US Oncology
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Health Policy REPORT

Wednesday, July 6, 2011

Debt Ceiling Agreement Remains Uncertain as August Deadline Approaches

On Tuesday, President Obama announced that he would hold a summit this week with Republican and Democratic congressional leaders in order to reach agreement on a debt limit deal before the approaching August 2 deadline.

The meeting, to be held tomorrow (July 7), is intended to help develop a plan on reducing the federal deficit and raising the nation's debt ceiling by July 22 – thereby giving bipartisan negotiators enough time to draft legislation that could be voted on and approved by the deadline the Treasury Department has set for avoiding a government default.

The summit comes after a recent breakdown in negotiations: Following seven weeks of productive talks in which bipartisan negotiators had tentatively agreed to more than $1 trillion in savings, Republican lawmakers pulled out of discussions on June 23, calling on President Obama to meet with senior party leaders to resolve an ongoing stalemate over taxes. Democratic negotiators had called for as much as $400 billion in new taxes on corporations and top-earning households, while senior Republicans characterized such a move as a deal-breaker for reaching agreement on a plan.

According to reports this week, administration officials are willing to cut tens of billions from Medicare and Medicaid – primarily through cuts in Medicare payments to hospitals, nursing homes and other health care providers. The depth of these cuts, however, will depend upon whether Republicans are willing to accept any increases in taxes.

The White House wants to include a multiple-year Sustainable Growth Rate (SGR) formula fix within the debt limit package as the American Medical Association (AMA) continues to push for a permanent fix. Republicans want to include the fix within another legislative package that would fully account for and offset the cost of the fix but they want to attach it to measures that are very unlikely to pass in the Democratically-controlled Senate (i.e. repealing health reform's individual coverage mandate).

If an SGR fix is left out of the debt limit deal and the politically palatable payfors are used within the budget package it will become more difficult to find remaining payment offsets to delay the nearly 30 percent cut to physicians in 2012.

According to recent estimates a one-year fix would cost around $20 billion and a permanent fix would cost nearly $300 billion. If Congress continues to follow the past practice of employing budgetary tactics to push cuts into the future the cost will exceed $500 billion in just a few years.

The importance of reaching a deficit-reduction deal was highlighted by a Congressional Budget Office (CBO) report issued last month forecasting U.S. public debt to reach up to 190 percent of the nation's Gross Domestic Product (GDP) by 2035.

In a blog commentary on the report, CBO Director Doug Elmendorf said that deficits are expected to drop in the coming years due to economic growth, but that the aging baby-boomer population and rising health care costs would then lead to a "daunting" situation.

CMS Releases Proposed Rule for 2012 Medicare Physician Fee Schedule

On July 1, 2011, the Centers for Medicare and Medicaid Services (CMS) posted the Proposed Rule for the **2012 Medicare Physician Fee Schedule (MC-PFS).** The official notice will be reflected in the Federal Register and will be open for comment until August 30, 2011. It is important to realize that unless congressional action takes place physician payments for services to Medicare patients are scheduled to decrease by approximately 29.5% in 2012.

Key changes being proposed include:

- A Conversion Factor (CF) of $23.9635 (current CF is $33.9764)
- Implementing the third year of a four year transition to new Practice Expense (PE) RVUs which began in 2010

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CMS Releases Proposed Rule for 2012 Medicare Physician Fee Schedule *(Cont'd)*

- Expanding the 50% Multiple Procedure Payment Reduction (MPPR) for advance diagnostic imaging to include the professional component (interpretation services).
- Revisions to the PE Geographic Practice Cost Indices (GPCIs) for each Medicare locality to reflect changes in practice expenses such as rent and labor outlined in the American Community Survey, and employee compensation data from the Bureau of Labor Statistics
- Reimbursing for certain Part B drugs using the substitution methodology of AMP+3% when drug pricing is found to be less than ASP by 5% or greater

On a positive note, other proposed features include:

- Continuing the PQRS program with a 0.5% payment bonus for successful participation in 2012, and adding proposed new Quality Measures (QMs) to the program
- Consolidating the PQRS Group Reporting options (currently two) by simply defining a Group Practice as 25 or more Eligible Providers (EPs)
- Continuing the E-Rx program with a 1.0% payment bonus for successful participation in 2012 for EPs that are not participating in the Medicare EHR incentive program and certifying meaningful use
- Establishing a pilot program to ease administrative burden in reporting meaningful use for the EHR incentive program by allowing Clinical Quality Measures (CQMs) and PQRS measures to be reported directly by the EHR
- Expanding Tele-Health by adding codes for additional services such as smoking cessation counseling

CMS is proposing to criteria for adding a new **"value modifier"** as mandated in the health care reform law and to recognize value-based payment. This is the development phase leading to implementation between 2015 and 2017.

CMS estimates that excluding the 29.5% reduction of the CF, payments for services in medical oncology, rheumatology, gastroenterology and dermatology would not decrease, radiation oncology services would decrease 4% and diagnostic imaging services would decrease 4%.

CMS estimates specific cuts to the radiation oncology services in freestanding community based cancer facilities in 2012 will include the following:

- 6.5% cut to intensity modulated radiation therapy (IMRT)
- 2.5% cut to 3-Dimensional Conformal Radiation Therapy (3D-CRT)
- 5.78% cut of stereotactic radiosurgery (SRS)
- 4.5% cut to stereotactic body radiation therapy (SBRT)

As part of its effort to continue to identify, review and adjust "potentially misvalued codes" in the proposed rule, CMS has requested that the AMA Specialty Society Relative Value Scale Update Committee (RUC) review the following radiation oncology codes:

- 77421 (Stereoscopic X-Ray Guidance)
- 77301 (Radiotherapy Dose Plan, IMRT)
- 77014 (Ct Scan for Therapy Guide)

McKesson Specialty Care Solutions | US Oncology will submit comments on the 2012 Medicare Physician Fee Schedule proposed rule by the end of August 2011. The final rule is expected on November 1, 2011, and will become effective January 1, 2012.

Proposed $400 Million Medical Imaging Cuts Removed From Senate Trade Bill

Under the leadership of Senator John Kerry (D-MA), $400 million in proposed cuts to Medicare payments for advanced diagnostic imaging services (MRI, CT) were removed as an offset in the free trade agreement under consideration by the Senate Finance Committee. Current law assumes that advanced diagnostic imaging equipment is in use 75 percent of the work week, and payments are priced accordingly. This proposal would have reduced Medicare payments by increasing this assumption to 80 percent in 2012 and 90 percent in 2013.

McKesson Specialty Care Solutions | US Oncology worked successfully with physician groups and industry stakeholders as part of the Access to Medical Imaging Coalition (AMIC) to fight back against these cuts to advanced diagnostic imaging services. *(Continued on page 3)*

Proposed $400 Million Medical Imaging Cuts Removed From Senate Trade Bill *(Cont'd)*

Click here to read the AMIC letter sent to the Senate Finance Committee Chairman.

Click here to read talking points used to argue against these cuts.

CMS to Cover Avastin & Provenge, Despite FDA Advisory Panel Decision on Avastin Approval

On June 30, the Centers for Medicare and Medicaid Services (CMS) announced a positive national coverage decision (NCD) on Provenge for the treatment of advanced prostate cancer. This was expected following the CMS Medicare Evidence Development & Coverage Advisory Committee (MEDCAC) draft guidance released in March.

On the same day, a spokesman for CMS said the agency would continue to pay for Avastin for breast cancer treatment even if the Food and Drug Administration (FDA) revokes the drug's approval.

On June 29, an advisory committee of the FDA voted 6-0 that approval of the drug as a breast cancer treatment should be withdrawn. The panel said two key studies on Avastin show it is not effective as a breast cancer treatment and concluded that the risks of the drug outweighed its benefits.

A final decision on Avastin will be made by Commissioner Margaret Hamburg, but the FDA usually follows the advice of its committees. Avastin is still approved as a treatment for other cancers and that status isn't affected by the committee's vote.

The CMS spokesman said that while there were no plans for a NCD on this issue right now, he could not rule out that Medicare might one day undertake a NCD to decide whether to pay for Avastin for breast cancer. This process would take at least a year and would involve extensive stakeholder and public input.

FDA Calls for Restricted Use of Erythropoietin-Stimulating Agents

On June 24, the Food and Drug Administration (FDA) stated that the risks associated with Epogen, Aranesp and Procrit, used to treat anemia in cancer and kidney patients, are high enough that doctors should consider avoiding the medicines altogether in some patients and using lower doses in others.

Due to growing evidence that erythropoietin-stimulating agents may lead to deadly heart attacks and strokes and speed the growth of cancerous tumors, the agency said the treatments should only be used in patients suffering from severe anemia.

Critics have called for a reduction in the use of the treatments due to their reported risks as well as their costs to the Medicare program. Moving forward, the medicines will contain new warning labels for physicians, and this action may also lead to a change in the way Medicare pays for the drugs.