Proposed Cuts to Radiation Oncology, Need for Increased Transparency Gain Increased Attention

Roll Call: There Is Bipartisan Opposition to CMS Proposed Cuts to Radiation Therapy

On October 8, an op-ed penned by Vantage Oncology's Chris Rose, M.D., was published in Roll Call, warning that CMS' proposal to remove the vault as a direct expense would negatively impact patients and taxpayers, writing, "In addition to risking patient access to care, the CMS' proposed change is financially imprudent. Medicare pays significantly more to hospitals than freestanding facilities for radiation therapy services and the proposed rule will exacerbate that differential by cutting payments to freestanding facilities while giving a boost to hospital-based doctors. Such a change wouldn't save the taxpayer money. Instead, it would lead to more Medicare spending as hospitals would begin to treat more patients and freestanding settings would treat fewer."

Dr. Rose further commends the bipartisan groups of lawmakers in both chambers of Congress who expressed concern to CMS that the proposed cuts would be harmful to patients by undermining the delivery of cancer care for all Americans.

In closing, Dr. Rose writes, "Hopefully, [CMS] will consider the facts, reconsider its proposed action and recognize radiation treatment vaults are a direct practice expense."

Inside Health Policy: Bipartisan Groups Of Lawmakers Ask CMS To Adopt Doc-Pay Transparency This Year

On October 23, Inside Health Policy published an article highlighting the bipartisan support in both the House and Senate for accelerating CMS' proposal to allow providers time to comment on proposed payment changes before they take effect.

The article reads, in part, "At the urging of providers, large bipartisan groups of lawmakers asked CMS to use a transparent rate-setting process, and CMS officials this year said they will start including new and revised pay rates in annual proposed rules, starting with the 2016 pay cycle, to give providers an opportunity to weigh in on pay rates before they are included in the final rule... While the proposed rule for 2015 pay rates says the new process will start with the 2016 pay cycle, radiation oncologists want CMS to bump up the start date to the 2015 cycle."

The Hill: Prostate cancer patients fight for a say

In an op-ed published October 7 in The Hill, Jamie Bearse, President and CEO of ZERO - The End of Prostate Cancer, raises concerns related to sweeping changes in how certain cancer treatments in doctors' offices will be classified and paid for beginning January 2015, expected out of CMS on early November, for which the prostate cancer community has had no opportunity to comment.

Bearse writes, "Patients should be afforded the opportunity to comment on dramatic changes such as these; CMS recognizes the current system is broken and has proposed greater transparency in its rulemaking process. Unfortunately, this
Aunt Minnie: Payment parity in radiation therapy best serves cancer patients

In an October 17 op-ed published in Aunt Minnie, 21st Century Oncology senior vice president Dr. Paul Wallner disputes a recent report, which asserts that radiation oncology services provided in the freestanding setting cost more to the Medicare program than services provided in the hospital. He clarifies that the data used in the report is outdated and relies on patient information collected from 2004 to 2009. Since that time, freestanding radiation oncology centers have experienced significant declines in Medicare reimbursement.

He goes on to address the importance of stability in Medicare payments for freestanding radiation oncology services and cautions against the proposed cuts of 4 percent to radiation oncology and 8 percent to freestanding radiation therapy centers in the 2015 Proposed Physician Fee Schedule Rule. He instead recommends payment reforms to ensure payment parity across settings, which he writes will protect patient choice and access.

Dr. Wallner writes, "Volatility in Medicare payments is not appropriate in any setting, and a site-of-service differential in payments isn’t right when the direct costs for providing patient care are similar in both settings. The radiation oncology community would be best served by a new payment system that ensures stability in payments under a fee schedule that pays the same rate regardless of point of service."

JAMA Study Finds Spending on Hospital Care Higher than Physician Office Care


The goal of the study, which examined commercial HMO costs in California between 2009 and 2012, was to determine whether total expenditures per patient were higher in physician organizations owned by local hospitals or multihospital systems compared to groups owned by physicians. The authors studied 158 organizations:

- 118 physician organizations (75%) were physician-owned
- 19 organizations (12%) were owned by local hospitals
- 21 organizations (13%) were owned by multihospital

According to the report, in 2012, physician-owned physician organizations had mean expenditures of $3,066 per patient, hospital-owned physician organizations had mean expenditures of $4,312 per patient, and physician organizations owned by a multihospital system had mean expenditures of $4,776 per patient.

In conclusion, the authors write, "Although organizational consolidation may increase some forms of care coordination, it may be associated with higher total expenditures."
AMA Report Finds U.S. Commercial Health Insurance Markets Highly Concentrated

The American Medical Association (AMA) has published the 2014 update to *Competition in Health Insurance: A Comprehensive Study of U.S. Markets*, which offers the most comprehensive picture of competition in health insurance markets for 388 metropolitan areas in all 50 states and the District of Columbia. The study uses 2012 data captured from commercial enrollment in fully and self-insured plans as well as participation in consumer-driven health plans.

According to an [AMA press release](http://www.ama-assn.org), the new report "is intended to help researchers, lawmakers, policymakers and regulators identify markets where mergers and acquisitions among health insurers may cause competitive harm to patients, physicians and employers."

The updated report finds that most commercial health insurance markets in the U.S. are highly concentrated. In 90 percent of US markets, at least one insurer held a commercial market share of 30 percent or greater.

The AMA cautions that highly concentrated insurance markets may negatively impact patients and their doctors.

"The AMA is greatly concerned that in 41 percent of metropolitan areas, a single health insurer had at least a 50 percent share of the commercial health insurance market," said AMA President Robert M. Wah, M.D. "The dominant market power of big health insurers increases the risk of anti-competitive behavior that harms patients and physicians, and presents a significant barrier to the market success of smaller insurance rivals."

AMA Issues New Recommendations to Strengthen Meaningful Use Program

The American Medical Association (AMA) released a "blueprint" for improving the Centers for Medicare and Medicaid Services' (CMS) Meaningful Use program on October 14, calling for new federal health IT policies to strengthen physician practices and improve care for patients.

Specifically, the blueprint recommends the following:

- Adopting a more flexible approach for meeting Meaningful Use to allow more physicians to successfully participate;
- Better aligning quality measure requirements including reducing the reporting burden on physicians and helping relieve them from overlapping penalties;
- Ensuring quality measures and clinical decision support within the program are current to improve care for patients and ensure physicians are following the latest evidence; and
- Restructuring EHR certification to focus on key areas like interoperability.

The AMA also sent a [letter](http://www.ama-assn.org) to the Office of the National Coordinator for Health Information Technology (ONC) detailing its recommendations in advance of the proposed rule for Stage 3 of the Meaningful Use program. AMA also echoes its concerns with Stages 1 and 2 of the program and provides suggestions on how best to address these previous concerns.

The AMA writes:

"We strongly believe that measures are only meaningful when they meet the ongoing demand and complexity of our health care delivery system and serve the needs of providers and patients. Flexibility is essential to obtaining the envisioned goals of the EHR MU program. The Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) could achieve this increased flexibility through a number of ways, including: alternative reporting options; alignment between the various quality..."
initiatives; and less ridged reporting criteria. In addition, many of the requirements depend upon interoperable EHR systems, which have not yet been realized, as well as the adoption of other new technologies that are still evolving. The MU program should ensure that such health IT is available and effective before holding physicians accountable to these standards."

To view the full blueprint, click here.

**MedPAC Commissioners Examine RVUs in Medicare Fee Schedule**

The Medicare Payment Advisory Commission (MedPAC) met on October 10 to discuss the validation of relative value units in Medicare's fee schedule for physicians and other health professionals.

MedPAC staff presented data regarding relative value units (RVUs) in the physician fee schedule with a focus on work RVUs. As part of their review, MedPAC staff raised concerns regarding the current "bottom-up" approach to develop RVUs and has developed a "top-down" method for validating RVUs. Although Chairman Hackbarth indicated he did not "envision that we are moving towards a formal recommendation," he did state that MedPAC's findings would be communicated with CMS "through personal interactions with CMS staff and potentially also in our public comment letters."

To view the presentation, click here.

**Open Payments Site Launches Amidst Physician Concern**

The Centers for Medicare and Medicaid Services (CMS) made public its Open Payments database on September 30. The first data made public by CMS includes information on 4.4 million payments valued at almost $3.5 billion. A provision of the Affordable Care Act (ACA), known as the "Sunshine Act," requires drug and device makers to report financial relationships with physicians and teaching hospitals.

Although CMS offered physicians an opportunity to review the data submitted by drug companies and manufacturers before it was published, many physicians complained that the Open Payments site was difficult to navigate, therefore impeding the review process. According to reports, many physicians are worried that web site deficiencies have led to publication of inaccurate and misleading data.

Leading physician groups have warned that misinformation will give the American public the wrong impression about industry relationships.

The American Medical Association (AMA) has been publicly voicing concern over the data's validity and the submission and review process for several months. "Patients deserve to have access to accurate information, yet publishing inaccurate data leads to misinterpretations, harms reputations and undermines the trust that patients have in their physicians. It can also discourage research and care delivery improvements that benefit patients," the AMA said in a statement on September 30.

Even if physicians are able to demonstrate that data reported on Open Payments is flawed, CMS has announced it won't update the Open Payments database to reflect the correct information until early next year, raising additional concerns among the physician community.

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