

Friday, May 24, 2013

Community Oncology Supports the Bipartisan Preserve Community Care Cancer Act

On May 20, community oncology organizations released a [statement](#) in support of bipartisan legislation (S. 806) introduced by Senators Pat Roberts (R-KS) and Debbie Stabenow (D-MI) – and co-sponsored by Senators Robert Casey (D-PA) and Sherrod Brown (D-OH) – to protect cancer patients' access to care in their communities and control costs for seniors and the Medicare program.

The coalition of organizations and clinics agreed that cancer care is being threatened by a payment calculation in Medicare that has made it increasingly difficult for local clinics to absorb the additional cuts imposed by sequestration.

The statement said “Under the current system, prompt pay discounts are negotiated terms between the manufacturer and pharmaceutical distributors for their drug delivery and supply chain management services.

However, the law requires these prompt pay discounts to be included in the drug reimbursement formula even though community cancer clinics don't have access to the same drug discounts. This shortfall has already placed severe financial strain on oncology practices across the country. Since 2008, more than 1,200 community cancer centers have closed, consolidated, or reported financial problems.”

The statement was signed by the ASCO, COA, ION Solutions, The US Oncology Network, BDI Pharma, Inc., Cardinal Health, Inc., Curascript Specialty Distribution, H.D. Smith, HDMA, Health Coalition, Inc., Healthcare Distribution Management Association Intellogics, Lung Cancer Alliance, National Patient Advocate Foundation, Society for Gynecologic Oncology, UPMC Cancer Centers.

Numerous news reports in the past few months have reported an acceleration of local clinics having to close or move patients into the hospital setting since sequestration took effect on April 1.

Community cancer clinics across the country have reported that they either will no longer be able to treat Medicare patients or eventually close, thereby depriving their whole communities of care in their local cancer clinic.

For seniors, the closing of community cancer clinics mean disruptions in care that result in traveling farther, waiting longer, and paying more out of pocket. In 2012, Medicare beneficiaries who contacted the National Patient Advocate Foundation cited transportation costs as the primary factor contributing to medical debt crises.

The Preserve Community Care Cancer Act (S. 806) and House companion (H.R. 800) sponsored by Congressmen Ed Whitfield (R-KY), Gene Green (D-TX), and Congresswoman Diana DeGette (D-CO) would make Medicare reimbursement to community oncology centers consistent with providers' actual costs, stemming higher costs and the tide of seniors losing access to care.

We urge Senators to cosponsor and pass S. 806, the Preserve Community Care Cancer Act, for Medicare patients. To Contact Your Member of Congress [CLICK HERE](#)

NJ Congressmen Seek Member Support Against Cuts to Medicare Part B

U.S. Congressmen Lance (R-N.J.) and Pascrell (D. N.J.) sent a request to fellow Members of the House on May 21 to sign and support a letter to Majority Speaker John Boehner (R-OH) and Minority Leader Nancy Pelosi (D-CA) expressing concerns about any potential cuts to Medicare Part B reimbursement.

The letter specifically asks Congressional leadership to “reject further cuts to Medicare

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Part B reimbursement for drugs and biologics that fight cancer and other serious diseases” citing further access problems for patients if more cuts are implemented to pay for deficit reduction proposals currently under consideration.

In the letter to their colleagues requesting their support, Lance and Pascrell also stressed that the problems have already arrived with the impact that the 2% sequestration cuts have had on patient access to community cancer clinics across the country.

“Over the past several years, financial pressures have resulted in the closure of hundreds of cancer clinics, and hundreds more report that they are struggling to remain open. These closures have resulted in reduced clinical staff, as well as created a systemic access problem for patients in need of affordable care,” the letter said.

CBO Says President's FY 2014 Budget Would Cut Medicare Spending \$364 Billion

According to a May 17 report released by the Congressional Budget Office (CBO) on President Obama's budget proposal for fiscal year 2014, Medicare spending would be cut by \$364 billion over 10 years.

The CBO analysis is similar to the White House's own estimates, which called for \$371 billion in Medicare cuts over 10 years, with the impact affecting mostly providers, such as hospitals, nursing homes, managed care plans, and home health agencies.

Under current law, Medicare's payment rates for physicians' services are slated to drop by 24 percent in January 2014. The White House proposal would develop new payment models to replace the formula in current law. CBO said its estimate cannot encompass the details of any specific new approach

rates since the new models have not yet been identified, so its estimate includes all other Medicare cost reduction proposals except the physician payment fix.

The budget included several provisions to modify payments to health care providers such as hospitals and skilled nursing facilities as well as cost-sharing responsibilities for certain Medicare beneficiaries.

CBO's projections of Medicaid spending are higher than the administration's for the 2014-2023 period. While CBO said the proposals to improve Medicaid drug rebate and payment policies would result in a decrease of \$10.2 billion, the White House said its budget would reduce Medicaid spending by about \$22 billion over 10 years, less than half of the \$56 billion proposed in the FY 2013 plan.

House Votes Again to Repeal Health Law, GOP Attacks IRS Control of Individual Mandate

On May 16, the Republican-led House voted 229-195 to pass the Patients' Rights Repeal Act (H.R. 45), a bill that would fully repeal the Affordable Care Act (ACA).

Republicans in the House have now voted to approve legislation to partially or fully repeal the health care reform law 37 times. Like the other efforts, legislation that would fully repeal the health reform law is unlikely to advance in the Democrat controlled Senate. Congressional Republicans have been highlighting reports of higher health insurance premiums, higher taxes, and reduced delivery of health care that may be linked to the health care reform law.

In a May 16 statement, John Boehner (R-Ohio) applauded the repeal vote. “Fully repealing ObamaCare will help us build a stronger, healthier economy, and will clear the way for patient-centered reforms that lower health care costs and protect jobs,” he said.

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In turn the White House released a statement promising to veto the repeal legislation if it reaches the President's desk stating it "strongly opposes House passage of H.R. 45 because it would cost millions of hard working middle class families the security of affordable health coverage and care they deserve. It would increase the deficit and detract from the work the Congress needs to do to focus on the economy and create jobs."

Republicans also defeated an amendment offered by Congresswoman Lois Capps (D-Calif.) that would have preserved certain ACA benefits by excluding from repeal provisions such as:

- the elimination of cost sharing for preventive health services, including breast cancer screening;
- access to health care coverage for children and adults with pre-existing conditions;
- elimination of lifetime and annual limits on benefits;
- dependent coverage for adult children until age 26.

Instead, Republicans have also introduced bills sponsored by Senator John Cornyn (R-TX) and Congressman Tom Price (R-GA) challenging the Treasury Department's authority through the IRS to enforce the health law, particularly the law's individual mandate.

The new effort to tie opposition to the health law to the IRS stemmed from news reports last week that Sarah Hall Ingram, who directed the IRS unit that deals with tax-exempt organizations at the time when it was targeting tea party groups, is now the director of the IRS office that's implementing the health care law.

The IRS is responsible for collecting data from insurers and the new insurance exchanges to determine who has met the law's coverage requirements. It also has to determine who's eligible for the subsidies that could help an estimated 20 million Americans buy health insurance.

The agency also has to collect the slew of new taxes and fees under the law — including the medical

device tax and the insurance tax, among others. The law includes at least 42 provisions that will either add to or amend the tax code.

Republicans have refused to give the agency any more implementation funding, even though Obama asked for \$440 million additional dollars and nearly 2,000 full-time workers next year to put the law in place. So far, the agency says it has spent about \$488 million to implement the law.

House Democrats expressed skepticism of the latest push to connect the IRS with the health law. "Any issue that comes up they will try to exploit," House Minority Leader Nancy Pelosi told reporters before the vote. "Some of them are legitimate issues, but they should not dominate everything."

Tavener Is First Confirmed CMS Administrator Since 2006, Eyes a Significant Change

On May 15, the U.S. Senate voted 91-7 vote to confirm Marilyn Tavener as administrator of the Centers for Medicare & Medicaid Services - the first Senate-confirmed administrator for the agency since 2006.

As the head of CMS, she is responsible not only for Medicare and Medicaid, but also for implementing the insurance reforms and marketplaces, or exchanges, included in the Affordable Care Act.

Tavener has served for more than a year as acting CMS administrator and received bipartisan praise from lawmakers and provider groups.

Before the vote, Senator Orrin G. Hatch (R-UT), ranking Republican on the Finance Committee, said Tavener would be "one of the best leaders in the government." Senate Finance Committee Chairman Max Baucus (D-MT) described Tavener as "the right person to lead CMS."

Hospital groups such as the American Hospital

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Association and the Federation of American Hospitals released statements in support of Tavenner's confirmation stating her willingness to reduce red tape and work with health care providers.

Debra L. Ness, president of the National Partnership for Women & Families, a patient advocacy group stated, "the nation will be better off" with Tavenner at the helm of CMS.

The seven senators who voted against the nomination were Minority Leader Mitch McConnell (R-Ky.), Mike Crapo (R-Idaho), Ted Cruz (R-Texas), Ron Johnson (R-Wis.), Mike Lee (R-Utah), Rand Paul (R-Ky.), and James E. Risch (R-Idaho).

A former emergency room nurse, Tavenner served for four years as Virginia's secretary of health and human resources prior to assuming her CMS leadership role. Before that, she served two decades as an executive with the Hospital Corporation of America, the nation's biggest for-profit hospital chain.

Tavenner has already outlined her priorities including bringing stability to CMS, preparing the agency to effectively manage enrollment in the health care law exchanges set to begin Oct. 1, outreach and education of the exchanges and Medicaid expansion as well as build good will with members of Congress.

SGR hopes face tough realities | \$139 billion, new payment formula still needed

Legislators on both sides of the aisle in Congress have expressed interest in overhauling the Medicare physician payment system, however, no concrete plan has developed to address the biggest obstacles to scrapping the sustainable growth-rate (SGR) system.

Congress needs to come up with an estimated \$139

billion over the next decade to permanently eliminate the SGR.

The SGR formula, created by the 1997 Balanced Budget Act, links physician fees and costs to the U.S. gross domestic product. It includes a "clawback" mechanism that reduces Medicare fees if overall spending exceeds a formula-driven target.

During last week's Senate Finance Committee meeting, the first SGR hearing in the upper chamber since 2007, the panel sent a request for provider feedback on possible payment changes.

Among the early details that appear to be part of the House legislation is a five-year transition to any new payment system. Congressman Phil Roe (R-TN) said that Republicans agree with many physician advocacy groups against a quick transition to a replacement system because "that's just not enough time to implement something as big as how you pay all of the physicians."

However, while the Democratic-led Senate is focused on short-term changes that gradually wean physicians from the fee-for-service payment model, the House has focused on long-term replacement models.

Broad agreement has emerged on the need for a replacement system that ties much more of future physician payments to the quality of care they deliver. However, House Republicans are unlikely to give additional power to CMS regulators to make the final decisions on physician pay.

The two parties also remain far apart on an appropriate way to cover the cost. Both sides agreed that finding a funding source will wait until late summer or the fall, when Congress is expected to debate raising the debt ceiling.

San Francisco Chronicle
Cancer patients hit by
cuts to Medicare

Newsday
Cancer Patients May Be
Unintended Victims of Budget Cuts

The Salt Lake Tribune
Utah cancer clinics turning
away Medicare patients

The Columbus Dispatch
Cancer clinics feel cuts' pain

Star-Telegram
Medicare cuts would
hurt cancer patients

The Charlotte Observer
Some cancer clinics
rejecting Medicare patients

The Star-Ledger
Cutting Medicare Part B payments
could make cancer treatment
more expensive

Cuts Put America's Cancer Patients At Risk

Due to a series of Medicare cuts, including the sequester, community cancer clinics across the country have been forced to close or consolidate,* forcing thousands of patients to seek care outside of their communities in more expensive hospital settings.

Now the President's budget proposes even deeper cuts to cancer care by reducing Medicare Part B payments for life-sustaining chemotherapy drugs and cancer treatments.

Studies show that when patients' access to community-based care is compromised, the result is higher costs for cancer treatment for Medicare, seniors, and all taxpayers.

Congress and the Administration have a responsibility to support cancer care delivery in America, especially at a time when our cancer care system and the patients it serves are increasingly vulnerable. Cuts to community cancer care must be stopped.

* Community Oncology Practice Impact Report; Community Oncology Alliance, March, 2012

PROTECT CANCER CARE FOR AMERICA'S SENIORS

 #StopCancerCuts

NPAF National Patient
Advocate Foundation
The Patient's Voice | since 1996

 The US Oncology
Network

 ACCC
Association of Community Cancer Centers

APAO ASSOCIATION OF
PHYSICIAN ASSISTANTS
IN ONCOLOGY
partners in cancer care

 COION
CANCER
ALLIANCE

 Bio
Biotechnology
Industry
Organization

 CHDMA
Healthcare Distribution
Management Association

 ION Solutions
AmerisourceBergen Specialty Group

 COA
COMMUNITY ONCOLOGY
ALLIANCE

 LUNG CANCER ALLIANCE