The US Oncology Network
Health Policy Report

Thursday, March 21, 2013

Contact Members of Congress regarding the 2% Medicare Sequestration Cuts beginning April 1st

Starting April 1, a 2% cut to Medicare payments to providers on claims with service dates on or after April 1, 2013 will take effect, decreasing payments received from Medicare starting in mid-April. The 2% cut is on the 80% billed to Medicare, including Part B drugs, but will not impact the 20% coinsurance responsibility typically paid by the beneficiary or private Medigap plan. As a result, the effective rate for office-administered drugs will be ASP+4.3% and for other physician fee schedule services, the effective rate will be 98.4% of the current rate.

In addition, Eligible Professionals that receive their Medicare EHR Incentive Program payments on or after April 1, 2013 can expect to see a 2% reduction due to the cuts mandated under the sequestration. If you have attested to Meaningful Use and have not received your incentive payment, there will be a 2% reduction to the total expected payment equaling $360 for first year attestations and $240 for second year.

We have partnered with ASCO, COA and other patient advocacy organizations to push a unified message to legislators on Capitol Hill that advocates the aversion of the 2% cuts to Part B drugs. Our message on the Hill is to reverse sequestration cuts to Part B drugs or mitigate those cuts by passing H.R. 800, which removes the prompt pay discounts between manufactures and distributors that is calculated in the current ASP+6% formula.

It is crucial that you 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. Please contact your members of Congress by CLICKING HERE NOW.

Deal Reached to Avoid Government Shutdown, Differing Budget Plans Emerge

With the passage today of a continuing resolution (CR), lawmakers have reached a deal that will keep the government operational until September 30. Debate continues, however, on the overall budget and how to remedy the nation's deficit.

House Republicans and Senate Democrats have each proposed a budget plan with differing approaches for tackling the deficit. In the Senate, Democrats propose raising $975 billion in new tax revenue while cutting the same amount in federal spending, and pouring $100 billion into an economic stimulus package.

House Republicans, on the other hand, have successfully passed their version of a budget with no new tax revenue, no new stimulus, and approximately $4.6 trillion in government spending cuts.

House Republicans' Budget – The plan passed by House Republicans aims to drastically reduce government spending – cutting it by five times as much as proposed by Senate counterparts.

It would not stop sequestration, but would shift the impact of those across-the-board cuts from defense spending toward discretionary programs – effectively increasing defense spending by $550 billion and trimming domestic programs by $250 billion.

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The Republican plan emphasizes "budget neutrality" and would address taxes by closing loopholes and using that resulting tax revenue to offset the cost of dropping both the top individual tax rate and the corporate rate to 25 percent.

In terms of healthcare and entitlements, House Republicans are calling for a repeal of the Obama Administration's healthcare law, which would yield $4.6 trillion. The plan would also cut $205 billion in Medicare funding and $770 billion from Medicaid.

Senate Democrats' Budget – Senate Democrats propose dealing with spending by replacing the sequester's $1.2 trillion in cuts with a series of smaller cuts and tax increases. The plan also incorporates a stimulus package of roughly $100 billion that would finance transportation, school and job programs.

The Democrats' plan also addresses taxes by closing individual and corporate tax loopholes. In terms of healthcare and entitlements, Senate Democrats propose a modest $275 billion in health care cuts achievable by changing the manner in which providers are reimbursed, and by eliminating waste, fraud and abuse. And although President Obama may have become slightly more receptive to changing Medicare and Medicaid, Senate Democrats seem unwilling to make any drastic changes to benefits.

Absent a new budget deal, another fiscal deadline looms for this summer, when the nation's $16.7 trillion debt ceiling will again be reached. A deal, if reached, would likely come somewhere in the middle of the two proposals. Many believe grand bargain is currently out of reach but a smaller, less ambitious plan could be achieved this year.

MedPAC Issues Report on Payment Policy

The Medicare Payment Advisory Commission (MedPAC) issued its 2013 *Report to Congress on Medicare Payment Policy* last week, and emphasized the on-going need to provide beneficiaries with access to high-quality services while encouraging efficient use of resources.

Among its recommendations in this year's annual report, MedPAC urged Congress to increase inpatient and outpatient hospital pay by 1 percent but keep payment the same for long-term-care hospitals, inpatient rehabilitation facilities, skilled nursing facilities and home-health providers. The report also provided additional details on recommendations MedPAC made in January to repeal the sustainable growth rate (SGR) formula and replace it with legislated updates and incentives for more organized healthcare delivery.

At a House Ways & Means Hearing following release of the report, lawmakers had the opportunity to question Gene Hackbarth, MedPAC chairman, about details within the report about how to balance payment updates to providers and streamline Medicare by encouraging payment and delivery system reforms. Lawmakers expressed interest in Hackbarth's counsel particularly related to repealing the SGR – an issue he called "urgent" if Congress wants to keep Medicare solvent.

Although not detailed in its most recent report, MedPAC expressed interest in policy that would reduce Medicare payments to hospital outpatient departments (HOPDs) and put them on par with physician offices and other ambulatory clinics. When pressed about this issue in the hearing, Hackbarth said MedPAC was looking at reimbursement disparities and did not believe Medicare should be paying more for the same service in the outpatient setting. One proposal – a "site-neutral" policy — would recommend that HOPDs and ambulatory care settings receive similar Medicare payments. The recommendation would expand policy to 66 additional ambulatory payment classifications, which could reduce hospital Medicare payments by $900 million.

MedPAC's report is available in its entirety here.

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CMS Drops Coverage Ban on PET Tracers Leaving Decision to Local MACs

In a decision released March 7, the Centers for Medicare & Medicaid Services (CMS) announced that local Medicare Administrative Contractors (MACs) may determine coverage within their respective jurisdictions for positron emission tomography (PET) that uses radiopharmaceuticals for cancer imaging. It is still unclear what the 15 MACs will do.

The change comes in response to a formal request by the Medical Imaging & Technology Alliance to permit local MACs to make the determination. CMS has emphasized that the change is not for positive national coverage of any specific use of PET or a new PET tracer -- the change merely allows new PET radiopharmaceuticals to be subject to local MAC determinations. The new policy would not include screening uses of PET scanning.

The full decision by CMS is available here.

My Care Plus℠ Patient Portal Reaches Milestone

McKesson Specialty Health's secure patient portal – My Care Plus℠ – is now being utilized by more than 25,000 U.S. patients, allowing them access to convenient, comprehensive, secure medical information via the internet.

More than 40 community oncology practices are among the growing number of groups offering My Care Plus℠ to patients. The portal integrates with the iKnowMed Electronic Health Record (EHR) thereby offering patients online access to records, test results and other personal health information. Patients can review important details about their cancer diagnosis and stage, health-concerns, medications, allergies, as well as approved clinical lab results with physician comments. The health information can be downloaded and printed, providing a health record summary in a matter of minutes, and allowing patients to remain knowledgeable and involved with their own care.

In addition to serving as an important resource for patients, My Care Plus℠ is part of McKesson's participation in CMS' Meaningful Use program. Practices that demonstrate "Meaningful Use" of approved EHR platforms are eligible for financial incentives. Additional information about My Care Plus℠ is available here.

ICD-10 Implementation Guides Released

In advance of the October 2014 rollout of new ICD-10 codes, CMS has released a set of comprehensive implementation guides to aid practices in the transition. The guides provide step-by-step resources and guidance tailored to the individual practice type. CMS' resource material breaks down the transition from ICD-9 to ICD-10 in phases: planning, communication and awareness, assessment, implementation, testing, and transition.

The transition to ICD-10 codes is required for everyone covered by the Health Insurance Portability Accountability Act (HIPAA), although it does not affect CPT coding for outpatient procedures and physician services. Resources are available for small and medium practice providers, large practice providers, small hospitals and payers. Additional information is available here.

CMS Proposes changes to Oncologic Imaging, Restricting Use of PET for Subsequent Therapy Planning

The Center for Medicare and Medicaid Services recently released a proposal from their coverage and analysis group relative to Medicare coverage for PET imaging. As we understand it today, CMS proposes to end its Coverage with Evidence Development (CED) process through the National Oncologic PET Registry and replace it with a pure coverage determination. Unfortunately, CMS is also proposing to pull back on national coverage previously available under past National Coverage Determinations for the use of PET imaging for

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subsequent therapy planning. Specifically, CMS proposes to limit this coverage to a single subsequent scan. We are working with our allies in this space to achieve a more favorable coverage regime and we will be in touch on how you can help comment to CMS on this important issue.