US Oncology
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CMS Acknowledges Criticism of ACOs; Announces Three Initiatives to Encourage Participation

On Tuesday, May 17, almost two months after issuing its widely criticized proposed rule for accountable care organizations (ACO) within the Medicare Shared Savings Program (MSSP), Centers for Medicare and Medicaid Services (CMS) Administrator Donald Berwick announced three initiatives for the Center for Medicare and Medicaid Innovation (Innovation Center) that aim to provide more options and incentives for providers to form ACOs.

First, the CMMI will support the Pioneer ACO model, which is predicted to save Medicare up to $430 million over three years. This model is designed to provide organizations that have already started coordinating care for patients to begin participating in shared savings. Applicants hoping to participate in the Pioneer ACO model must submit a nonbinding letter of intent by June 10. According to CMS Administrator Donald Berwick, the Pioneer model is designed to better align provider incentives in order to improve quality and health outcomes for patients and achieve cost savings.

Secondly, CMS announced that the Innovation Center will be accepting public comments on an advance payment initiative, which would allow certain ACO participants to access a portion of their savings in advance. The upfront money would be intended to help providers with necessary staffing and infrastructure investments during the transition to an ACO.

Finally, the agency announced that it will begin to host free "accelerated development learning sessions" for providers interested in learning more about necessary steps towards becoming part of an ACO. There will be four sessions in 2011 focused on improving care delivery to improve quality and reduce costs; using health information technology and data resources; and managing financial risks.

In response to CMS's announcement, many provider organizations have already expressed concerns that the new initiatives will make the process of becoming part of an ACO even more burdensome, creating additional stipulations, guidelines and deadlines.

On Tuesday, May 24, Republican Sens. Tom Coburn (OK), Mike Crapo (ID), John Cornyn (TX), Jon Kyl (AZ), Mike Enzi (WY), Pat Roberts (KS) and Richard Burr (NC) sent a joint letter to Department of Health and Human Services Secretary Kathleen Sebelius and Administrator Berwick to express concerns they have regarding the proposed rule on ACOs. While they commended the Administration for its commitment to "rewarding high quality, efficient providers based on positive patient outcomes," they expressed specific concerns about the fact that many of the leading innovative integrated health care providers feel that within the regulation, "incentives and accountability are misaligned," "detailed requirements are complex," and "return on investment is uncertain." Within the letter, the Senators request that the Administration "withdraw this proposed rule and re-engage experienced stakeholders to craft a new rule that fulfills the promise of ACOs."

The Senators' letter comes on the heels of a joint letter submitted last week to Administrator Berwick from the ten multi-specialty groups taking part in CMS's Physician Group Practice (PGP) Demonstration. The group raised serious concerns over "the economics and complexity" of the shared savings model introduced in the CMS proposed rule and stated that they will be unable to participate in the ACO program unless a variety of issues are addressed, including implementation costs, quality metric expansion and potential beneficiary and physician confusion.

Government Officially Reaches Debt Limit; Congress Continues Debate Over FY 2012 Budget

On Monday, May 16, the Treasury secretary, Timothy F. Geithner, officially informed Congress that the government had reached its $14.3 trillion debt limit and had begun taking "extraordinary measures" to meet the country's existing financial obligations while the Administration and Congress continue discussions on how to raise the debt limit. In a letter to Congressional leaders, Sec. Geithner stated that on August 2, "the borrowing authority of the United States will be exhausted."

On Thursday, May 26, the Senate is scheduled to vote on the House-passed budget for 2012, allowing Democrats an opportunity to oppose the budget's Medicare cuts on the record.

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Government Officially Reaches Debt Limit; Congress Continues Debate Over FY 2012 Budget (Cont'd)

Specifically, the House budget would convert the federal health care system for older and disabled Americans into a voucher-like program. Beginning in 2022, new Medicare beneficiaries would choose a private health plan, and the U.S. government would subsidize the cost.

Senate Republican Leader Mitch McConnell (Ky.) made it clear that he will vote for the House budget resolution, but is not putting pressure on his Republican colleagues to do the same. McConnell has said that the House of Representatives has offered a "budget to address our most pressing problems head-on at a moment when the president and other Democrat leaders simply refuse to do so themselves."

While the Senate is unlikely to pass the budget, it is still unclear whether or not the Senate will produce its own budget resolution. On Tuesday, May 17, Senator Tom Coburn (R-Okla.) announced that he was pulling out of the bipartisan "Gang of Six" talks, leading to speculation over whether or not Senate Budget Committee Chairman Kent Conrad (D-ND) would in fact produce a fiscal 2012 budget resolution.

New York Times Reporter Walt Bogdanich discusses "Radiation Boom" series on NPR

On Monday, May 16, *New York Times* reporter Walt Bogdanich was a guest on NPR's Fresh Air, hosted by Terry Gross, to discuss his recent "Radiation Boom" series that highlights instances of over-radiation in both medical imaging and radiation therapy. Bogdanich began his series two years ago after receiving a tip from a source at a major New York City hospital that premature babies were receiving much higher radiation doses than what is typically recommended during certain procedures. This tip prompted Bogdanich to begin investigating instances of over-radiation in both diagnostic imaging and radiation therapy and pushing for greater oversight and regulation in both of these areas of practice.

Within his comments specific to radiation therapy, Bogdanich started by mentioning the importance of radiation therapy in cancer care. He stated that advanced radiation therapy technologies have given oncologists "the ability to treat cancer and to kill cancer cells without having to cut it out, and to do so with incredible precision and accuracy in fewer treatments," but that in order to ensure patient safety, there is a need for greater regulation in terms of safety procedures, medical error reporting and licensing standards for certain radiologic personnel. He referenced the Consistency, Accuracy, Responsibility and Excellence (CARE) in Medical Imaging and Radiation Therapy Act, expected to be introduced in the next few weeks introduced in the next few weeks, as a positive policy solution that would set national minimum educational and licensing standards for key medical personnel involved in administering radiation.

Click HERE for a full transcript of Walt Bogdanich's NPR interview, or HERE to listen to the full interview.

Click HERE for information on the CARE Act.

Ways and Means Committee continues ongoing discussions on "doc fix"

On Thursday, May 12, the Ways and Means health subcommittee held a hearing to discuss the ongoing effort to find a replacement for the Medicare physician payment formula to prevent Medicare reimbursement cuts of 29.4 percent scheduled for Jan. 1, 2012. This hearing followed a similar Energy and Commerce hearing held a week earlier.

The subcommittee heard from representatives of health care organizations in three states that suggested innovative and successful approaches to paying physicians. Policies discussed included gainsharing, balance billing, tort reform and various forms of capitation payment models. The panelists all agreed that Medicare should move away from fee-for-service and encouraged clinical integration. Subcommittee Chairman Wally Herger (R-Ca.) was also in agreement that the payment system should be transitioned from a fee-for-service system to one in which "incentives are aligned with better patient care."

"It is my hope, that by starting early, we will arrive at a payment system overhaul that can pass the House," said Herger. He added that the hearing will be the first of a series of hearings that the subcommittee will hold on Medicare physician payment reform.

MSCS | US Oncology Submits Comments to CMS Regarding Medicare Billing Code for Prostate Cancer Drug

On May 17, McKesson Specialty Care Solutions | US Oncology submitted comments to the Centers for Medicare and Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS) Workgroup concerning the billing code for prostate cancer drug, PROVENGE®. In the comments, it was recommended that the Workgroup create a permanent J-code for PROVENGE®, effective 1/1/12. Currently, PROVENGE® is billed with a temporary C-code which will be replaced with a Q-code starting July 1, 2011.

McKesson believes that the current billing code is problematic because (1) The FDA has classified Provenge as a drug/biological; therefore, it should be assigned a J-code, similar to all other drugs/biological; (2) Some non-Medicare payers do not recognize or accept Q-codes; therefore, the coding assignment could result in unnecessary confusion and paperwork for hospitals; (3) the descriptor for the Q-code has proven to be confusing to providers and contractors who have had difficulty entering the description and dosage into billing and claims processing systems. Dendreon, the manufacturer of Provenge ® is also urging CMS HCPCS Workgroup to create a permanent J-code. The company agrees that establishing a permanent code as soon as possible will decrease provider confusion and help ensure patient access to the prostate cancer drug.

Within the comments to CMS, we encouraged the HCPCS Workgroup to reach out to our excessive network of physicians to discuss the likely operational issues and challenges if the Q-code is made permanent rather than using a J-code.