

Thursday, September 13, 2012

The US Oncology Network Submits Comments to CMS on 2013 Medicare Physician Fee Schedule Proposal

Take Action to Support House and Senate Letters to CMS on Proposed Radiation Therapy Payment Cuts

On July 6, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule on Medicare physician payments that would result in an overall 15% reduction in payment for radiation oncology services, and 19% for community-based radiation therapy centers, effective January 1, 2013. The proposed cuts represent a \$300 million cut to the treatment of Medicare beneficiaries fighting cancer.

On September 4, Dr. Edward George, Chairman of the National Policy Board for The US Oncology Network, sent comments to CMS representing the thoughts of physicians in The Network on the proposed rule. The comments encourage CMS to remove inequities in payment parity when the same services are provided in different care settings. The comments express concern about resulting shift of cancer care from the physician office setting to the hospital outpatient department setting, stressing the striking cost impacts of this shift for Medicare, and the dire consequences that would result from the drastic cuts proposed for radiation therapy.

To address these concerns, The US Oncology Network recommends that CMS:

- Support the creation of a single outpatient services fee schedule for both hospitals and physician offices that is applicable regardless of the site of service;
- Consistently and actively manage code-specific payment rates on all outpatient services provided in a physician's office and a hospital outpatient department toward parity, and swiftly relative to outpatient cancer care services;
- Recognize the importance of payment parity across sites of service as discretionary payment policy decisions are implemented under the current siloed payment systems;

- Support changes to the Medicare FFS benefit design to incent beneficiaries through lower co-pays and lower co-insurance percentages to seek care at the lower cost setting;
- Work with the Congress to adopt MedPAC's recent recommendations to reduce the instance of significant beneficiary bad debt. MedPAC proposes to reform the patient coinsurance obligations under the Medicare FFS benefit design so that the 20% coinsurance is no longer limitless and instead has a reasonable beneficiary out of pocket maximum that would be in line with the maximums under commercial health plans;
- Support removing the assumed overhead cost differential from code-specific reimbursement rates and instead reimburse those overhead costs directly to provide heightened transparency and a better opportunity for parity on a service-specific basis; and
- Reconsider the proposal to change the time assumptions associated with IMRT and SBRT resulting in the drastic cuts to radiation therapy.

How You Can Help

Senators Debbie Stabenow (D-MI) and Richard Burr (R-NC) and Congressmen Joe Pitts (R-PA) and Frank Pallone (D-NJ) are joining forces to author two congressional letters to CMS opposing the proposed cuts to radiation oncology.

This proposed rule puts a serious financial strain on our community oncology practice and undermines access to cancer care not only for our practices but for the 850,000 patients treated annually across the nation by The US Oncology Network.

We urge you to make your voices heard on this critical issue. Take a few moments to make a phone call (talking points provided) or send an email (draft provided) to explain to your Members of Congress the seriousness of these proposed cuts. Encourage them to sign the Stabenow/Burr and Pitts/Pallone letters to ensure cancer patients access to radiation therapy.

(Continued on page 2)

Thursday, September 13, 2012

The US Oncology Network Submits Comments to CMS on 2013 Medicare Physician Fee Schedule Proposal (*cont'd*)

[Click Here](#) to contact your Members of Congress to sign the congressional letters.

[Click Here](#) to view the Stabenow/Burr letter.

[Click Here](#) to view the Pitts/Pallone letter.

[Click Here](#) to review The US Oncology Network Comments to CMS.

U.S. Preventive Services Task Force Recommends Against Routine Ovarian Cancer Screening

On September 10, the U.S. Preventive Services Task Force (USPSTF), an independent panel of 16 experts appointed by the government, again recommended against routine screening for ovarian cancer in healthy women at average risk of developing the disease. The panel concluded that blood tests and ultrasound scans do not lower the death rate from ovarian cancer and that false-positive testing results can lead to unnecessary harm, such as major surgery.

The USPSTF made the same recommendation regarding ovarian cancer screenings in 2004, and its latest recommendation is based on the largest clinical trial on such screenings published to date. In the study of more than 78,000 women ages 55 to 74, half were screened with transvaginal ultrasounds and blood tests while the other half were not. After being followed for 11 to 13 years, the death rate from ovarian cancer was the same in the two groups. In addition, nearly 10% of those screened – 3,285 women – had false-positive test results, and approximately one-third of those women had surgery, putting them at risk for complications such as blood clots, infections and surgical injuries to other organs.

The American Congress of Obstetricians and Gynecologists does not recommend ovarian cancer screening for women who are not showing symptoms, and the American Cancer Society says there is no screening test proven to be effective and sufficiently accurate in the early detection of ovarian cancer.

Cancer care advocates such as the Ovarian Cancer National Alliance have said in response to the latest recommendation that the important thing to remember is that if women have a family history of ovarian cancer or symptoms, such as pelvic pain or persistent urinary or bowel changes, they should see their doctor.

Ovarian cancer has the highest mortality rate of all types of gynecological cancer and is the fifth-leading cause of cancer death among women in the U.S.

Click [here](#) to read more about the USPSTF recommendation.

Congress Returns for Brief Session, Lawmakers Seek Continuing Resolution

Following the August in-district work session and recent Republican and Democratic National Conventions held in Tampa and Charlotte, respectively, Congress returned to Washington this week for a brief session before it will again adjourn for the final weeks of campaigning prior to the November elections.

The primary order of business for Senators and Representatives will be passing a fiscal year 2013 continuing resolution (CR) to avoid a government shutdown in advance of the November elections. In August, Senate and House leaders agreed to a six-month CR to fund the federal government at an annual level of \$1.047 trillion, the amount set last year in the Budget Control Act of 2011 (BCA). Under the agreement, Senate and House appropriations committees were to use the August recess period to develop a measure for both chambers to pass in September. A House vote on the CR may occur as early as this week.

The other priority issue for Congress at this time is the 2% sequestration cuts scheduled to take effect on January 2, 2013 under the terms of the BCA. Bipartisan lawmakers have called on Congress and President Obama to come up with a replacement for the across the board cuts, which will result in \$94 billion in discretionary spending and \$16 billion in mandatory spending cuts next year according to the Congressional Budget Office (CBO). Automatic cuts to Medicare will begin in February 2013 and extend through February 2014.

(Continued on page 3)

Thursday, September 13, 2012

Congress Returns for Brief Session, Lawmakers Seek Continuing Resolution (*cont'd*)

The White House is expected to deliver a detailed report to Congress this week on the impact of the automatic 2% spending cuts as called for in the Sequestration Transparency Act signed into law on August 7.

MedPAC Explores Options for Medicare Premium Support

On September 6, the Medicare Payment Advisory Commission (MedPAC) outlined possible options for a Medicare premium support model, termed by the commission as “competitively determined plan contributions” (CPCs).

The concept of premium support has become politically charged approaching the November elections. Republicans are supporting the model, which would provide seniors with a limited amount of money each year to use to purchase health insurance from a menu of options. Democrats are strongly opposed to this transformation to Medicare. However, if GOP Presidential nominee Mitt Romney wins in November, his administration will heavily rely on MedPAC for technical policy advice in converting Medicare to a premium support system.

Existing Medicare private plan alternatives, called Medicare Advantage plans, follow administered pricing. This means that payments to Medicare Advantage plans are based on average per capita costs in traditional Medicare, which determines what rates it will pay providers for services rather than relying on market forces to determine what it wants to pay. CPCs, however, would determine how much the government contributes financially to plans by having it bid competitively on how much it would charge to provide Medicare benefits.

The commission’s discussion on CPCs focused on several issues to consider, such as whether seniors should be offered a standard benefits package, how CMS should define federal contributions, whether fee-for-service Medicare would be included as a competing plan and whether Medicare should be included as a bid in calculating how much the government would pay seniors to buy insurance.

Next, MedPAC staff will conduct research to help the commissioners consider the value of the various design options. How the commission addresses such design questions will determine key matters such as how much of the premium the government will pay on behalf of beneficiaries and the willingness of plans to compete in different parts of the country.

Click [here](#) to link to the MedPAC presentation outlining CPC benefit design.

CMS: EHR Incentive Payments Total Nearly \$6.6 Billion

According to the Centers for Medicare and Medicaid Services’ (CMS) latest report on data available through July, 3,884 hospitals and 267,221 eligible health care providers are now enrolled in the Medicare and Medicaid electronic health record (EHR) system incentive payment programs.

To date, the programs have distributed almost \$6.6 billion, with \$4.2 billion going to hospitals and nearly \$2.4 billion to physicians and other eligible health care professionals. Between Medicare and Medicaid, Medicare has paid \$3.27 billion and Medicaid has paid \$3.14 billion. In addition, more than \$189 million has been paid to eligible professionals through Medicare Advantage organizations. Approximately 48 percent of eligible professionals enrolled in the programs have received incentive payments, and 93 percent of enrolled hospitals have received payments.

According to a recent survey by Medscape, most physicians currently use an EHR system or are in the process of implementing one. The survey suggests that the widespread use of EHRs can be attributed in large part to the meaningful use incentive program.

In the survey of more than 21,000 physicians from 25 specialties, 82 percent reported using an EHR system or being in the process of installing one. In addition, 44 percent reported already attesting to meaningful use, and 31 percent said they expected to within the next year.

Click [here](#) to read more about the survey.