114 Members of Congress Send Bipartisan Letter to CMS Opposing Cuts for Community Cancer Care

Congressmen Paul Tonko (D-NY) and Devin Nunes (R-CA) along with 112 bipartisan members of the House of Representatives sent a letter to the Centers for Medicare and Medicaid Services (CMS) on October 23rd urging reconsideration of the proposed cuts to community cancer clinics contained in the 2014 Medicare Physician Fee Schedule proposed rule.

CMS is proposing to cap 2014 payments to community cancer clinics at 2013 hospital payment rates not just for chemotherapy administration but also for other essential cancer care services such as diagnostic imaging, therapeutic radiation, and pathology.

“ Millions of American patients and their families battling cancer rely on Medicare coverage and community based comprehensive cancer care clinics to provide their care and support for longer, better quality lives,” said Ira Zackon, M.D of New York Oncology Hematology (NYOH). “I know all of the physicians and support staff at NYOH join with similar practices across our country in applauding Congressman Tonko’s leadership in standing up for seniors with cancer and for the dedicated caregivers who provide for them.”

CMS’ proposal will cut payment for community cancer care and, in the process, substantially widen the payment rate differential for cancer care services between settings. Under the proposed 2014 Medicare payment rules, community cancer clinics would be paid 50% less than hospital rates for a representative mix of chemotherapy administration services and 35% less than hospital rates for a representative mix of radiation therapy services.

Over the past six years, 288 community cancer treatment facilities have closed and more than 469 practices have merged into, or become affiliated with, hospitals due to inadequate reimbursement rates. This has resulted in individuals with cancer losing access to care close to home — particularly in rural areas.

In the letter to CMS, members of Congress ask Medicare officials to reconsider its proposal to cap reimbursement rates for codes related to chemotherapy administration, diagnostic imaging and therapeutic radiation citing threat of more facility closures and reduced access to care for vulnerable patients.

“The proposed payment policy fundamentally threatens community cancer care as we know it today,” said Congressman Nunes. “Hundreds of facilities have already closed due to misaligned payment rates, and many others are being swallowed into hospital systems. We will not achieve our goal – delivering quality care at the best price – by driving community care into the hospital setting. This bipartisan letter encourages CMS to reconsider its proposal.”

To read the Representative Paul Tonko (D-NY) press release on the letter CLICK HERE

To read the bipartisan letter from 114 Members CLICK HERE

President Signs Bill to End Shutdown, Raise Debt Limit

After a 16-day government shutdown, Congress approved and President Barack Obama signed the legislation (HR 2775) into law legislation to reopen the government and lift the debt ceiling on October 17th.

President Obama said the shutdown should not be repeated and called on Congress to “get out of the habit of governing by crisis.”

The standoff “inflicted completely unnecessary damage (to) our economy” by slowing growth and
slowing growth and increasing borrowing costs, Obama said, declaring "there are no winners here."

Hours before the U.S. was set to reach its borrowing limit, the Senate passed the bill 81-18. Later, the House cleared the bill 285-144.

The measure funds the government through Jan. 15 at the fiscal 2013 post-sequestration spending level and suspends the debt limit until Feb. 7.

“This compromise we reached will provide our economy with the stability it desperately needs,” said Senate Majority Leader Harry Reid. “It’s never easy for two sides to reach consensus. It’s really hard, some times harder than others. This time was really hard.”

Despite some lawmakers’ efforts to dismantle or defund the Affordable Care Act, the only provision related to the 2010 law included in the final deal requires the Department of Health and Human Services to verify the income qualifications of people who apply for tax subsidies to help buy health insurance.

In the final days before Congress reached an agreement to fund the government, lawmakers axed proposals to repeal or delay the Affordable Care Act’s 2.3 percent excise tax on medical devices.

As part of a broader fiscal deal, both chambers agreed to reconcile their budget resolutions adopted earlier this year and report by December 13. Congressional leadership also announced members of a budget conference committee tasked with accomplishing a resolution. However, there is no binding language that would require this committee to produce an agreement.

In New Budget Talks, Changes to Medicare May Take Center Stage

The latest federal budget showdown has set the stage for the next one, as Republicans and Democrats have just three months to craft a new agreement to avoid another shutdown crisis.

There is skepticism in both parties that House Budget Committee Chair Paul Ryan (R-WI) and Senate Budget Committee Chair Patty Murray (D-WA), who will lead upcoming budget negotiations, can avoid another impasse in Congress.

The 29-member panel has a Dec. 13th deadline to reach consensus over deep fiscal policy differences between the two parties. However, this deadline is not binding so many are skeptical the committee will produce results.

In a joint statement, Murray and Ryan pledged to work together to find a way around the automatic spending cuts known as "sequestration" now governing federal spending. "We hope we can reduce the deficit in a smarter way," they said.

Medicare is expected to also be a major part of the panel's deliberations as both parties have agreed on some Medicare changes, including asking wealthier beneficiaries to pay more for their coverage.

Wealthier Medicare Beneficiaries

Current law already requires individuals whose incomes are $85,000 and above to pay a larger share of Medicare Part B (outpatient services including doctor visits and laboratory services) and Part D (prescription drug) premiums. While most beneficiaries pay 25% of Part B premiums, higher-income beneficiaries pay 35 to 80%, depending on income.

Obama's fiscal 2014 budget proposal would increase the range of premiums for higher income beneficiaries to between 40% and 90%. His plan would also freeze the income thresholds for those
higher premiums until a quarter of beneficiaries paid them, the result of inflation pushing more recipients into those income levels.

**Medigap Changes**

Both sides may also agree to discourage the use of "first-dollar" Medicare supplemental policies.

Starting in 2017, the president's budget plan would require new beneficiaries who purchase more generous Medigap plans to face a surcharge of approximately 15% of the average Medigap premium.

In an Oct. 8 op-ed in the Wall Street Journal, Ryan said Medigap premiums could be overhauled "to encourage efficiency and reduce costs."

**Higher Beneficiary Cost Sharing**

The President's budget plan includes a higher Part B deductible for those enrolling in 2017 and thereafter as well as a new copayment for home health services. The administration says these changes would "strengthen program financing." Seniors' advocates say it's an additional cost to people already struggling on fixed incomes. In 2012, nearly half of Medicare beneficiaries had annual incomes below $22,500.

**Provider Cuts**

Reimbursements to the hospitals and other providers that care for Medicare beneficiaries could also be on the table. Providers are already facing more than $700 billion of cuts from the 2010 healthcare law plus an additional 2% as part of ongoing automatic spending cuts known as "sequestration." Providers will balk at more cuts but they are expected to be part of the negotiations.

**Drug Rebates**

Proposals could appear to alter drug costs for approximately 11 million low-income Medicare beneficiaries, particularly those known as "dual eligibles" because they qualify for both Medicare and Medicaid.

As part of the creation of the Medicare Part D prescription drug program, the drug coverage for duals shifted to Medicare. But the rebates that Medicare Part D plans receive are not as generous as those paid to Medicaid. Part D plans also pay higher prices for drugs than Medicaid does. The Obama Administration has proposed requiring drug makers to pay the difference between rebate levels they now provide to Part D plans and the Medicaid rebate levels.

**CBO To Score Senate SGR Bill As Lawmakers Consider Timing During Upcoming Budget Talks**

The Congressional Budget Office is scoring legislation drafted by the Senate Finance Committee to replace the Sustainable Growth Rate (SGR) formula that determines Medicare physician pay. The deal reached in October to extend the debt ceiling and end the government shutdown also set the stage for a new round of negotiations to cut Medicare spending, which in turn could create another opening for replacing the Medicare pay formula.

However, the timeline in the deal to fund the government until Jan. 15th could put SGR reform legislation in a precarious position as the SGR formula that cuts Medicare physician pay by 25 percent kicks in Jan. 1st. Congress could pass short-term or long-term legislation to fix the SGR formula as a stand-alone bill in December. It is also possible the Congress will pass a very short-term patch to allow time for a larger fix to move along with government-funding legislation due by Jan 15.

The Senate measure does not currently include offsets though lawmakers are preparing a list of offsets to choose from. On the House side, CBO already scored a bill drafted by the Energy &
Commerce Committee estimated to cost $175 billion - considered an unwieldy amount for many House Republicans looking to reduce spending. The Ways & Means Committee is also working on an SGR reform bill and Ways & Means health subcommittee Chair Kevin Brady (R-TX) hopes to reduce the cost of SGR legislation to the cost of a pay freeze, which CBO estimates at $138 billion over 10 years.

The conference on the budget resolution could give instructions to other congressional committees with broad parameters to cut federal spending. Those committees then would come up with policy through reconciliation and SGR could be included in that second step. The budget resolutions that the House and Senate passed earlier this year both included provisions calling for deficit neutrality on Medicare physician pay policies.

**Health Insurance Exchange Launched Despite Signs of Problems; Sebelius Scheduled to Testify to Congress**

When the new online health insurance marketplace hosted at Healthcare.gov went live on Oct. 1st, the website reportedly locked up shortly after midnight as about 2,000 users attempted to complete the first step of enrollment.

U.S. Chief Technology Officer Todd Park has said that the government expected HealthCare.gov to draw 50,000 to 60,000 simultaneous users but that the site was overwhelmed by up to five times as many users in the first week.

U.S. Chief Technology Officer Todd Park has said that the government expected HealthCare.gov to draw 50,000 to 60,000 simultaneous users but that the site was overwhelmed by up to five times as many users in the first week.

On October 24, private contractors in charge of building the online health insurance marketplace testified in front of the House Energy and Commerce committee that the administration went ahead with the Oct. 1 launch of HealthCare.gov despite insufficient testing.

“The there’s no sugarcoating it: The Web site is too slow; people have been getting stuck during the application process,” President Obama said at a White House event. “No one is madder about the Web site than I am, which means it’s going to get fixed.”

Obama also said government officials are “doing everything we can possibly do” to repair the site, including 24-hour work from “some of the best IT talent in the country”

Congressional Republicans have called for the firing of Health and Human Services Secretary Kathleen Sebelius over the enrollment problems.

Though the White House kept close tabs on the creation of the online exchange, managing the details of the software development was left to the Centers for Medicare and Medicaid Services (CMS) under Sebelius’ oversight. Sebelius is scheduled to testify before the Energy and Commerce Committee on Oct. 30th on the issues plaguing enrollment. Marilyn Tavenner, administrator of the Centers for Medicare & Medicaid Services, will testify in front of the House Ways and Means Committee on Oct. 29th.

About a month before the exchange opened, CMS invited about 10 insurers to help test the Web site. The testing group urged agency officials not to launch it nationwide because it was still riddled with problems.

Days before the launch, government officials and contractors tested a key part of the Web site to see whether it could handle tens of thousands of consumers at the same time. It crashed after a simulation in which just a few hundred people tried to log on simultaneously.
In their remarks in front of the House Energy and Commerce committee, executives of the IT companies building the website said that full tests of the Web site that should have been carried out months in advance, but began just two weeks before its rollout.

Initial problems centered on account registration, a function that takes place early in the process and was in part a responsibility of contractor QSSI. While that function has improved, it is not fixed. Additional problems are now showing up in the shopping and enrollment parts of the process, applications that are largely the responsibility of CGI, the person said.

“We are working around the clock to identify issues with the site, diagnose them and fix them,” said Joanne Peters, a spokeswoman for Health and Human Services. “We know the site is working significantly better than it was on day one, with more people able to get through the process and enroll everyday, but we still have more work to do. We have to get this right so that everyone who wants coverage can get it, and we are committed to doing so.”

NEJM Article Analyzes Urology Practices Use of IMRT

On October 24th, the New England Journal of Medicine (NEJM) published an article examining the association between ownership of Intensity Modulated Radiation Therapy (IMRT) services and the use of IMRT to treat prostate cancer.

The study, led by Dr. Jean M. Mitchell, Ph.D., claims that less than one-third of newly-diagnosed prostate cancer patients who sought treatment from an integrated urology group received Intensity-Modulated Radiation Therapy (IMRT).

In a statement, the Large Urology Group Practice Association, (LUGPA) which represents more than 1,800 urologists nationwide, said Mitchell’s study is methodologically flawed, factually inaccurate and fails to provide useful information regarding improving prostate cancer care.

LUGPA contends that despite the author’s intent to draw a parallel between ownership and utilization, the findings are in line with data from academic literature that predates the development of integrated groups.

Further, they point out that the fact that integrated groups’ rates of active surveillance and surgery held constant further illustrates that ownership of IMRT did not affect these groups’ clinical decision making.

Moreover, LUGPA argues that the study was commissioned specifically to persuade lawmakers to undermine competition in the market place in favor to the study’s sponsor – the American Society for Radiation Oncology (ASTRO).

Legislative changes based on questionable data could drive up costs as many patients will be unnecessarily forced to seek care in the more expensive hospital setting, and harm patient access to specialized, integrated care.