The US Oncology Network
Health Policy Report

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CMS Responds to Inquiry from 124 Lawmakers on Impact of Sequester

On June 3, Centers for Medicare and Medicaid Services (CMS) Acting Administrator Marilyn Tavenner responded to a April 19 letter from a bipartisan group of 124 members in the House expressing concern that Medicare cuts to critical cancer medications are forcing oncologists to turn away cancer patients.

Led by Congressmen Pete Sessions (R-TX), Gene Green (D-TX), Mike Burgess (R-TX), Ed Whitfield (R-KY), Ron Kind (D-WI) and Congresswoman Allyson Schwartz (D-PA), lawmakers asked CMS to use their authority to provide the 2% sequestration cuts only on the 6% service payment, not the underlying drug cost of the Medicare Part B payment.

The letter's authors asked CMS to answer a series of questions by April 29 regarding the agency's flexibility in applying the sequester cut to Medicare Part B drugs as well as plans for monitoring the effect of this cut on Medicare beneficiaries.

In response, Tavenner stated that the law does not allow discretion to administer the sequestration reductions in a manner that is different from the across the board approach that has been used to implement it. Currently, existing exemptions from sequestration do not encompass payment for Medicare Part B drugs.

"We do not believe that we have the authority under the Budget Control Act of 2011 to exempt Medicare payment for Part B drugs," Tavenner wrote. "The Office of Management and Budget memorandums M-13-03 and M-13-06 referenced in your letter pertain to any flexibility regarding the agency's budgetary resources for internal operations such as the hiring o f new employees. This is separate from the agency's administration of Medicare payments, which are subject to the sequestration reductions, as noted above."

In their letter to CMS, lawmakers questioned whether CMS had the statutory authority to reduce Medicare Part B drug reimbursement as well as expressed concern regarding access issues to community-based cancer care, citing news reports of clinics forced to turn away Medicare patients.

In an op-ed in Roll Call on June 5, National Patient Advocate Foundation CEO Nancy Davenport-Ellis calls on Congress to protect cancer patients from cuts to Medicare included in the sequester.

New Study Shows Alarming Shift in Outpatient Chemotherapy

Encourage Support for Legislation to Address Reimbursement Issues

On June 3, a new study by The Moran Company, sponsored by The US Oncology Network, Community Oncology Alliance, and ION Solutions, illustrated the dramatic shift of cancer care to the outpatient hospital setting from 2005 - 2011.

While the majority of Medicare patients are still treated in community oncology practices (67%), this is down dramatically from 2005 levels (85%).

A 2011 study by Milliman demonstrated that the care of a cancer patient receiving chemotherapy costs Medicare $6,500 less per patient per year and a Medicare beneficiary $650 less when the care is managed in a community cancer clinic rather than the hospital outpatient setting.

Not surprisingly, the study reports that Medicare payments for chemotherapy administered in the more expensive hospital outpatient settings have more than tripled since 2005 while payments to physician community cancer clinics have decreased by 14.5%. In an attempt to address some of the Medicare Part B payment problems causing this shift in cancer care site of service, members of Congress have introduced two important pieces of legislation.

The first is the Preserve Community Cancer Care Act (H.R. 800 / S. 806), also known as the prompt pay discount legislation that would correct an erroneous reduction in the drug and biologics reimbursement payment formula for community based oncologists. The second, is the Cancer Patient Protection Act (H.R. 1416) that would reverse the sequestration cuts to Medicare Part B drugs.

Show your support for these legislative efforts by CLICKING HERE NOW!

To view the joint press release on the Moran Study CLICK HERE

To read the results of the Moran Study CLICK HERE

GAO Recommends National Standards For Advanced Diagnostic Imaging

On May 31, the Government Accountability Office (GAO) issued an analysis including recommendations for CMS to establish national standards for the accreditation of advanced diagnostic imaging service providers.

The recommendations follow the Medicare Improvements for Patients and Providers Act of 2008 that mandated that diagnostic services, such as magnetic resonance imaging, computed tomography, or positron-emission tomography, be accredited by an organization approved by CMS.

However, GAO officials believe CMS has not established clear standards for the three organizations - the American College of Radiology (ACR), the Intersocietal Accreditation Commission (ICA) and the Joint Commission - that accredit providers of diagnostic services.

Instead the agency has relied on the three accrediting organizations to establish their own standards for quality and safety, standards that have differed significantly among the three organizations according to GAO's analysis.

"As a result of these significant differences among the accrediting organizations, which arise from the lack of minimum national standards, important aspects of imaging, such as qualifications of technologists and medical directors and the quality of clinical images, are difficult for CMS to monitor and assess," the GAO report states.

ACR, the oldest accrediting body for medical imaging and radiation oncology facilities, released a statement supporting GAO's recommendations for minimum national standards for the accreditation, an oversight framework for evaluating accrediting organization performance and more specific requirements for accrediting organization audits.

"If accreditation is actually going to achieve a national standard of quality and safety for patients, there have to be legitimate, meaningful standards in place. [The] GAO report is a significant step in the right direction. The ACR looks forward to working with Congress, HHS, and other stakeholders to put the GAO recommendations into action," said Paul H. Ellenbogen, M.D., FACR, chair of the American College of Radiology board of chancellors.

Survey Implies Drug Shortages Endanger Cancer Patient Care

About 83% of cancer specialists said they were unable to prescribe their preferred drug for chemotherapy in the past six months, and 92% said patients' care has been affected, according to a survey of 245 doctors released June 3 in Chicago at the annual meeting of the American Society of Clinical Oncology.

The survey was conducted between September 2012 and January 2013 by researchers at the University of Pennsylvania.

In February, the University of Utah Drug Information Service reported national and regional shortages of 320 drugs, the highest since 2010.

The American Society of Clinical Oncology also released its own survey results of surveys of its own members showing that though chemotherapy drug shortages may have eased slightly between October 2012 and April 2013, doctors were still forced to substitute in other drugs for preferred therapies.

In fact, 38% of doctors switched from a generic to a more expensive, name-brand drug - vastly increasing the cost of treatment according to the June 3 study co-authored by Keerthi Gogineni at the University of Pennsylvania School of Medicine.

The result, according to the survey, is that cancer specialists who couldn't afford to provide the most appropriate drug were forced to make painful choices:
• 79% switched chemotherapy regimens, which may be less effective.
• 43% delayed treatment, which can give cancers more time to spread.
• 37% chose among patients, leaving some patients to go without a critical medication.
• 29% omitted doses, which can reduce the chance of controlling cancer.
• 20% reduced doses, which also may harm a patient's chances of surviving.
• 17% sent patients to other doctors.

While all fields of medicine have been hit by drug shortages, cancer patients have been hit especially hard, however, because many of the shortages involve sterile injectable drugs. Shortages of intravenous vitamins also have affected cancer patients, who often have special nutritional needs. Further, 70% of doctors said their hospitals or practices had no formal guidelines about how to allocate scarce drugs, the survey found.

Chemotherapy drugs most commonly reported to be in short supply, according to the survey include:
1. Leucovorin, 68% (used to treat colorectal cancer).
2. Liposomal doxorubicin, 63% (used in ovarian cancer, multiple myeloma, others).
3. 5-FU, 19% (used in many gastrointestinal cancers).
4. Bleomycin,18% (used in testicular cancer, Hodgkin lymphoma and others).
5. Cytarabine, 7% (used to treat acute myeloid leukemia, non-Hodgkin lymphoma, others).

The FDA said the number of new shortages declined to 117 in 2012 from 251 shortages in 2011 thanks to efforts including requiring manufacturers to provide earlier notifications of potential shortages to the agency.

Lawmakers Mull SGR Options, House Panels Work on Separate Bills

On May 28, Republicans on the House Energy and Commerce Committee unveiled draft legislation to repeal the current Sustainable Growth Rate (SGR) system and replace it with a new system of physician payment in the Medicare program.

The draft legislation incorporates feedback received from stakeholders on the initial proposal and establishes an improved fee for service system in which providers - working with the Secretary of Health and Human Services - develop quality measures that will lead to better care in a more efficient manner.

In addition, providers will have the option of leaving the fee for service system and opt instead for new ways of delivering care that put an even greater emphasis on quality and efficient care.

Though the draft bill calls for a period of stable pay after which physicians would be paid for performance it does not say how much physicians would be paid or how long this period would last.

Up until recently, Republicans on the House Energy & Commerce and Ways & Means committees were

working together on legislation and jointly released a legislative outline in April.

Now the panels are working on separate "doc fix" bills. The committees previously had touted their joint effort as reason to be optimistic about passage of a bill this year.

"We will continue working closely with Ways and Means Committee Chairman Camp as well as maintain our ongoing dialogue with committee Democrats as we work toward long-term solutions in the effort to improve quality of care," said full committee Chairman Fred Upton (R-MI).

Energy and Commerce is asking providers to send feedback on the latest draft by June 10, 2013 and plans to hold a hearing on the bill June 5.

CMS Launches Round Two of Health Care Innovation Awards

The Center for Medicare and Medicaid Services (CMS) Innovation Center is investing $1 billion in grants to be awarded to organizations seeking to develop new payment models that improve care in federal health programs at a lower cost.

On June 3, CMS officials announced they would accept letters of intent to apply for the second round opportunity to apply for innovation awards until June 28. CMS will accept formal applications starting from June 14 until August 15 of this year.

The innovation center is favoring models that will grapple with health care problems considered the costliest for Medicare, Medicaid and the Children's Health Insurance Program, particularly reduction of costs in Medicare and Medicaid outpatient hospitals and other settings; care for specialized populations, such as patients with Alzheimer's disease or HIV/AIDS; support specialties, such as oncology, cardiology and others treating patients with complex chronic diseases.

"We believe there are organizations that are out there eager to transform the way health care is delivered and help [the Centers for Medicare & Medicaid Services] develop new payment systems to support these innovations," said Richard Gilfillan, MD, director of the innovation center.

Officials hope the target areas will fill gaps in the current pay system, Dr. Gilfillan said. The innovation center also will judge applicants on their ability to demonstrate that the pay models will improve health care quality and be sustainable over the long term.