Radiation Oncology

POLICY UPDATE

SEPTEMBER 2011

BY LIBERTY PARTNERS GROUP

Members Chosen for Joint Select Committee on Deficit Reduction

The Joint Select Committee on Deficit Reduction (also known as the "Super Committee") was created under the Budget Control Act of 2011 (S.365), signed into law on August 2. The Joint Select Committee is tasked with forming a plan to reduce the deficit by at least $1.5 trillion over FY2012-FY2021. Unless a Joint Select Committee bill achieving $1.2 trillion is enacted by January 15, 2012, an across-the-board sequestration would occur on January 2, 2013, and each subsequent year through 2021, to achieve $1.2 trillion in savings. The bill limits cuts to Medicare under the sequestration process to 2 percent per year.

Pursuant to the Budget Control Act, Senate Majority Leader Harry Reid (D-NV), House Speaker John Boehner (R-OH), Senate Minority Leader Mitch McConnell (R-KY), and House Minority Leader Nancy Pelosi (D-CA) were required to each chose three members from their respective chambers for the Joint Select Committee by August 16.

Joint Select Committee Members:

- Senator Patty Murray (D-WA). Co-chair of the Joint Select Committee. Senator Murray also is Chair of the Democratic Senatorial Campaign Committee.
- Representative Jeb Hensarling (R-TX). Co-chair of the Joint Select Committee. Representative Hensarling also is the House Republican Conference Chair and served on President Obama's fiscal commission last year.
- Senator Max Baucus (D-MT). The chairman of the Senate Finance Committee, which has jurisdiction over Medicare, Medicaid and tax issues, Senator Baucus has been an avid supporter of health reform. Senator Baucus also "helped to negotiate the deals with several health industries, including PhRMA, hospitals and nursing homes.[1]"
- Senator John Kerry (D-MA). A senior member of the Senate Finance Committee, Senator Kerry is a strong supporter of teaching hospitals, medical devices and home health.[2]
- Representative Dave Camp (R-MI). Representative Camp is the chair of the House Ways and Means Committee which shares jurisdiction over Medicare.
- Representative Fred Upton (R-MI). Representative Upton is the chair of the House Energy and Commerce Committee which has jurisdiction over Medicaid and shares jurisdiction of Medicare with the Ways and Means Committee.

- Senator John Kyl (R-AZ). Senator Kyl is Minority Whip and a member of the Senate Finance Committee. He has traditionally been an ally to physicians.[3]
- Senator Rob Portman (OH). Senator Portman served as the Director of the Office of Management and Budget under President George W. Bush. Senators Portman and Kyl and Representatives Camp and Upton have supported medical malpractice reform[4].
- Senator Patrick Toomey (R-PA). Senator Toomey is a member of the Senate Budget Committee.
- Representative James Clyburn (D-SC). Representative Clyburn is the Assistant House Democratic Leader and a strong advocate of increasing the number of community health centers improving access to medical care for Americans[5].
- Representative Xavier Becerra (D-CA). Representative Becerra is the Democratic Caucus Vice Chair and a member on the Ways and Means Committee. Representative Becerra and Senator Patrick Toomey are the only two on the Joint Select Committee to vote against the Budget Control Act.
- Representative Chris Van Hollen (D-MD). Representative Van Hollen is ranking member on the House Budget Committee.

Other Key Dates:

- September 16: The Joint Select Committee is required to hold its first meeting.
- October 14: Other Congressional committees may submit recommendations to the Joint Select Committee no later than October 14.
- November 23: The Joint Select Committee is required to vote on its legislative package to reduce the deficit by November 23.
- December 23: The House of Representatives and the Senate must vote to approve or disapprove the Joint Select Committee's legislative package without amendment.

AHRQ Opens Prostate Cancer Evidence Review for Comment

On August 16 the Agency for Healthcare Research and Quality (AHRQ) announced that the following draft report is available and open for comment until September 13, 2011:

- An Evidence Review of Active Surveillance in Men with Localized Prostate Cancer.

According to the report, although more men are being diagnosed with early stage prostate cancer, whether active monitoring with curative intent is an appropriate option remains unclear.

To view and comment on this draft research report, please click here.

HHS Announces Bundled Payments Initiative

On August 25, CMS released a notice announcing a request for applications (RFA) for organizations to participate in one of four models under a "Bundled Payments for Care Improvement" initiative. In a related FAQ, CMS notes, "CMS may be implementing the National Pilot Program required by the Affordable Care Act to be in place by January 1, 2013 at a later date. The Bundled Payments for Care Improvement initiative is a separate initiative being undertaken under the Innovation Center's authority." In its notice, CMS outlines the four models to be tested as follows:

- Model 1: Retrospective payment models around the acute inpatient hospital stay only.
- Model 2: Retrospective bundled payment models for hospitals, physicians, and post-acute providers for an episode of care consisting of an inpatient hospital stay followed by post-acute care.
- Model 3: Retrospective bundled payment models for post-acute care where the episode does not include the acute inpatient hospital stay.
- Model 4: Prospectively administered bundled payment models for the acute inpatient hospital stay only, such as prospective bundled payment for hospitals and physicians for an inpatient hospital stay.

As noted in a related "Request for Application" document, each of the four models is organized around a hospitalization. However, CMS also states "[t]his RFA is the first in the series of activities focused on care episode redesign" and "lessons learned through Models 1-4 will inform the development of other CMS endeavors ..."

Accountable Care Organization News

Physician Group Practice Demonstration Update

On August 8 CMS released the results from fifth year of the Physician Group Practice (PGP) Demonstration. The PGP program was mandated under the Medicare, Medicaid and SCHIP Benefits Improvement Act of 2000 and was the first pay-for-performance incentive for physicians under the Medicare program. The Accountable Care Organization (ACO) model contained in the Affordable Care Act (ACA) was modeled on the PGP Demonstration.

The stated goals of the PGP Demonstration are to

- Encourage coordination of Part A and Part B services;
- Promote cost efficiency and effectiveness through investment in care management programs, process redesign, and tools for physicians and their clinical care teams; and
- Reward physicians for improving health outcomes.

CMS announced for the fifth year that seven out of ten groups met or exceeded the benchmarks of all 32 performance measures, and the remaining three groups met or exceeded on 30 performance measures. Four of the groups will receive incentive payments of $29.4 million for meeting quality benchmarks and achieving program savings.

Beginning on January 1, 2011, all ten physician groups participating in the PGP Demonstration continued to participate in a two-year extension of the program – The PGP Transition Demonstration – as the broader ACO program becomes operational.

Increasing Trend of Hospitals Hiring Physicians

In related news, a Center for Studying Health System Change found in an August issue brief that hospital employment of physicians has accelerated in recent years. The article suggests hospitals' objectives in this trend relate to shoring up referral bases, capturing admissions and "as a way to prepare for payment reforms that ... make providers more accountable for the cost and quality of patient care." However, the article further notes that the trend "does not guarantee improved clinical integration will occur" and "runs the risk of raising costs and not improving quality of care unless broader payment reform reduces incentives to increase volume and creates incentives for providers to change care delivery to achieve efficiencies and higher quality."

Second ACO Accelerated Development Learning Session

In an effort to educate providers interested in the benefits of Accountable Care Organizations (ACOs), the Center for Medicare & Medicaid Innovation is holding several learning sessions. The next learning session will be held in San Francisco, CA on Thursday, September 15 and Friday, September 16. For additional information, and registration please click here.

CMS Sued Over RUC

The Center for Primary Care, located in Georgia, filed a lawsuit against HHS and CMS on August 8. The plaintiffs claim that "AMA RUC's failure to properly evaluate RVUs with regard to primary care has had a devastating effect upon the provision of primary care services in America (including family medicine, general internal medicine, and pediatrics), as well as a devastating effect upon the nation's health and health care spending." The suit charges that CMS has followed the panel's recommendations 90 percent of the time.

In light of the lawsuit, Representative Jim McDermott (D-WA) continues to promote the Medicare Physician Payment Transparency and Assessment Act of 2011 (H.R.1256) – legislation he introduced earlier this year. The objective of the legislation is to strengthen the use of analytic contractors in identifying and analyzing potentially misvalued codes.

AMA Raises Concerns Regarding the Release of Medicare Data

On August 8 the American Medical Association (AMA) sent a letter to CMS regarding a proposed rule that would allow Medicare data to be accessed by "Qualified Entities" for the evaluation of the performance of physicians; CMS's proposal implements Section 10332 of the Affordable Care Act. Says the AMA, "If done correctly, public reporting has the potential to help provide appropriate and accurate information to patients, physicians and other stakeholders that can improve quality at the point of care. If not approached thoughtfully, however, public reporting can have unintentional adverse consequences for patients." In particular, the AMA urges that physicians have the opportunity for prior review, comment and appeal with regard to any data publicly released through this process.

Individual Mandate Ruled Unconstitutional

On August 12, in a 2-1 ruling, an 11th U.S. Circuit Court of Appeals declared that the individual mandate, created under the Affordable Care Act, is unconstitutional. This is the second federal appellate court to rule on the mandate this year. A 6th Circuit Court of Appeals ruled the mandate constitutional in June. Given the differing opinions of these rulings, the likelihood has increased that the constitutionality of the federal health law will be heard before the Supreme Court. On April 25, the U.S. Supreme Court turned down the early opportunity to review the constitutionality of the federal health care law as they rarely hear a case before the appellate courts.

HHS Announces New Exchange Regulations

On August 17, HHS announced the latest in a series of regulations relating to the establishment of health insurance exchanges ("Exchanges") required under the Affordable Care Act.

The three proposed regulations focus on the following:

- Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers. This regulation builds on previously released Exchange framework regulations to provide further details to the operations of individual and small group markets in an Exchange.

- Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010. This regulation provides guidance on the coordination of Exchanges with Medicaid and CHIP eligibility.

- Health Insurance Premium Tax Credit. This regulation provides guidance on the eligibility for premium tax credits for the purchase of subsidized health insurance in an Exchange.

HHS states in the first aforementioned regulation that "subjects included in the Affordable Care Act to be addressed in future separate rulemaking include but are not limited to: (1) Standards outlining the Exchange process for issuing certificates of exemption from the individual responsibility provision and payment under section 1411 (a)(4); (2) defining essential health benefits, actuarial value and other benefit design standards; and (3) standards for Exchanges and QHP issuers related to quality."

As noted in previous newsletters, the Congressional Budget Office (CBO) estimates that 8 million Americans will receive health insurance coverage through these Exchanges beginning in 2014 and that number will increase to 24 million by 2018.

GAO Report on Medicare Physician Feedback Program

On August 12, the Government Accountability Office (GAO) issued a report entitled, "Medicare Physician Feedback Program: CMS Faces Challenges with Methodology and Distribution of Physician Reports." In the report, GAO notes that the Affordable Care Act directs HHS to adjust Medicare payments to physicians based on the quality of care provided compared to the cost using a "value-based payment modifier," beginning on January 1, 2015 with a limited group of physicians. Importantly, the ACA requires HHS to coordinate the value-based payment modifier with the Physician Feedback Program. CMS intends to use the quality and cost measures from Physician Feedback Program to develop the payment modifier.

However, GAO states, "CMS faces the challenge of incorporating into its feedback reports quality measures that are available, *apply to specialists*, and provide information on patient outcomes." (italics added). GAO also notes in its report that CMS's methodological criteria excludes many specialists from receiving feedback reports and that 90 percent of CMS's Phase II Physician Feedback Program reports were created for generalists. Although CMS plans to revise its methodology for Phase III reports, GAO believes "significantly increasing the number of physicians who are eligible will be challenging." On the other hand, GAO's report indicates CMS is willing to work with specialty societies to ensure selected measures accurately reflect physicians' practices, but CMS prefers to use NQF-endorsed quality measures and many of the measures that specialty societies have created have not yet achieved NQF endorsement. In addition, CMS anticipates using PQRS measures that are applicable to specialists, but it has not done so yet because of limitations with the PQRS program, such as low physician participation rates. CMS states it expects PQRS participation rates to increase when physicians will be subject to penalties under the PQRS program.

CBO Releases Annual August Update

On August 24, the Congressional Budget Office (CBO) released it August update to the budgetary baseline. According to CBO's most recent estimates, the cost of extending a zero percent update for physicians under Medicare, rather than implementing a 30 percent reduction on January 1, 2012, would be $298 billion over the next 10 years.

CMS Meaningful Use Call

CMS hosted a national provider call reviewing meaningful use on August 18. The presentation briefly described the three steps of meaningful use and then discussed the specifics of participating in Stage 1. During the call, a CMS official announced that CMS will be issuing the Stage 2 proposed regulation in January 2012.

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1 Lotven, Amy. "CMS Issues Major Health Reform Rules, Super Committee In Place." *InsideHealthPolicy.com*. Inside Health Policy, 15 Aug. 2011. Web. 30 Aug. 2011.
2 Ibid
3 Ibid
4 Kapur, Sahil, Rachana Dixit, and John Wilkerson. "GOP Super Committee Picks Spark Mixed Reactions From Health Lobbyist." *InsideHealthPolicy.com*. Inside Health Policy, 17 Aug. 2011. Web. 30 Aug. 2011.
5 Sanders, Bernie, and James Clyburn. "Opinion: Local Health Centers Key to Care - Sen. Bernie Sanders and Rep. Jim Clyburn - POLITICO.com." *Politics, Political News - POLITICO.com*. Politico, 21 Jan. 2009. Web. 18 Aug. 2011.</p>

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