The US Oncology Network
Health Policy Report

Friday, October 28, 2011

McKesson Specialty Health | The US Oncology Network Webinar Showcases Value of Community Cancer Care, Need to Reject Proposed $3 Billion Cut to Cancer Drugs

On Thursday, October 27, McKesson Specialty Care Solutions | The US Oncology Network hosted a webinar attended by Capitol Hill staffers, media and members of the cancer care community. The webinar described the results and implications of a new study performed by Milliman finding that per-patient-per-month (PPPM) chemotherapy service costs and patient copay amounts for Medicare beneficiaries are significantly lower in community-based care settings.

The study showcases the cost and utilization differences for Medicare patients receiving their chemotherapy in physician offices versus other settings. Data indicate that total PPPM allowed costs for physician office care were approximately $600 per patient per month less. Taking into account the average number of member months that chemotherapy patients experience in a year, this amounts to a difference in cost of just under $6,500 per cancer patient annually. In addition, patient copay amounts were found to be approximately 10 percent lower for physician office-based care, which totals more than $650 per patient per year.

Following a brief presentation of the study findings from Milliman Principal and Consulting Actuary Bruce Pyenson, F.S.A., M.A.A.A., Roy Beveridge, M.D., Chief Medical Officer of The US Oncology Network; Ted Okon, Executive Director of the Community Oncology Alliance; and Nancy Davenport-Ennis, Founder and Chief Executive Officer of National Patient Advocate Foundation and Patient Advocate Foundation explained the importance of the value of community-based care as it relates to the proposed $3 billion Medicare reimbursement cut to cancer care offered to the Joint Select Committee on Deficit Reduction (Select Committee) as a potential payment offset within federal debt reduction efforts.

To read the press release regarding the webinar click here.

To read the study click here.

New Editorial from National Patient Advocate Foundation Founder and CEO: "Let's Not Shift the War on Cancer to Cancer Care"

An October 26 editorial in TheHill.com by National Patient Advocate Foundation (NPAF) and Patient Advocate Foundation (PAF) Founder and CEO Nancy Davenport-Ennis urges the Joint Select Committee on Deficit Reduction to maintain access to cancer care in the local oncologist office and reject the proposed $3 billion cut in reimbursement to doctors who care for Medicare beneficiaries.

The editorial states:

While at first glance the proposal appears to be a straight $3 billion cut in reimbursement to doctors, ultimately the cut will impact patients' access to care.

Without adequate reimbursement, providers will close their doors forcing patients to either forego treatment or be relocated to inpatient facilities, many outside their communities or region. Eighty four percent of cancer patients receive their care in community clinics – many of which are already closing.

A closed office means everyone in the community loses access to the care once provided by those nurses and physicians. According to the Community Oncology Alliance, approximately 200 community-based cancer clinics have closed in the past three years, and 389 more are struggling to survive through mergers with local hospitals. These mergers often reduce capacity to serve the overall population in the community who are facing cancer.

These projections are not merely words on the page, but have real life consequences that impact patient care…

Davenport-Ennis is a two-time breast cancer survivor; her organizations have helped eliminate barriers to care for over 600,000 patients with cancer and other chronic, debilitating diseases.

To read the editorial click here.

The US Oncology Network
Health Policy Report

Friday, October 28, 2011

American Action Forum Report on Medicare Part B Reimbursement: "Why Change a Market-Driven System that Works Well at Controlling Costs?"

American Action Forum President Douglas Holtz-Eakin and healthcare staff assistant Han Zhong released a report on October 26 noting that the current average sales price (ASP) + 6 percent reimbursement for Medicare Part B drugs is working, that proposed changes to ASP do not cover physician costs, and that changes will restrict access to cancer patients.

As the report notes, "The Joint Select Committee on Deficit Reduction must focus on mandatory spending programs to be successful. Unfortunately, proposals to alter Medicare Part B drug reimbursement place a successful program and the patients it supports at risk and thus are not sound and sustainable reform policies that support overall debt reduction."

Regarding the cut's impact on patient care, it states, "While perhaps attractive from a narrow budgetary perspective, such a change would threaten Medicare beneficiaries' access to care. Cutting payments to physicians in a program that works as intended will only create greater accessibility issues and lower quality of care."

Dr. Holtz-Eakin previously was Director of the non-partisan Congressional Budget Office (CBO) and Chief Economist of the President's Council of Economic Advisers under President George W. Bush. He serves on the Boards of the Tax Foundation, National Economists Club and Committee for a Responsible Federal Budget, and the Research Advisory Board of the Center for Economic Development.

To read the report click here.

Senate Special Committee on Aging Told Provider Cuts Will Only Improve Medicare Finances in the Short Term

According to researchers and budget experts testifying before the Senate Special Committee on Aging this month, provider reimbursement cuts could improve Medicare's finances in the near term, but a longer-term approach to strategic reform will be needed in order to prepare the program to cover retiring baby boomers in the coming years. Witnesses included Joseph Antos, American Enterprise Institute scholar; John Holahan, director of the health policy research center at the Urban Institute; Maya MacGuineas, president of the bipartisan Committee for a Responsible Federal Budget; and Douglas Holtz-Eakin, former director of the Congressional Budget Office (CBO). They said that while provider cuts could save a significant amount over the next 10 years, cuts would not improve the underlying spending crisis afflicting Medicare. To address these issues, they suggested delivery system reform, changes in beneficiary cost sharing and a permanent fix to Medicare's flawed sustainable growth rate (SGR) physician payment formula.

The witnesses were asked to submit a list of Medicare reforms that could garner bipartisan support, which will be provided to the Joint Select Committee on Deficit Reduction.

Senate Aging Committee Chairman Sen. Kohl Sends Letter to Select Committee Recommending Changes to Medicare Part B Payments

On October 12, Aging Committee Chairman Herb Kohl (D-WI) sent a letter to the Joint Select Committee on Deficit Reduction outlining 11 recommended changes to health care spending that he said could save more than $140 billion over the next decade.

Three of these recommendations are related to Medicare Part B and are as stated as follows in the letter:

- Require drug manufacturers to pay rebates for Medicare Part B drugs;
- Allow Medicare to negotiate drug prices in Medicare Part B when it is the majority purchaser; and
- Reduce incentives for doctors to prescribe high cost drugs over safe, effective and cheaper generic drugs.

This last recommendation would require a study on doctors' Part B reimbursements in order to "create a more equitable payment structure for the drugs and eliminate the disincentive to prescribe lower-cost, equally efficacious drugs." *(Continued on page 3)*

The US Oncology Network
Health Policy Report

Friday, October 28, 2011

Senate Aging Committee Chairman Sen. Kohl Sends Letter to Select Committee Recommending Changes to Medicare Part B Payments *(Cont'd)*

The Pharmaceutical Research and Manufacturers of America (PhRMA) quickly rejected these recommendations, saying "We believe these policy proposals are bad for patients, bad for the economy and would slow innovation of new medicines."

In his letter, Sen. Kohl asked the committee to have the Congressional Budget Office (CBO) score the proposals to quantify the savings for consumers and taxpayers.

Another Short-Term SGR Fix Looking Likely

At this time it remains unclear whether a fix to the sustainable growth rate (SGR) formula will be addressed by the Joint Select Committee on Deficit Reduction (Select Committee) or by Congress as a separate legislative measure. According to recent reports citing Congressional sources, however, a one or two-year fix seems to be emerging as the most likely scenario.

The notion of the Select Committee using Medicare savings to pay for an SGR fix has received considerable support from lawmakers and advocates in recent weeks:

On October 20, House Ways & Means and Energy & Commerce Democrats sent letters to the Select Committee recommending that any Medicare savings be used to fix the SGR. The letter does not specifically suggest the committee include the cost of repealing the SGR as part of its deficit reduction plan.

On October 6, 113 House lawmakers, including 21 House Republicans, signed a letter led by Rep. Allyson Schwartz (D-PA) urging the Select Committee to permanently replace the SGR now, before the estimated $300 billion cost of repeal soars to $600 billion over the next five years.

On October 20, a group of leading health care stakeholders, including the American Medical Association, AARP, American Academy of Family Physicians, American College of Physicians, Medicare Rights Center and Center for Medicare Advocacy, sent a letter to the chairs and ranking members of the House and Senate committees of jurisdiction urging them to permanently fix the SGR, saying that any savings generated from Medicare should be returned to Medicare.

Meanwhile, following its October 6 vote to approve its draft SGR fix recommendations, the Medicare Payment Advisory Commission (MedPAC) sent a letter to the chairmen and ranking members of the House committees on Ways & Means and Energy & Commerce and the Senate Committee on Finance encouraging them to act quickly to repeal the SGR, noting that it would face a more expensive endeavor and additional payment instability in the future without doing so.

A permanent SGR fix continues to face considerable challenges because the larger targeted savings within Medicare and Medicaid remain under major debate, with Democrats largely opposed to beneficiary cuts such as an eligibility age increase and Republicans resisting savings through areas such as prescription drug spending.

Unless some action is taken, physicians are set to receive a 30 percent payment cut under the SGR effective January 1, 2012. According to recent estimates, this action will cost between $20 billion and $25 billion over 10 years.

CMS Releases Final Rule on Accountable Care Organizations

CMS Keeps Primary Care Focus While Attempting to Expand Eligibility

On October 20, 2011, the Center for Medicare and Medicaid Services (CMS) released the final rule that will begin to establish accountable care organizations (ACOs) as called for by the Affordable Care Act. After receiving widespread criticism about the proposed ACO rule, this final rule drops dozens of proposed requirements and increases eligibility for some in an attempt to expand uptake of ACOs.

CMS stated they did not see the need to design distinct cancer specific or end stage renal disease (ESRD) ACOs, stating that such entities are not prohibited from participating in the program so long as they join as an ACO participant in an ACO containing one or more of the organizations that are eligible to form an ACO (hospitals and/or primary care physicians). The final ACO rule calls for the following:

- **Beneficiary assignment –** the proposed rule required retrospective assignment based on the use of primary care services and the final rule is in reality still retrospective assignment *(Continued on page 4)*

CMS Releases Final Rule on Accountable Care Organizations *(Cont'd)*

  - While the final rule calls the assignment "preliminary prospective" it is a hybrid assignment process that provides ACO professionals with information upfront and periodically about the beneficiaries for whose care the ACO will likely be responsible, but is, in actually, a retrospective assignment process
  - This process will capture any cancer patient who sees a primary care physician during the year and then receives the plurality of their primary care services from a primary care physician who is participating in an ACO
  - Cancer patients who see a primary care physician during the year but receive the plurality of their primary care services from an oncologist will not be ACO eligible
    - Cancer patients who receive all of their primary care services through their oncologist will only be eligible for assignment to an ACO if their oncologist has elected to participate in an ACO that offers primary care services through primary care physicians, Federally Qualified Health Centers, or Rural Health Clinics
  - Given these restrictions, it is certainly possible that cancer patients could be under-represented in ACOs
- **ACO savings benchmarks** will be established using the most recent available 3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO
- **Two available risk models**
  - one-sided risk model – shared savings only for the entire three years of the agreement with no losses in the third year as in the proposed rule
  - two-sided risk model – sharing savings and losses for all three years while receiving a higher share of the savings (60% vs. 50% while many believe these percentages need to be increased) than the one-sided model
- **Performance payment limit** – the cap on potential savings recoupment is 10% (formerly 7.5%) of an ACO's benchmark under the one-sided model and 15% (formerly 10%) under the two-sided model
- **First dollar savings** – stipulates that ACOs in both one- and two-sided risk models may share from first dollar savings once the minimum savings rated (2%) has been achieved.
- **Outlier exclusion** – truncates claims at the 99th percentile limiting catastrophic costs and continuing to hold ACOs accountable for those costs that are likely to be within their control according to CMS
- **Quality measures** – instead of the initial 65 measures in 5 domains, CMS reduced the number to 33 measures in 4 domains
- **Health IT** – modifies the proposed rule such that electronic health record participation is no longer a condition of participation but remains one of the quality measures
- **Advance payment ACO model –** allows two types of ACOs to receive advanced payments for future savings in an attempt to boost participation by (1) physician-owned ACOs that include primary care physicians to capture beneficiary assignments but that do not include any inpatients facilities and (2) ACOs in which the only inpatient facilities are Critical Access Hospitals and/or Medicare low-volume rural hospital. In both instances, participation is further restricted by limits on the total annual revenues of eligible entities
- **Rolling application period** – the first round of applications due early in 2012 and the first agreements beginning in April & July of that year
- **Performance payment Withhold** – eliminates the 25% performance payment withhold from the proposed rule, which was meant to ensure an ACO could pay back any potential losses in the future

To read the final ACO rule click here
To read HHS Fact Sheets on the ACO rule click here
To read the HHS press release on the ACO rule click here

CDC to Launch Initiative to Lower Rate of Infection in Oncology Clinics

As reported by *The Wall Street Journal*, on October 25, the Centers for Disease Control and Prevention (CDC) announced a new campaign to lower the rate of infection among cancer patients receiving chemotherapy and radiation in outpatient oncology clinics. According to the CDC, over the past decade more than 125,000 outpatient clinic patients have had to be notified of possible exposure to disease from unsafe injection practices. Outpatient oncology clinics are estimated to treat more than one million cancer patients annually.

The voluntary campaign will encourage close adherence to hand-hygiene guidelines, sterile practices for preparing and administering medications, and safe-injection principals. In addition, a new patient website will help patients learn more and avoid infection.