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Impact of Sequestration on Community Cancer Care Receives National Media Coverage

The impact of the Medicare sequestration cuts on community based cancer care began to receive national media attention last week. The Medicare sequestration 2% cut went into effect on April 1st, amounting to a 28% cut to the services side (the 6% of ASP + 6%) of community cancer care drug reimbursement.

Following the release of a [statement](#) and letter to Congress by the community oncology community (ASCO, COA, ION Solution, The US Oncology Network) explaining this crisis to the public, the story of cancer clinics nationwide being forced to turn away Medicare patients due to the devastating effect of the sequester cuts was picked up by “inside the beltway” publications here in DC ([CQ-Roll Call](#), [Politico](#), [The Hill](#)) and soon made it to the front page of the [Washington Post](#) and then on to the major networks ([CNN](#), [ABC](#), [MSNBC](#)).

A Congressional letter from Congressmen Pete Sessions (R-TX), Gene Green (D-TX), Michael Burgess (R-GA), Allyson Schwartz (D-PA), Ed Whitfield (R-KY) and Ron Kind (D-WI) is being circulated to in order to convince the Centers for Medicare and Medicaid Services (CMS) to alleviate this crisis by using their authority to greatly reduce the cuts.

In addition, on April 9, Congresswoman Renee Ellmers (R-N.C.) introduced legislation designed to reverse these sequester cuts retroactively.

We strongly suggest that you take a moment to contact your Members of Congress on how the cancer care crisis is impacting their constituents by [CLICKING HERE NOW](#)

Major Cuts to PET Coverage for Cancer Treatment Proposed by CMS

A recently proposed [decision memorandum](#) from the Centers for Medicare and Medicaid Services (CMS) regarding positron emission tomography (PET) imaging threatens to severely curtail the ability to order follow-up PET scans for subsequent cancer treatment planning. It is estimated that this policy would preclude CMS coverage of up to 50% of the PET cases performed at community based cancer centers.

Thomas Flynn, MD, Chairman, National Policy Board and Landis Griffeth, MD, PhD, Director of Functional Imaging, submitted [comments](#) to CMS expressing deep concern with this proposed decision memorandum. Those who have developed individual comments from their practices should know that **[comments have been extended through tomorrow Sat, April 13, 2013](#)** (see the links below). The deadline was extended due to technical problems on CMS’ web portal that have since been fixed.

CMS plans to reverse course and cover a maximum of only **TWO** PET scans for the lifetime of each oncology patient; one for initial treatment strategy and one performed for subsequent treatment strategy. In the past, CMS has not placed limits on the number of scans that can be performed for subsequent treatment strategy, as needed for potential changes in patient management, restaging after therapy, assessment of suspected recurrence, etc.

CMS does leave open the possibility for the local carriers to pay for additional subsequent treatment strategy PET scans, with approval on a “tumor-by-tumor” or even “case-by-case” basis. However, getting approval for each of those “case-by-case” scans is likely to be very cumbersome, if

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not impossible.

CMS did agree to lift the CED requirement for FDG-PET for most of the remaining tumors (note that coverage for NaF PET still remains under CED). Notably, CMS excluded prostate cancer from this new coverage, and now proposes that FDG-PET for prostate carcinoma be nationally "noncovered," meaning that prostate cancer would not be covered either outside or inside of those participating in the National Oncologic PET Registry (NOPR).

For community based oncologists who have utilized PET scans for assessing efficacy of therapy, deciding when a new therapy should be instituted, assessing new or persistent abnormalities seen on CT or MRI, assessing the significance of rising tumor markers, or delineating suspected recurrences earlier than is possible with other imaging modalities, this will create a major void in your ability to manage patients.

While this proposal would immediately affect only payment through Medicare, it is likely that private payers will quickly adopt any CMS-recommended limitations in PET coverage.

To view the comments from The US Oncology Network on this proposed decision memorandum [CLICK HERE](#)

To view the CMS proposed decision memorandum [CLICK HERE](#)

To view comments on this proposed decision thus far [CLICK HERE](#)

For suggestions and guidelines on submitting comments [CLICK HERE](#)

To post/submit your practice's comments by Saturday, April 13 [CLICK HERE](#)

Community Oncologists React with Disappointment as President sends 2014 Budget Blueprint to Congress

On April 10, the Obama Administration sent its \$3.8 trillion budget proposal for fiscal year 2014 to Congress this week, which calls for deep cuts to Medicare, including more than \$300 billion in provider payments and \$50 billion from seniors. A coalition of community oncologists released a [statement](#) on Thursday criticizing the cancer care proposals found in the President's budget, stating that they would worsen the recent cancer care crisis stemming from the sequestration cuts and further jeopardize access to community cancer care for seniors.

It is essential to keep in mind that Administration budgets do not have the force of law even if passed and it would take subsequent actual non-budget legislation to achieve the policies proposed in this Budget. **Given the existing political landscape this budget has little chance of passage in anything resembling the current form.** Nevertheless, this budget contains proposals that are of great concern to community-based oncology and portend political battles to come, including the following:

- Reverses the sequestration cuts but calls for a reduction of Medicare Part B drug reimbursement from ASP + 6% down to ASP+3%
- Restricts the Stark in-office ancillary services provision for certain providers of imaging and radiation therapy services that don't meet as yet undefined accountability standards
- Calls for prior authorization for imaging services and Medicare cuts to clinical laboratory service payments

President Obama's new budget has been criticized by many in his own party and has been immediately dismissed by the Republican leadership of both chambers. While not without controversy on both sides of the aisle, the President appears to be

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aiming this budgetary exercise towards ending the long partisan standoff over the national debt.

Despite proposing entitlement reforms unpopular with his base, including \$130 billion reduction in Social Security spending by adopting a slower-growing measure of inflation called chained-CPI as well certain Medicare changes requiring seniors to increase Medicare payments or reduce their coverage, top Republican leaders in both chambers criticized the proposal as not going far enough to address the deficit.

To view the oncology coalition statement on the President's Budget [CLICK HERE](#)

House GOP releases revised proposal for replacing SGR

Last week, House Republican leaders released a revised proposal to replace Medicare's sustainable growth-rate (SGR) physician payment formula with a hybrid of fee-for-service (FFS) and pay-for-performance payment models.

Currently, the SGR formula is scheduled to trigger a 24.4% pay cut on January 1, 2014, unless Congress acts to avert it.

Congressmen Dave Camp (R-MI) and Fred Upton (R-MI), chairmen of the House Ways and Means and Energy and Commerce committees respectively, issued the revised proposal on April 3 with a letter to the "provider community" requesting comments by April 15.

The new proposal responds to comments on the previous draft issued February 7 emphasizing the need for stable, predictable fee-for-service payments for an unspecified period while new payment models based on clinical quality, performance from previous years, and improvement activities are developed.

With quality measures, physicians could choose to undergo a peer-to-peer comparison, or else be graded on how their scores change over time. Efficiency measures would be developed by providers, and adjusted for both risk and geographic differences.

The House Republican proposal calls for provider organizations to work together with the US Department of Health & Human Services (HHS) and develop physician performance metrics.

The revised plan also calls for specialty-specific performance measures risk-adjusted to account for the severity of patient illness, payment rates partly based on patient experience, and development of an appeals process to contest or reconsider a provider's quality score. Providers also could choose whether their quality score would be collected at the individual or group-practice level.

Under the House Republican proposal, physicians could earn even more if they score well "on efficient use of healthcare resources" of which HHS would consider per-capita costs as well as costs over an episode of care during evaluation. The revised plan also gives physicians the option at any stage to participate in an alternate payment model (APM), such as those underway in the private sector, Medicaid, and Medicare.

The Energy and Commerce Committee plans on holding another hearing on the SGR topic either later this month or in early May. Chairman Upton has reportedly said he hopes to have a bill passed by this summer.

The American Medical Association, which supports repealing the SGR, has cautioned against penalties for physicians who attempt quality improvement activities but fall short of predetermined benchmarks.

To see the letter to the provider community & overview of the plan: [CLICK HERE](#)

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CMS Director Nominee Marilyn Tavenner Sails through Confirmation Hearing

Acting Administrator of Centers for Medicare and Medicaid Services (CMS) Marilyn Tavenner sailed through a confirmation hearing before the U.S. Senate Finance Committee on April 9 receiving praise from both Republicans and Democrats.

Senate Republicans, who remain opposed to the Patient Protection and Affordable Care Act and have raised concerns about the way the CMS is implementing its provisions, did not raise much opposition to Tavenner.

Members of both parties did press her to provide more regular updates on implementation of the law. Republicans also demanded that the agency reveal the budget for setting up the health insurance exchanges. Tavenner promised to provide biweekly updates on the status of the law and said a price tag on the federal exchange is coming.

With a budget of nearly \$1 trillion, CMS is the lead federal agency responsible for health care for millions of Americans through its administration of Medicare, Medicaid and programs related to implementation of The Affordable Care Act.

If confirmed, Tavenner would be the first leader at CMS to get through the Senate since 2004, when Republican Mark McClellan got Senate approval. He stepped down in 2006.

Congress has been unable to confirm a leader for the agency due to increasing partisan division over the Medicare program. This is the second time President Obama has nominated Tavenner to lead CMS; she didn't get a hearing last year because of the election-season tensions surrounding healthcare.

However, supporters of Tavenner are encouraged that Senate Republicans

granted a confirmation hearing and believe it may signal bipartisan support in the Senate. Tavenner has received the support of House Majority Leader Eric Cantor (R-Va.) who has praised her work with Virginia's Medicaid program and reputation for bipartisanship.

Tavenner, who has served as CMS Acting Administrator for 18 months, was a nurse for almost 20 years and ultimately rose to serve as a hospital CEO in Richmond. She also served as Virginia's Secretary of Health and Human Resources in the administration of then-Governor Tim Kaine.

Senate Finance Committee Chairman Max Baucus (D-Mont.) told reporters that he hopes to hold a vote as soon as next week. U.S. Senators Mark R. Warner (D-Va.) and Tim Kaine (D-Va.) have urged swift Senate confirmation of Tavenner's renomination to lead CMS.

Senate Inquiry Finds Abuse of Discount Drug Program At Three NC Hospitals

On April 3 the Charlotte Observer ran a story reporting that an inquiry by U.S. Sen. Chuck Grassley, R-Iowa, found that three nonprofit hospitals in North Carolina made millions from a discount drug program intended to help the poor and uninsured.

Hundreds of U.S. hospitals, including more than 40 in North Carolina, obtain deep discounts on outpatient drugs under a rapidly growing federal program called 340B. The plan requires drug manufacturers to cut prices to hospitals that treat large numbers of financially needy patients.

Congress set up the program to offset the cost of treating Medicaid patients, but hospitals can buy discounted drugs for all outpatients, including those with private insurance. Federal auditors and Grassley fear that some hospitals are increasingly using the program for profits, not charity.

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Information obtained from Duke University Hospital, Carolinas Medical Center and UNC Hospitals raises questions about whether the program is functioning as intended.

Last year, Duke University Hospital purchased \$65.1 million in drugs through the discount program, which saved \$48.3 million. It sold the drugs to patients for \$135.5 million, for a profit of \$69.7 million. The profit would have been \$21.4 million if Duke had not participated.

“These numbers paint a very stark picture of how hospitals are reaping sizeable 340B discounts on drugs and then turning around and up-selling them to fully insured patients ... in order to maximize their spread,” Grassley wrote in a letter last week to the administrator of the Health Resources and Services Administration (HRSA), the federal agency that oversees the drug program.

Carolinas Medical Center has not yet answered Grassley’s questions about how much revenue it has generated from the 340B program. Last week, Grassley sent another letter, giving CMC a week to provide its 340B revenue figures “to enable an accurate comparison” to those already provided by Duke and UNC Hospitals.

About 42 percent of CMC’s 340B patients were covered by commercial insurance in 2011, and about 11 percent were uninsured. The rest were covered by Medicare and Medicaid.

At Duke, about 67 percent of patients who received those discount drugs were covered by commercial insurance companies, which often pay hospitals many times over cost for medications. Only 5 percent of the Duke patients were uninsured. Duke’s savings on discounted drugs were significantly more than the free or reduced-price care the hospital provided during the same year: \$35.2 million.

UNC reported receiving \$65.4 million in revenue from drugs bought through the program from 2008 to 2011. UNC officials said they were unable to calculate the profit figures for the drugs.

Grassley, Congress’ leading critic of nonprofit abuses, requested information from the three North Carolina// hospitals in September in response to an investigation by the Observer and The News & Observer of Raleigh. Those stories found that large nonprofit hospitals are dramatically inflating prices on chemotherapy drugs – often two to 10 times over cost – at a time when they are cornering more of the market on cancer care.

Hospitals typically save 20 percent or more on drugs bought through the program, experts say. Drugs given to inpatients don’t qualify for the program.

In a 2011 report, the U.S. Government Accountability Office found that the program got inadequate oversight. The GAO also found that “the 340B program has increasingly been used in settings, such as hospitals, where the risk of improper purchase of 340B drugs is greater.”

The number of U.S. hospitals participating in the 340B program has increased dramatically in recent years, from 591 in 2005 to 1,673 last year, according to the GAO. Some drug manufacturers have questioned whether all those hospitals need a discount drug program.