started in January 2011). Currently, more than 1.1 million beneficiaries are receiving care from providers participating in Medicare shared savings initiatives. CMS is now reviewing more than 150 applications from ACOs seeking to enter the program on July 1, 2012.

A summary of the new ACOs is available here and a press release is available here.

CMS Releases Proposed Clinical Quality Measures (CQMs) For Stage 2 Meaningful Use

This newsletter previously reported on requirements for Stage 2 of the "meaningful use" criteria for the Electronic Health Record (EHR) Incentive Program. Among these requirements, physicians are required to report on clinical quality measures (CQMs). On

April 10, CMS released its proposed CQMs for Stage 2 eligible providers. Starting in 2014, CMS proposes that physicians report on a total of twelve clinical quality measures. Cancer-related measures include, among others:

- Percentage of patients, regardless of age, with a diagnosis of pancreatic or lung cancer receiving three dimensional (3D) conformal radiation therapy with documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues, (NQF # 0382);
- Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain, (NQF # 0383);
- Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified (NQF # 0384);
- Percentage of patients, regardless of age, with a diagnosis of clinically localized prostate cancer receiving external beam radiotherapy as a primary therapy to the prostate with or without nodal irradiation (no metastases; no salvage therapy) who receive three-dimensional conformal radiotherapy (3D-CRT) or intensity modulated radiation therapy (IMRT), (NQF # 0388); and
- Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer, (NQF # 0389).

CMS Delays ICD-10 Compliance Date, Proposes Administrative Simplifications

On Monday, April 9, HHS Secretary Kathleen Sebelius announced a proposed rule that would delay the compliance date for ICD-10 from October 1, 2013 to October 1, 2014. The proposed rule, the third in a series of simplification rules, also would implement several administrative simplification provisions for providers of the Affordable Care Act. The rule would adopt a standard for a unique health plan identifier (HPID), adopt a data element that would serve as an "other entity" identifier (OEID), and add a National Provider Identifier (NPI) requirement.

Provider groups had expressed serious concerns about their ability to meet the October 1, 2013 compliance date. The proposed change in the compliance date for ICD-10 is intended to give providers and other covered entities more time to prepare and fully test their systems to ensure a smooth and coordinated transition to these new code sets.

A press release and fact sheet are available.

CMS Provides Application Guidance for Models 2-4

On April 19, CMS hosted a webinar to discuss key areas of an application guidance document for Models 2 – 4 of the Bundled Payment for Care Improvement (BPCI) initiative. The document focused on several areas of the BPCI application including the areas below.

- *Episode Design*
    - Because CMS is interested in supporting awardees whose model design lends itself to rapid replication and scaling, in later stages of the selection process, CMS may request changes from applicants on specific aspects of their proposals, including episode definitions, to promote certain commonalities among awardees.
    - End of the Episode.
        - In Model 2, applicants are expected to propose a definition of the end of the episode, which must be at least 30 days following discharge from the acute care hospital.
        - In Model 3, applicants are expected to propose a definition of the end of the episode, which must be at least 30 days following the initiation of the episode.
        - In Model 4, the end of the episode of care is 30 days following discharge from the acute care hospital.
    - CMS is seeking broad episode definitions with few proposed exclusions.
- *Provider Engagement*
    - CMS is seeking applications that present strong evidence of other participating providers' commitment.
    - CMS is interested in robust plans to obtain and retain widespread endorsement and engagement by physicians/practitioners at the applicant organization during the course of this initiative.
- *Care Improvement*
    - In all models, CMS is seeking applications that present strong evidence of physician/practitioner commitment to align incentives through care redesign.
    - In all models, applicants are asked to describe their proposed comprehensive care redesign interventions, including how these proposed care redesign interventions include and respond to beneficiary experiences of care.
    - CMS is interested in understanding the proposed methodology applicants will use to track changes in behavior, patterns of care, and quality.
- *Gainsharing*
    - Applicants may propose to use gainsharing as a tool to align incentives to redesign care. Payments must be tied to actual changes in behavior and/or increases in quality.

- Gainsharing in the BPCI initiative includes distribution of gains accrued due to internal organizational cost savings during the episode of care, as well as distribution of gains received via episode reconciliation payment(s).

- *Financial Model*
  - If an eligible beneficiary is admitted to be a BPCI participant and then transferred to another acute inpatient hospital, he or she is included in the program if the admission at participant is for an anchor MS-DRG.
  - Applicants should provide proposed target prices or bundled payment amounts in terms comparable to a Medicare approved amount, without considering copayments or deductibles that may apply.
- *Quality of Care and Patient-Centeredness*
  - Applicants are provided the opportunity to showcase past experiences in quality improvement and discuss how planned care improvement interventions in its proposal will result in improved quality and patient experience of care.
  - Applicants should provide the certifications and accreditations for the applicant organization.
  - In all models, applicants are asked to describe their beneficiary protections, including protecting the beneficiary's freedom to choose his or her own provider, and the applicant's plan to promote beneficiary engagement and education.

BCPI Accelerated Development Learning Session

On April 6, CMS held an Accelerated Development Learning Session to discuss options in building an effective gainsharing program. Three presenters discussed experiences with gainsharing in their respective organizations. Generally applicable recommendations included the recommendations below.

- *Identifying and Communicating Goals for Gainsharing*
  - Achieve greater efficiency, cost savings and higher quality by aligning incentives.
  - Reduce variation in practice.
  - Reward physicians for improved performance, meaningful collaboration.
  - Start up quickly, make payments to physicians within nine months, improvements begin immediately.
  - Design for low complexity, maximum flexibility.
  - Deliver, on a regular basis, the data that will provide insight/guidance on behavior changes necessary to reach the goals.
- *Targets for Improved Performance*
  - Fewer marginal, but costly, diagnostic test.

- Reduction in pharmacy expense (generics, formulary, etc.).
- Evidence-based selection and purchase of medical devices and hardware.
- Reduction in duplicative services.
- Improved quality scores on process measures.

- *Patient Protection/Methodological Design Decisions to Consider*
  - Adjustment for Severity of Illness insures correct amount of resources are used in setting benchmark targets (eliminates incentives to "cherry pick", "stint" and "steer").
  - Best Practice Norms derived from practice in the community.
  - Incentive amounts are reasonable.
  - Limit on incentive payments to discourage new and untried practices.
  - Physician incentives are conditioned upon compliance with quality measures.
- *How to Secure Physician "Buy-in"*
  - No change in process or form of current physician payments.
  - Provide detailed data on individual physician utilization and quality metrics, adjusted for severity of illness.
  - Provide ongoing, regular feedback to physicians.
  - Encompass non-clinical and clinical opportunities.
  - Quality evaluation based on overall performance.
  - Provide loss of income protection.
  - Transparency – notification to patients about program.

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