

Friday, March 8, 2013

Your Voice Needed: Contact Congress About Effects of Sequestration

The federal budget sequester (outlined below) will begin severely impacting community cancer care practices next month. Members of Congress need to hear, directly from you, that cuts to cancer care have already reached unsustainable levels, and sequestration cuts could push many practices over the edge. Let Congress know about the impact of these cuts to your practice and your patients and encourage them to co-sponsor H.R. 800, which will begin to mitigate these devastating cuts by moving Medicare Part B drug payment in the right direction. 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 the 2% sequester cut and the importance of fixing the disparity in Medicare reimbursement. [CLICK HERE NOW](#) to contact your Members of Congress

We hope you will also take a moment to complete an important [online survey](#) about sequestration and its effects on community oncology practices. Please complete this survey by close of the day on Monday, March 11, 2013.

Sequestration Goes into Effect March 1, Affects Medicare Claims Beginning April 1

After more than a year and a half of discussion and negotiations, the federal sequester officially went into effect March 1 – setting in motion across-the-board spending cuts expected to reach \$85 million in 2013.

Although not felt immediately, [results of the sequester](#) are expected emerge over the course of the next weeks and months. The sequestration order, signed by President Obama March 1 after lawmakers failed to reach a deal, requires a 7.8 percent cut in discretionary defense spending, a 5 percent cut in discretionary domestic spending, a 2 percent cut to Medicare, and a 5.1 percent cut to domestic mandatory programs.

The 2 percent Medicare cuts will apply to claims with service dates on or after April 1, 2013, resulting in lower payments received from Medicare starting in mid-April. It is expected that the cuts would apply only to the government-paid 80 percent of Part B services, and not impact the 20 percent coinsurance responsibility typically paid by the beneficiary or a private Medigap plan. Officials say this would not change the underlying Medicare allowable rate, which may be a basis for private payer reimbursement rates, but instead only the amount Medicare actually pays out for its 80 percent portion of the Medicare allowable.

Beyond the impacts to healthcare, Federal agencies are already warning employees of expected furloughs, which will likely begin in early April and affect agencies like the Federal Aviation Administration, Federal courts, Homeland Security, and the Internal Revenue Service, among others.

The next milestone deadline surrounding the sequester and ongoing budget debate is March 27, by which time lawmakers must agree on a measure that would avoid a government shutdown.

A joint coalition of cancer care providers has drafted a set of helpful talking points and related information about the sequester impacts, available [here](#).

Key Lawmaker on House Committee Highlights “Site Neutral” Payments

At a recent meeting of hospital representatives, Congressman Kevin Brady (R-TX), the incoming chairman of the Ways and Means Health Subcommittee, made clear lawmakers’ growing concern about payment disparities for the same services in outpatient settings.

In his speech before the Federation of American Hospitals, Brady called on providers to “do more” to ensure Americans receive the highest value for the Medicare dollar. “We need to make sure that taxpayers and seniors don’t pay nearly twice as much for an evaluation office visit in a hospital

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outpatient setting versus a physician office,” Brady said in his speech. He also expressed concern about the recent trend of hospitals acquiring medical practices, and then billing Medicare for procedures at a higher, hospital outpatient rate.

Lawmakers have faced opposition from hospital groups in equalizing payments for identical services performed in an independent doctor’s office versus a hospital outpatient setting, but Brady indicated the House Ways & Means Committee’s Health Subcommittee would continue working on the issue.

There is currently no legislation requiring site-neutral payment, although Brady said lawmakers are looking at how the issue affects other settings, like post-acute care in skilled nursing facilities, rehab centers and home health.

iKnowMed EHR Earns Practices \$12 Million in Incentives Under Meaningful Use

McKesson Specialty Health’s successful [iKnowMed](#) Electronic Health Record (EHR), developed in cooperation with US Oncology Network physicians, reached an [important milestone](#) last month – with more than 90 percent of physicians who have adopted the platform demonstrating Meaningful Use.

Part of a program developed by the U.S. Department of Health and Human Services’ Office of National Coordinator for Health Information Technology, providers who demonstrate “Meaningful Use” of certified EHR technology to improve patient care are eligible for financial incentives.

Physicians using the iKnowMed EHR – and successfully attesting for [Meaningful Use](#) under the federal guidelines – have so far earned their practices more than \$12 million in financial incentives in Phase 1 of the initiative. To demonstrate Meaningful Use Stage 1, providers are required to report on 20 of 25 objectives aimed at improving data capture and sharing. iKnowMed’s Meaningful Use support team helps physicians utilize the EHR to meet the

requirements as part of their daily workflow – enabling their practices to improve efficiency and focus on delivering high-quality patient care.

Practices that successfully attest under Phase 1 for two or more years by the end of 2013 will transition to Stage 2 in 2014. Stage 2 will also require the use of a patient portal, which iKnowMed will offer via McKesson Specialty Health’s My Care PlusSM patient portal. My Care PlusSM currently provides more than 20,000 enrolled patients with secure, online access to their health records.

iKnowMed was recently named the [top-ranked EHR for oncologists](#) and hematologists by Black Book Rankings for the second consecutive year.

National Commission Encourages Reforming Physician Payment Methods

A national [commission](#) convened by the Society of General Internal Medicine is calling for the elimination of the fee-for-service physician payment model, and the “fast-tracking” new models that encourage high-quality, cost-effective care.

Among its recommendations in last week’s [report](#), The National Commission on Physician Payment Reform encouraged repealing the Sustainable Growth Rate (SGR), transitioning away from fee-for-service, and eliminating higher payment for facility-based services that can be performed in lower-cost settings.

According to the commission, the United States spends approximately \$8,000 per person on health care each year, yet the health of Americans pales in comparison to that of other nations. A chief driver of high healthcare costs and uneven healthcare quality is the fee-for-service model – where doctors are paid for each service they provide – since its skewed financial incentives promote fragmented care and encourage doctors to provide more (and more costly care) regardless of its benefit to patients.



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Eliminating higher payments for facility-based services that could be performed in lower-cost settings – an issue that the US Oncology Network [has supported](#) – is a key element of reforming the system. The report notes that Medicare pays \$450 for an echocardiogram performed in a hospital, while it pays \$180 for the same procedure performed in a physician's office. The Medicare Payment Advisory Commission (MedPAC) has made [similar recommendations](#), concluding that payment parity between hospital and non-hospital settings could reduce Medicare spending by between \$1 billion and \$5 billion over five years.

“Choosing Wisely” Campaign Details 5 Cancer Tests & Treatments to Question

As part of its larger [national campaign](#) to educate consumers and spark conversations between patients and providers about potentially unnecessary and harmful treatments, “[Choosing Wisely](#)” released a list of 5 cancer-related areas where clinical value may not be supported by evidence.

The [list](#), compiled in cooperation with the American Society of Clinical Oncology (ASCO), includes tests and treatment options the group says should not be administered unless the physician and patient have carefully considered if their use is appropriate in the individual case.

Cancer care is one of the 17 medical specialties participating in this year's campaign, which offers a total 90 tests and treatments to question. The cancer care recommendations advise doctors and patients:

- Don't use cancer-directed therapy for solid tumor patients with the following characteristics: low performance status (3 or 4), no benefit from prior evidence-based interventions, not eligible for a clinical trial, and no strong evidence supporting the clinical value of further anticancer treatment.

- Don't perform PET, CT, and radionuclide bone scans in the staging of early prostate cancer at low risk for metastasis.
- Don't perform PET, CT, and radionuclide bone scans in the staging of early breast cancer at low risk for metastasis.
- Don't perform surveillance testing (biomarkers) or imaging (PET, CT, and radionuclide bone scans) for asymptomatic individuals who have been treated for breast cancer with curative intent.
- Don't use white cell stimulating factors for primary prevention of febrile neutropenia for patients with less than 20 percent risk for this complication.

The complete list and additional information is available at www.choosingwisely.org.

Patient Groups Oppose Medicare Part B Cuts in Letter to Congress

Thirty-five patient advocacy groups collectively sent a letter to House and Senate Leadership this week, expressing opposition to cuts to Medicare Part B reimbursement.

The letter reads in part: “We are very concerned that reducing Part B reimbursement to a lower percentage will increase the likelihood that physicians will stop providing critical treatments to the most vulnerable patients. Of course, if physicians or other providers decide to no longer provide such treatments, it is the patients who will ultimately suffer the most.”

Full text of the letter is available [here](#).