Senate, House Lawmakers Lead Efforts to Prevent Proposed Radiation Therapy Cuts

Senators Debbie Stabenow (D-MI) and Richard Burr (R-NC) and Congressmen Paul Tonko (NY-20) and Devin Nunes (CA-22) are leading efforts in the U.S. Congress to gather signatures on two letters to the Centers for Medicare & Medicaid Services' (CMS) Acting Administrator Andy Slavitt expressing serious concerns with the proposed Medicare cuts to radiation oncology in the proposed Physician Fee Schedule (PFS) Rule for 2016.

If the proposed PFS changes were adopted, the payments for a course of care for prostate and breast cancer will be reduced by 25% and 19%, respectively. Moreover, the same care will be reimbursed 36% less and 32% less, respectively, in the freestanding setting than care delivered in the hospital setting. The Senate and House lawmakers strongly urge CMS to reconsider the proposed cuts to radiation therapy and encourage collaborative work on behalf of America's cancer patients.

These and other letters are expected to be finalized in September.

JAMA Studies Find Shorter Course of Radiation Therapy at Higher Doses is Less Toxic for Breast Cancer Patients

Two new studies published in JAMA Oncology on August 6 found that for women diagnosed with early-stage breast cancer, treatment using higher doses of radiation therapy over a shorter course of care may be less toxic and lead to better quality of life than a longer course at lower doses.

In one study, 287 women aged 50 and older who had been diagnosed with early-stage breast cancer and had undergone breast-conserving surgery, 149 received conventionally fractionated whole-breast irradiation, or CF-WBI, (at a dose of 50 Gy/25 fractions plus a "boost" dose) and 138 received hypofractionated whole-breast irradiation, or HF-WBI, (at a dose of 42.56 Gy/16 fractions plus a boost).

Researchers found that those receiving HF-WBI experienced much lower incidence of acute dermatitis, severe itching, breast pain, hyperpigmentation, and fatigue. The same group also reported less trouble meeting family needs after six months.

Another study assessed the toxic effects of both HF-WBI and CF-WBI during one week of treatment. Five hundred seventy women who received whole breast radiation therapy after undergoing breast-conserving surgery received HF-WBI and another 1,731 received CD-WBI.

Patients who underwent CF-WBI had greater incidence of skin reactions, breast pain, and fatigue than those who received HF-WBI, showing similar results to the previous study. CF-WBI patients also had increased burning, stinging, swelling and hurting.

The research team says the findings indicate "simple adjustment to dosing schedules" with HF-WBI offer a less costly, convenient treatment for patients with early-stage breast cancer.
To access the reports, click here and here.

SFC Releases Recommendations for Improving Health Outcomes for Chronic Conditions

The Senate Finance Committee (SFC) is currently reviewing 530 recommendations it received from provider organizations, beneficiary advocates and disease groups offering recommendations on how to address chronic conditions, which the Committee made public on July 29. To read the SFC statement, click here.

In May, SFC leaders issued a letter seeking input on developing solutions that improve health outcomes for Medicare patients with multiple chronic conditions.

In June, the American College of Radiation Oncology (ACRO) submitted a letter, recommending "episode-based bundled payments for radiation therapy as an option that holds significant promise as a Medicare APM for the oncology sector." ACRO outlines the key features and benefits of a possible episodic payment APM.

The American Society of Clinical Oncology (ASCO) submitted a letter to the Committee strongly supporting efforts to address the difficult challenges involved in caring for individuals with chronic diseases. ASCO outlines several initiatives and issues it feels should be reviewed as lawmakers develop policies for addressing chronic disease, including cancer such as ASCO's Patient-Centered Oncology Payment (PCOP) model and The ASCO Value Framework.

To see all submissions to the SFC, click here.

BillsIntroduced in House, Senate to Protect Access to Breast Cancer Screening

Congresswomen Renee Ellmers (R-N.C.) and Debbie Wasserman Schultz, (D-Fla.), and Senators Barbara Mikulski (D-Md.), and Kelly Ayotte, (R-N.H.), recently introduced the Protecting Access to Lifesaving Screenings Act (PALS Act), which would stop the U.S. Preventive Services Task Force (USPSTF) from issuing its review on the potential benefits of routine mammography for women in their 40s.

The legislation would place a two-year moratorium on the USPSTF draft breast cancer screening recommendations. This would allow time for Congress and others to review the impact these recommendations would have on women being screened for breast cancer, as well as more closely examine the USPSTF process.

In April, the USPSTF, an independent advisory arm of the Department of Health and Human Services (HHS), proposed changes to the national breast screening guidelines for women between the ages of 40 to 49. If the guidelines are finalized as drafted, health plans would no longer be required to cover free annual mammograms for women between the ages of 40 and 49.

To view the House bill (HR 3339), click here.

To view the Senate bill (S 1926), click here.

New Report Shows Majority of States Missing Opportunities to Reduce Toll of Cancer

According to a new report entitled, How Do You Measure Up?: A Progress Report on State Legislative Activity to Reduce Cancer Incidence and Mortality, released by the American Cancer Society Cancer Action Network (ACS CAN) on August 6, a majority of states are not measuring up on legislative solutions that prevent and fight cancer. The
report rates how well states are implementing policies that have proven effective in preventing cancer.

Specific to state progress, the ASC CAN reports that half of all U.S. states only reached two or fewer of the nine legislative priority areas measured by ACS CAN; 22 states and the District of Columbia measured up in just three to five areas; only three states — Maine, Massachusetts and Vermont — meet benchmarks in six of the nine categories; and no state met benchmarks in seven or more policy areas.

Other key findings include:

- Five states passed legislation requiring insurance companies to cover oral (i.e. pill) forms of chemotherapy in the same manner as they cover intravenous (IV) forms of the drug. These laws are especially critical to cancer patients who don't live near treatment centers and who can't easily access IV treatment.
- No state passed bills implementing a statewide smoke-free ordinance that covers all workplaces, including restaurants and bars, and states overall are spending less than two percent of the revenue from tobacco taxes on proven programs to reduce tobacco use.
- Five states adopted ACS CAN's model legislation for supporting and promoting palliative care, which is proven to result in a better quality of life for cancer patients.

To read the ASC CAN press release, click here.

To view the full report, click here.

Bipartisan Policy Center Releases Proposals to Save Medicare Billions

The Bipartisan Policy Center (BPC) released a report, Transitioning from Volume to Value: Accelerating the Shift to Alternative Payment Models, on July 30, which outlines Medicare reforms the think tanks says could lead to hundreds of billions of dollars in savings for the federal government.

The BPC report says reforming Medicare's Part B drug payment, modernizing Medicare benefits and allowing all Medicare providers to participate in alternative payment models (APMs), could reduce the federal budget deficit by $166 billion by 2025. By 2035, implementing these reforms could reduce the deficit by $537 billion, the report says.

The report also includes recommendations specific to bundled payment reforms. In this area, the BPC recommends the following:

- CMS should prioritize the establishment of bundled payments for episodes of care that have a statistically meaningful clustering of costs, providers, utilization, and patient characteristics.
- Bundles should be developed as both an alternative to fee-for-service reimbursement and a mechanism for engaging specialists in ACOs.
- Providers should receive differential updates in fee-schedule payment rates as they adopt more advanced payment and delivery models, so that bundled-payment participants would over time access higher fee-schedule payment rates than those not participating in APMs.
- Transition from a benchmark based on provider-specific, historical experience at the beginning of the contract toward a community-experience benchmark. Updates based on historical experience should not be rebased for experience under bundled payment.
- Prospective versus Retrospective Payment: CMS should offer more options for prospectively paid bundles, while retaining retrospective bundles as a default payment mechanism.
Last, in its conclusion, the BPC states it will continue work in additional areas including:

**Market Consolidation** — To ensure adequate competition in individual health care markets, more work should be done to assure that market consolidation promotes efficiency rather than driving up prices. Some states have begun to take action to make information available, but federal and state laws make it difficult for researchers, patients, and consumers to understand whether market consolidation is done for the purposes of better integrating care and reducing costs or for consolidating market share and increasing costs.

To download the BPC report, [click here](#).

To read the BPC blog post, [click here](#).

**New Survey Finds Mixed Views on Health Care Delivery Reforms**

The Commonwealth Fund and The Kaiser Family Foundation released a new survey of primary care providers, including physicians, nurse practitioners, and physician assistants, which asked participants about their experiences with and reactions to recent changes in health care delivery and payment.

Providers' views are generally positive regarding the impact of health information technology on quality of care, but survey results showed mixed results on the increased use of medical homes and accountable care organizations (ACOs). Overall, providers are more negative about the increased reliance on quality metrics to assess their performance and about financial penalties.

Survey findings include:

- Health information technology received the most positive ratings, with half (50%) of physicians and nearly two-thirds (64%) of nurse practitioners and physician assistants saying it has made a positive impact.
- One-third (33%) of physicians and four of 10 (40%) nurse practitioners and physician assistants said they believe medical homes are having a positive impact on quality of care, while roughly one of 10 said the impact has been negative.
- Half of physicians (50%) and nearly four out of 10 nurse practitioners and physician assistants (38%) feel that the increased use of quality metrics to assess provider performance is having a negative impact on quality of care.
- Nearly half (47%) of physicians and about a quarter (27%) of nurse practitioners and physician assistants said that recent trends in health care are causing them to consider retiring earlier than they originally planned.

To view the survey issue brief, [click here](#).

**CMS: Medicare ACOs Improve Quality of Care, Generate Savings**

On August 25, the Centers for Medicare & Medicaid Services (CMS) issued 2014 quality and financial performance results showing that Medicare Accountable Care Organizations (ACOs) continue to improve the quality of care for Medicare beneficiaries and generate financial savings.

The CMS data suggest improvements in the quality of care for Medicare beneficiaries receiving care through ACOs. In the third performance year, Pioneer ACOs showed improvements in 28 of 33 quality measures and experienced average improvements of 3.6 percent across all quality measures. Shared Savings Program ACOs that reported quality measures in 2013 and 2014 improved on 27 of 33 quality measures.
CBO Projects Medicare Spending Increase

An updated budget outlook released by the Congressional Budget Office (CBO) on August 25 projects federal spending for all major healthcare programs will increase by $106 billion in 2015, or 13 percent.

Medicare spending is projected to rise to $639 billion, an estimated $35 billion increase, the fastest spending growth for the program since 2009, the CBO said.

The CBO last updated its spending projections in March. Since that time, the Medicare Access and CHIP Reauthorization Act was signed into law to repeal Medicare's sustainable growth rate (SGR) payment methodology. The law increased the CBO's estimates of Medicare spending by $124 billion.

To view the updated CBO estimates, click here.