Radiation Oncology

POLICY UPDATE

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BY LIBERTY PARTNERS GROUP

MedPAC Makes SGR Recommendation

On October 6, MedPAC held a meeting entitled, "Moving forward from the Sustainable Growth Rate system." During the meeting, staff presented the Commission various draft recommendations, including the following:

- "The Congress should repeal the sustainable growth rate and replace it with a 10-year path of statutory fee schedule updates. The path is comprised of a freeze in current payment levels for primary care and for all other services, annual payment reductions of 5.9 percent for three years, followed by a freeze. The commission is offering a list of options for Congress to consider if it decides to offset the cost of repealing the SGR system within the Medicare program."

The Commission passed the recommendation by a vote of 15-2. Commissioners Karen Borman, and Ronald Castellanos, a urologist with Southwest Florida Urologic Associates, voted against the recommendation. On October 14 MedPAC sent a letter to lawmakers detailing their recommendations to replace the SGR.

Prior to the meeting on October 6, the AMA and 40 other physicians groups sent a letter to MedPAC Chairman Glenn Hackbarth opposing the recommendation.

CMS Releases Final Rule on Accountable Care Organizations

On October 20, CMS released the Final Rule on the Medicare Shared Savings Program, also known as the "Accountable Care Organization" (ACO) program.

Under the Final 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 agreements with Medicare of not less than three years. 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.

The Medicare Shared Savings Program Proposed Rule published in the Federal Register on April 7 received a significant amount of provider criticism for being unworkable. Consequently, CMS made several modifications in the Final Rule to ease the regulatory burden of the Medicare Shared Savings Program. These changes included the option for an ACO to choose a "one-sided" model during an initial agreement period that allows for the possibility of shared savings without the possibility of shared risk to the ACO for Medicare spending above the ACO's benchmark. The Final Rule also reduced the number of quality measures for an ACO from 65 to 33.

However, under the Final Rule, cancer providers and other specialists remain secondary to primary care providers in several respects:

- First, although cancer providers are not excluded from ACOs, the rule does not allow for the creation of "cancer-specific" ACOs. Says CMS, "although we do not see the need to design distinct ESRD or cancer specific ACOs, neither of these providers types are in any manner excluded from participation in an ACO."
- Second, cancer providers and other specialists also will be secondary to primary care providers with respect to the assignment of beneficiaries to an ACO. In the Final Rule, CMS adopts the "step-wise," 2-step assignment approach. Under the approach, beneficiary assignment proceeds by first identifying all primary care services for Medicare beneficiaries rendered by primary care physicians (internal medicine, family practice, general practice, geriatric medicine). The beneficiary is assigned to the ACO if the primary care services provided by primary care physicians in the ACO are greater than the primary care services provided to that beneficiary by another ACO and primary care physicians not affiliated with an ACO. Under the second step, beneficiaries who have received primary care services, but not from a primary care physician (either inside or outside of an ACO), are assigned to an ACO if the primary care services for that beneficiary provided by all professionals in the ACO are greater than the primary care services provided by professionals in another ACO and professionals not affiliated with an ACO.
- Third, while some of the quality measures in the Final Rule might be considered generally applicable to an oncology patient (or any patient), other quality measures are not. There are no measures directly applicable to the treatment of cancer.

IOM Essential Health Benefits Recommendations

The Institute of Medicine (IOM) released the final report on Essential Health Benefits (EHBs) on October 6. Pursuant to the Affordable Care Act, the Health and Human Services (HHS) Secretary was assigned the task of defining the "essential health benefits" (EHBs) that are to be offered by individual and small group health plans,

including those plans in health insurance exchanges. In general, the ACA requires the EHBs to reflect benefits offered in a "typical employer plan" and the 10 broad categories of care listed in Section 1302 of the ACA.[1]

As part of this effort, HHS asked the IOM to "recommend a process by which the Secretary could define and subsequently update the [Essential Health Benefits]." In general, the IOM recommended (1) the initial EHB package should be a modification of what small employers are currently offering; (2) modifications to the EHB package should (a) take into account the ten general categories of the ACA, (b) apply committee-developed criteria to guide aggregate and specific EHB content and (c) develop a premium target; (3) the EHB package should be continuously improved, increasingly specific and evidence-based.

The ACA also required the Department of Labor to conduct a "survey of employer-sponsored coverage to determine the benefits typically covered by employers." However, the IOM found limited usefulness in reviewing plan documents as informative tool for determining whether a benefit is covered as a typical benefit. As such, the IOM concluded:

- [I]f a requested medical service can reasonably be construed to fall within one of the 10 covered benefit categories and is not expressly excluded, it should be considered eligible for coverage as long as it is judged medically necessary for a particular patient. For example, radiation therapy for cancer treatment might not be listed explicitly as a covered service but could reasonably be considered to fall within the general category of ambulatory patient services and, therefore, covered if judged medically necessary. The medical necessity of a particular treatment would be based on the specific type and state of the patient's cancer, as well as previous treatments applied to the individual's diagnosis. However, greater specificity in listing which classes of services are covered within in plan documents (e.g., listing of radiation therapy) would provide greater clarity and consistency across plan documents.

"Supercommittee" Receives Recommendations

As noted under prior Radiation Oncology newsletters, the Budget Control Act of 2011 requires Congress to achieve savings of $1.2 trillion over 10 years or an across-the-board sequestration will occur in 2013. Under the Budget Control Act, Congressional committees were provided the opportunity to submit recommendations to the Joint Select Committee on Deficit Reduction (JSC) with a deadline of no later than October 14.

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[1] Ambulatory patient services; Emergency services; Hospitalization; Maternity and newborn care; Mental health and substance use disorder services, including behavioral health treatment, Prescription drugs; Rehabilitative and habilitative services and devices; Laboratory services; Preventive and wellness services and chronic disease management; and Pediatric services, including oral and vision care.

While the majority and minority panels of several Congressional committees transmitted recommendations to the JSC, not all chose to do so. For example, Senate Finance Committee Democrats and Republicans on the House Energy and Commerce Committee and Ways and Means Committee chose not to transmit, probably because the chairs of those committees serve on the JSC itself. However, the recommendations of the Republicans on the Senate Finance Committee and the Democrats on the House Energy and Commerce Committee and Ways and Means Committee provide an indication of the potential healthcare related fault-lines for the JSC. For their part, Senate Republicans included a number of recommendations relating to the repeal of the Affordable Care Act, higher cost-sharing for Medicare beneficiaries, raising the Medicare eligibility age and only an acknowledgement of the scheduled 30 percent physician payment cuts under Medicare. In contrast, House Democrats recommended strengthening the Affordable Care Act, avoiding "cost-shifts" onto Medicare beneficiaries, a rejection of policies to raise the Medicare eligibility age and an explicit recommendation to fix the Medicare physician payment formula. A consensus recommendation for both parties was to address "waste, fraud and abuse" in the Medicare program.

The JSC also received a number of letters from physician groups on a range of issues:

- Nearly 100 physicians groups signed onto a letter asking the Committee to include "meaningful medical liability reforms," such as capping non-economic damages.

The American Cancer Society Cancer Action Network sent a letter asking that funds for cancer research and prevention not be cut.

Cancer groups also submitted recommendations asking that no additional cuts be made to "Medicare payments for cancer care" and "Medicare reimbursement for cancer-fighting drugs."

The American College of Cardiology sent a letter asking that no addition payment cuts be made for medical imaging services in light of significant imaging cuts over the past several years.

U.S. Preventative Services Task Force Makes Prostate Cancer Screening Recommendation

Prostate Cancer Screening

On October 11 the U.S. Preventative Services Task Force (USPSTF) posted its draft recommendation on screening for prostate cancer. Key points from the draft recommendation include:

- The USPSTF concludes that there is "moderate" certainty that the harms of PSA-based screening for prostate cancer (e.g. persistent worry about prostate cancer,

additional testing, adverse effects of radiation therapy) outweigh the benefits. According to the USPSTF, the evidence is convincing that for men aged 70 years and older, screening has no mortality benefit. For men aged 50 to 69 years, the evidence is convincing that the reduction in prostate cancer mortality 10 years after screening is small to none.

    - "Moderate certainty" means "the available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by factors such as: (1) the number, size, or quality of individual studies; (2) inconsistency of findings across individual studies; (3) limited generalizability of findings to routine primary care practice; or (4) lack of coherence in the chain of evidence. As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion."
- The USPSTF recommends against prostate-specific antigen (PSA)-based screening for prostate cancer. This is a grade D recommendation.
    - This recommendation applies to men in the U.S. population that do not have symptoms that are highly suspicious for prostate cancer, regardless of age, race, or family history. The Task Force did not evaluate the use of the PSA test as part of a diagnostic strategy in men with symptoms that are highly suspicious for prostate cancer. This recommendation also does not consider the use of the PSA test for surveillance after diagnosis and/or treatment of prostate cancer.
    - A 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." The USPSTF suggestion for practice is to "discourage the use of this service."
- The October 7, 2011 recommendation replaces the 2008 recommendation: whereas the USPSTF previously recommended against PSA-based screening for prostate cancer in men aged 75 years and older and concluded that the evidence was insufficient to make a recommendation in younger men, the USPSTF now recommends against PSA-based screening for prostate cancer in all age groups.

A review of the evidence used by the USPSTF to make this determination is available here. The USPSTF will be accepting comments on this draft recommendation statement beginning on Tuesday, October 11, 2011 until November 8, 2011. Comments can be made on this recommendation by clicking here.

Cancer Endorsement Maintenance

Prior to 2011, the National Quality Forum (NQF) endorsed 34 cancer-related quality measures including the areas of breast, lung, prostate and colon cancer, melanoma and leukemia. These measures were designed to improve the quality of care delivered to patients as part of a health care system, or in inpatient or ambulatory settings. On October 13, the National Quality Forum (NQF) launched the Cancer Endorsement Maintenance 2011 to build on prior NQF work under the Cancer Quality Measures

Project and identify and endorse additional measures related to cancer care. The results of this project will provide input to the Department of Health and Human services regarding the selection of performance measures for public reporting and performance-based payment programs.

The project timeline includes the following:

- Call for Nominations (open through November 14 at 6:00pm ET).
- Call for Implementation Comments (open through January 13 at 6:00pm ET).
- Call for Measures (open through January 13 at 6:00pm ET).

OIG Workplan

The Office of Inspector General (OIG) released their Work Plan for Fiscal Year 2012 on October 5.

The Work Plan briefly describes HHS programs the OIG plans to continue or initiate during Fiscal Year 2012. Among the reviews is the following:

- **Medicare Brachytherapy Reimbursement** We will review payments for brachytherapy to determine whether the payments are in compliance with Medicare requirements. Brachytherapy is a form of radiotherapy in which a radiation source is placed inside or next to the area requiring treatment. Medicare pays for radioactive source devices used in treating certain forms of cancer. (Social Security Act, Â§ 1833 (t)(16)(C), as amended by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Â§ 142.) (OAS; W-00-10-35520; W-00-11-35520; various reviews; expected issue date: FY 2012; work in progress)

CMS Establishes Medicare Economic Index (MEI) Technical Advisory Panel

The MEI measures annual price changes in the cost of physicians' time and operating expenses (i.e. inflation). The MEI has been rebased several times since 1975, including in 2003 by using 2000 base year data. In the CY 2011 PFS Final Rule, CMS finalized its proposal to rebase the MEI to reflect appropriate physicians' expenses in 2006. The rebasing of the MEI indicated to CMS that practice expenses and malpractice insurance now account for a higher fraction of physician practice revenue than they did 10 years ago. As such, CMS increased the payments for those factors, which resulted in an aggregate payment increases for certain specialties with relatively a higher proportion of practice expenses (e.g. radiation oncology).

In the CY 2011 PFS Final Rule, CMS also finalized its proposal to convene a MEI Technical Advisory Panel to study all aspects of the MEI including its cost categories, their associated cost weights and price proxies, and the adjustment of the index by an economy-wide measure of multi-factor productivity. On October 7, CMS announced the

establishment of this panel and requested nominations for individuals to serve on the Panel. Panel meetings generally will be open to the public and announced via a Federal Register notice. Following the technical review meetings, the Panel will issue a report that summarizes its recommendations for the MEI.

Ovarian and Cervical Cancer Awareness Act of 2011

Representative Nydia Velazquez (D-NY) introduced the Ovarian and Cervical Cancer Awareness Act of 2011 on October 12. This legislation is designed to increase the awareness and knowledge of ovarian and cervical cancer among health care providers and women.

CDC Launches New Program

The Centers for Disease Control (CDC) launched a new program on October 25 to help educate patients and providers about infections during cancer treatment. The program includes a new website which helps to inform patients on how to decrease the chance of an infection and notice the signs of an infection. The CDC also developed a booklet for providers to serve as a model for a basic infection control and prevention plan.

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