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Congress Breaks for Mid-Term Election Campaigning; Lame-Duck Session Approaching

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Health Affairs Report Findings Reinforce 340B Program Abuse Concerns

A *Health Affairs* article published this month concludes that the 340B program is shifting from its original intent to serve vulnerable patient populations and instead turning into a program that financially benefits hospitals and their affiliated clinics. [Read below](#)

Physician Groups Warn New Open Payments Site Contains Errors, Lack Accuracy

On September 30, the Centers for Medicare and Medicaid Services made public its Open Payments database reporting information on 4.4 million payments valued at almost \$3.5 billion despite broad concern from physician groups that the information lacks context and contains significant inaccuracies. [Read below](#)

Role of RUC in Assigning Medicare Payments Called into Question

A national non-profit organization representing consumer interests including safe and affordable health care called Public Citizen released a report last week that calls for an overhaul of the system for establishing Medicare physician payments. [Read below](#)

More than 160 Bipartisan Members of Congress Weigh in with CMS on Radiation Oncology Cuts



Last week, an overwhelming bipartisan group of Members of Congress sent letters to the Centers for Medicare and Medicaid Services (CMS) to express opposition to their recent proposal to change reimbursement for the radiation treatment vault, which would result in a 4 percent Medicare cut in radiation oncology and an 8 percent Medicare cut for radiation therapy centers.

The radiation therapy vault is an essential piece of medical equipment critical to the safe delivery of radiation therapy. If cuts of this magnitude take effect, they will severely undermine the delivery of cancer care for older Americans who rely on Medicare. Any further cuts would create an environment of instability, threaten patient access to community-based cancer care, and make it difficult for physician offices and freestanding cancer centers to operate.

Senators Debbie Stabenow (D-MI) and Richard Burr (R-NC) and 34 of their Senate colleagues along with Congressmen Devin Nunes (R-CA) and Paul Tonko (D-NY) and 128 of their House colleagues sent a letter to CMS Administrator Marilyn Tavenner asking CMS to revise their proposed rule and continue treating the radiation therapy vault as a direct expense.

A recent [Roll Call op-ed](#) authored by Chris Rose, MD commends this bipartisan group of lawmakers and calls on CMS to amend its proposal in the final rule to protect the delivery of radiation therapy for cancer patients. He writes, “It is now back in CMS’ court. It has the chance to make this right. Its final decision on the classification of the radiation treatment vault won’t happen until early November. Hopefully, it will consider the facts, reconsider its proposed action and recognize radiation treatment vaults are a direct practice expense.”

Thank you to all of those that took the time to contact their Member of Congress. Congressional outreach of this volume should make a difference as CMS finalizes the Medicare Physician Fee Schedule Rule around November 1.

To view the House letter, [CLICK HERE](#).

To view the Senate letter [CLICK HERE](#).

Congress Breaks for Mid-Term Election Campaigning; Lame-Duck Session Approaching

Congress broke in late September for the mid-term election cycle and is expected to return to Washington on November 12 for a “lame-duck” session – a term used to describe the period of time when Congress meets after its successor is elected, but before the successor's term begins.

According to news reports, Congress isn't likely to tackle an overhaul of Medicare's physician payment formula during the lame-duck session. The latest “doc-fix” expires at the end of March 2015. If Congress fails to fund a permanent solution before March, Medicare providers will likely face possible payment to fund another temporary payment patch.

To date, Congress has passed 17 patches to temporarily block Medicare cuts under the SGR formula. The Congressional Budget Office (CBO) projects it would cost about \$130 billion over 10 years to scrap the formula entirely.

The Senate Finance Committee and the House Ways and Means and Energy and Commerce Committees have placed high priority on developing a long-term solution, however lawmakers remain largely divided on how to fund the replacement.

Vehicles for possible SGR legislation next year include a measure to raise the debt ceiling in 2015. However, according to industry reports, there remains some hope in Washington that with the elections past during a lame-duck session, lawmakers will replace the SGR without identifying payment offsets.

Health Affairs Report Findings Reinforce 340B Program Abuse Concerns

In the October edition of *Health Affairs*, “[The 340B Drug Discount Program: Hospitals Generate Profits By Expanding To Reach More Affluent Communities](#),” concludes that the 340B program is shifting from its original intent to serve vulnerable patient populations and is instead turning into a program that financially benefits hospitals and their affiliated clinics. Originally created by the Veterans Health Care Act of

1992, the 340B drug discount program was started to make prescription drugs more accessible to indigent populations.

After examining 960 hospitals and 3,964 affiliated clinics registered with the 340B program in 2012 to see if the covered entities had expanded in ways that could maximize hospitals' profits, the authors found that hospital-affiliated clinics that registered for the 340B program in or after 2004 were not generally serving the communities the program was created to help. The authors found that these hospitals were primarily serving wealthier communities with higher rates of health insurance compared to communities served by hospitals and clinics that registered for the 340B program before 2004.

The 340B program has come under scrutiny by critics recently, including lawmakers and health care stakeholders. There is great concern that some 340B covered-entities are exploiting the drug discounts to increase profits instead of investing in programs for the poor or passing the discounts along to patients and insurers.

The authors write, "340B hospitals are not required to pass along their discounts to patients or insurers or to demonstrate their investments in outpatient programs for the poor. Consequently, these providers can generate 340B profits by pocketing the difference between the discounted price that they paid for the drugs and the higher reimbursement paid by insurers and patients."

Key findings include:

- *There has been significant growth in the number of newly registered 340B (disproportionate-share hospital) DSH hospitals and exponential growth in the number of outpatient clinics affiliated with them since 2004.*
- *Generally, DSH hospitals that registered for the 340B program in 2004 or later served communities with fewer low-income people, compared to DSH hospitals that registered before 2004.*
- *Hospitals that registered in the 340B program in 2003 or before had clinics that served significantly poorer communities than their parent institutions, compared to facilities that registered after 2004.*
- *Clinics affiliated with 340B entities that registered for the 340B program in 2004 or later served wealthier communities with higher levels of insurance, compared to clinics that registered before 2004.*

In conclusion the authors write, "Few data are available to systematically assess the impact that the expansion of 340B-qualified hospitals may be having on medical care spending, access, and quality...The pursuit of timely, transparent, and national assessments of whether and how the activities of 340B hospitals and their affiliated clinics are benefiting the populations originally targeted by the Veterans Health Care Act is an important policy goal."

Physician Groups Warn New Open Payments Site Contains Errors, Lack Accuracy



On September 30, the Centers for Medicare and Medicaid Services (CMS) made public its [Open Payments database](#) created under the Affordable Care Act, which contains information on 4.4 million payments valued at almost \$3.5 billion. In a provision known as the “Sunshine Act,” drug and device makers must report financial relationships with physicians and teaching hospitals. Before the information is made public, CMS is required to offer physicians time to review the data submitted by companies so that they may dispute any records believed to be inaccurate.

According to many industry groups, the Open Payments registration process was cumbersome and complicated, making review of the reported information difficult, therefore limited physicians’ ability to dispute the information before going public. Leading physician groups have warned that misinformation will give the public the wrong impression about industry relationships.

"Patients deserve to have access to accurate information, yet publishing inaccurate data leads to misinterpretations, harms reputations and undermines the trust that patients have in their physicians. It can also discourage research and care delivery improvements that benefit patients," the American Medical Association said in a [statement](#).

Of additional concern to the physician community is the fact that CMS has announced it won't update the Open Payments database to reflect the correct information until early next year.

Approximately 40 percent of the data released by CMS was listed in a de-identified format, meaning the public information does not name a specific physician or hospital. According to the agency, these listings were de-identified because the physician or teaching hospital could not review and dispute the record in the allotted time, however the information was released to provide a more complete picture of industry-provider relationships to the public.

Role of RUC in Assigning Medicare Payments Called into Question

A national non-profit organization representing consumer interests including safe and affordable health care called [Public Citizen](#) released a report last week that calls for an overhaul of the system for establishing Medicare physician payments.

In “Inside Job: How an Influential Group of Doctors Exerts Influence Over Medicare Payments to Physicians,” Public Citizen examines the process through which the Relative Value Update Committee (RUC) of the American Medical Association (AMA) helps determine payment rates for physicians delivering care to beneficiaries under Medicare Part B.

The report is highly critical of the RUC, specifically citing the following concerns:

- 1. Absence of Transparency: Despite its public function, the RUC is exempt from regulations that govern government committees. The RUC’s proceedings are conducted behind closed doors and its results and processes are largely hidden from the public.*
- 2. Self-Regulating: The RUC is an industry managed, industry funded committee whose recommendations are largely decisive in determining Medicare payments to physicians. Historically, its recommendations are accepted about 90 percent of the time, though the rate has declined slightly in recent years.*
- 3. Membership Imbalance: The RUC’s composition is overwhelmingly stacked in favor of specialists and against primary care givers.*

Based on these concerns, the report concludes that the RUC’s recommendations contribute to higher Medicare payments to specialists, therefore exacerbating the nation’s shortage of primary care physicians.

The report authors further express concern for the RUC’s influence beyond the Medicare program, writing, “The RUC’s influence over physician payments extends well beyond Medicare payments because private insurers also use the Medicare payment framework as a baseline for determining their payments. Private insurance companies often set their payments based on the underlying Medicare fee schedule.”

To read the full report [CLICK HERE](#).