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In this Issue:

The US Oncology Network's Dr. Barry Brooks Pens Op-Ed Highlighting Need for Site-Neutral Medicare Payment Reform

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Prompt Pay Discount Legislation Introduced in U.S. House

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CBO Releases Higher SGR Replacement Cost Estimate

The Congressional Budget Office increased its estimate for replacing Medicare's SGR formula via the bipartisan, bicameral agreement reached in 2014 by \$30.5 billion. [Read below](#)

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The US Oncology Network's Dr. Barry Brooks Pens Op-Ed Highlighting Need for Site-Neutral Medicare Payment Reforms



An op-ed by Dr. Barry Brooks was published February 25 in Roll Call – a widely read Capitol Hill publication – calling for Medicare payment reforms to equalize payments across site of service.

The op-ed highlights the disparities in Medicare payments between community-based care clinics and hospital outpatient departments (HOPD), which data show significantly increase overall Medicare spending and beneficiary costs.

The op-ed also addresses how current Medicare payment policies have resulted in hundreds of community cancer clinic closures in recent years and an increased trend of clinic consolidation with hospital centers, which leads to even higher Medicare spending and limits patient choice.

Dr. Brooks writes, “To advance such reforms in cancer care, Congress should adopt a policy to secure site-neutral payments to keep costs down for seniors fighting cancer, Medicare and taxpayers. Specifically, Congress should create a level playing field in Medicare payments for outpatient cancer-care services. This would preserve patient access to high-quality, cost-effective care in the community setting and help stem the tide of hospital acquisitions of community cancer clinics.”

To read the full op-ed, [CLICK HERE](#).

HHS Unveils New Payment Model for Cancer Care



The U.S. Department of Health and Human Services (HHS) revealed a new multi-payer payment and care delivery model this month called the Oncology Care Model (OCM), which aims to better support effective care coordination for cancer patients.

The new system will include 24-hour access to practitioners for beneficiaries undergoing treatment as well as an emphasis on value – rather than volume – of care. The announcement follows HHS’ decision to link 30 percent of traditional, fee-for-service Medicare payments to quality or value through alternative payment models by the end of 2016.

As part the OCM, medical practices will enter into payment arrangements that include financial and performance accountability for episodes of care surrounding

chemotherapy administration to cancer patients. The five-year program will begin in spring 2016.

According to CMS, “The Oncology Care Model encourages participating practices to improve care and lower costs through episode-based, performance-based payments that financially incentivize high-quality, coordinated care. Participating practices will also receive monthly care management payments for each Medicare fee-for-service beneficiary during an episode to support oncology practice transformation, including the provision of comprehensive, coordinated patient care.”

The OCM, which is part of the agency’s initiative to “better care, smarter spending, healthier people” approach to improving health delivery, will focus on three primary tenets:

- Linking payment to quality of care
- Improving and innovating in care deliver
- Sharing information more broadly to providers, consumers, and others to support better decisions while maintaining privacy

“Based on feedback from the medical, consumer and business communities, we are launching this new model of care to support clinicians’ work with their patients,” said Patrick Conway, M.D., CMS chief medical officer and deputy administrator for innovation and quality. “Improving the way we pay providers and deliver care to patients will result in healthier people.”

Ultimately, the aim of OCM is to “utilize appropriately aligned financial incentives to improve care coordination, appropriateness of care, and access to care for beneficiaries undergoing chemotherapy.” CMS expects the model will “result in better health outcomes, higher quality care, and lower Medicare costs”

Physician group practices and solo practitioners that provide chemotherapy for cancer and are currently enrolled in Medicare may apply to participate in the initiative. They must, however, meet the following criteria:

- Provide the core functions of patient navigation;
- Document a care plan that contains the 13 components in the Institute of Medicine Care Management Plan outlined in the Institute of Medicine report, [“Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis,”](#)
- Provide 24 hours a day, 7 days a week patient access to an appropriate clinician who has real-time access to practice’s medical records;
- Treat patients with therapies consistent with nationally recognized clinical guidelines;
- Use data to drive continuous quality improvement; and
- Use an ONC-certified electronic health record and attest to Stage 2 of meaningful use by the end of the third model performance year.

To be considered, interested medical practices must submit a letter of intent through the Oncology Care Model inbox at OncologyCareModel@cms.hhs.gov by 5:00 p.m., EDT on April 23, 2015. Practices will then receive an online application to be submitted by 5:00 p.m., EDT on June 18, 2015.

For the official CMS factsheet, [CLICK HERE](#).

For frequently asked questions, [CLICK HERE](#).

For OCM application materials and submission deadline, [CLICK HERE](#).

Prompt Pay Discount Legislation Introduced in U.S. House



Congressmen Edward Whitfield (R-Ky.) and Gene Green (D-Texas) have again introduced legislation ([H.R. 696](#)) that amends part B of title XVIII of the Social Security Act to exclude customary prompt pay discounts from manufacturers to wholesalers from the average sales price (ASP) for drugs and biologics under Medicare. The bill was jointly referred to the House Energy and Commerce Committee and the House Ways and Means Committee.

The bipartisan legislation, which is the same bill introduced in previous sessions of Congress and supported by The US Oncology Network, is cosponsored by Representatives John Shimkus (R-Ill.), Diana DeGette (D-Colo.), Ron Kind (D-Wisc.), Pat Tiberi (R-Ohio) and Devin Nunes (R-Calif.).

A companion bill will soon be introduced in the U.S. Senate.

The US Oncology Network urges Congress to improve the viability of community cancer care by more accurately aligning payment amounts with the actual costs for drugs and biologics under Medicare Part B. This bill would help protect patients' access to the nation's community-based cancer centers, which are put at risk financially under the existing payment model.

To download The US Oncology Network issue brief on prompt pay discounts, [CLICK HERE](#).

CMS Approves Medicare Coverage for Lung Cancer Screening

The Centers for Medicare and Medicaid Services (CMS) approved Medicare coverage for lung cancer screening by Low Dose Computed Tomography (LDCT) this month.

The decision marks the first time that the federal insurance program will provide the preventive tests to America's elderly population. The coverage went into effect earlier this month and is available nationwide.

To be eligible for yearly LDCT screenings, beneficiaries fit criteria established by CMS:

- Age 55 – 77 years;
- Asymptomatic (no signs or symptoms of lung cancer);
- Tobacco smoking history of at least 30 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes);
- Current smoker or one who has quit smoking within the last 15 years; and
- Receives a written order from a physician or qualified non-physician practitioner for LDCT lung cancer screening that meets certain criteria

Lung cancer is the third most common cancer diagnosed in the U.S., behind breast and prostate cancers. The National Cancer Institute estimated last year that the number of new lung cancer cases for that year was more than 220,000, with a median age at diagnosis of 70.

“We believe this final decision strikes an appropriate balance between providing access to this important preventive service and ensuring, to the best extent possible, that Medicare beneficiaries receive maximum benefit from a lung cancer screening program,” said Dr. Patrick Conway, chief medical officer and deputy administrator for innovation and quality for CMS.

For the full decision summary, [CLICK HERE](#).

CBO Releases Higher SGR Replacement Cost Estimate

The Congressional Budget Office (CBO) increased its cost estimate for the SGR Repeal and Medicare Provider Payment Modernization Act – legislation to replace Medicare's sustainable growth rate (SGR) formula – by \$30.5 billion. This bill received bipartisan, bicameral support in 2014, however Congress remains divided on how to fund the legislation.

The CBO estimates that the compromise legislation would cost \$174.5 billion from fiscal 2015 to 2025. In November 2014, CBO estimated the bill would cost \$144 billion from fiscal 2015 to 2024.

Medicare payments to physicians will be cut by approximately 21 percent on April 1 if Congress doesn't pass a permanent or temporary “doc fix” by March 31.

To view the new CBO estimate, [CLICK HERE](#).

Lawmakers Debate Preparedness for ICD-10 Transition

In a hearing hosted by the House Energy & Commerce Committee on February 11, lawmakers reviewed the processes and preparedness for implementation of ICD-10, the most recent coding system to be used by healthcare providers for reimbursement and other functions. Full implementation of the updated coding system has been delayed multiple times due to lawmaker and stakeholder concerns, but is now scheduled for October 1, 2015.

The US currently operates under the International Classification of Diseases, 9th Revision (ICD-9) code set, which has approximately 13,000 diagnostic codes. The updated ICD-10 has 68,000 diagnostic codes and 87,000 procedural codes.

The E&C Committee has been working with the Centers for Medicare and Medicaid Services for several months to ensure this deadline is successfully met.

Many lawmakers expressed concern that the nation's failure to implement ICD-10 means that we are lagging behind other developed nations in the area of healthcare technology. The World Health Organization began work on the tenth edition of the International Classification of Diseases (ICD-10) coding system in 1983, and it has been available for adoption by countries for over a decade.

In his [opening statement](#), Chairman Pitts stated, "The United States currently lags behind most of the rest of the world, which already uses the updated ICD-10. ICD-9 is more than thirty years old and does not capture the data needed to track changes in modern medical practice and healthcare delivery.

Witnesses at the hearing represented a broad cross section of stakeholders on the issue including the American Health Information Management Association, Athena Health, America's Health Insurance Plans, 3M Health Information Systems as well as several physician witnesses.

Overall there was broad support for proceeding with implementation as scheduled on October 15, 2015. All but one of the witnesses warned against further delay and testified that the healthcare system is prepared and should move forward as planned to ICD-10 for the benefit of providers, payers, and ultimately, patients.

William Jefferson Terry Sr., M.D., testifying on behalf of the American Urological Association was the only witness to express objection to the planned transition. In his testimony he stated, "Simply put, physicians are not prepared for this change... Physicians are growing exhausted; ICD-10 is just another expensive distraction with little demonstrated value to improving direct patient care."

To watch the hearing and download witness testimony, [CLICK HERE](#).

To download the hearing transcript, [CLICK HERE](#).