Congressional Letters to CMS on Cuts to Radiation Therapy Centers

This newsletter previously reported on bipartisan letters circulating in the House and Senate objecting to the 19% cut to radiation therapy centers contained in the CY 2013 Physician Fee Schedule (PFS) Proposed Rule. Those letters were led by Energy and Commerce Health Subcommittee Chair Joe Pitts (R-PA) and Energy and Commerce Subcommittee Ranking Member Frank Pallone (D-NJ) in the House and Senate Finance Committee Members Debbie Stabenow (D-MI) and Richard Burr (R-NC) in the Senate. The letters took issue with the magnitude of the cuts to radiation therapy and urged CMS to update all of the inputs to radiation oncology codes under review by the agency, rather than updating only a single input as the agency has done in the Proposed Rule.

On September 14, the letters closed with signatures from 104 Representatives and 28 Senators. Both letters have bipartisan support. A list of Members who signed the letters is provided below.

By the closing date for sign-on, 1,764 constituent letters and 93 constituent calls were recorded as transmitted to the Congress through the RTA's online portal.

The final Senate letter is available [here](#). The final House letter is available [here](#).

### Senate Signers

- Debbie Stabenow
- Richard Burr
- Daniel Akaka
- John Boozman
- Barbara Boxer
- Scott Brown
- Ben Cardin
- Saxby Chambliss
- Tom Carper
- Dan Coats
- Bob Casey
- John Cornyn
- Chris Coons
- Michael Crapo
- Diane Feinstein
- Lindsey Graham
- Kirsten Gillibrand
- Charles Grassley
- Kay Hagan
- Jon Kyl
- John Kerry
- Pat Roberts
- Amy Klobuchar
- Joseph Lieberman
- Robert Menendez
- Patty Murray
- Bill Nelson
- Ron Wyden
House Signers

Joseph R. Pitts
David Roe
Tom Price
Phil Gingrey
Leonard Lance
Gus Bilirakis
Dennis Ross
Scott DesJarlais
Martha Roby
Brett Guthrie
Aaron Schock
Vern Buchanan
Pete Olson
Marsha Blackburn
Sue Myrick
Joe Heck
Mike Rogers
Michele Bachmann
Mary Bono Mack
Steve Stivers
Daniel Webster
Devin Nunes
Charles Bass
Michael Turner
Jim Gerlach
Cathy McMorris Rodgers
C.W. Bill Young
Brian Bilbray
Bill Posey
Erik Paulsen
Peter Roskam
Paul Gosar
Steve Scalise
Jeff Miller

Frank Pallone
Hansen Clarke
John Dingell
Kurt Schrader
Robert Brady
Martin Heinrich
Steve Cohen
Allyson Schwartz
Charles Gonzalez
John Larson
John Barrow
Bill Pascrell
Joe Baca
Charles Rangel
Linda Sanchez
C.A. Dutch Ruppersberger
Brian Higgins
Maurice Hinchey
Debbie Wasserman-Schultz
Barney Frank
Jason Altmire
Jim Langevin
Kathy Castor
David Cicilline
Mark Critz
Hank Johnson
Raul Grijalva
Dave Loebsack
Lois Capps
Collin Peterson
Carolyn McCarthy
Mike Ross
Jim Matheson
Steve Israel
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<th>House Signers (cont’d)</th>
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<td>Chris Smith</td>
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<td>John Mica</td>
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<td>Tim Griffin</td>
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<td>Robert Latta</td>
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<td>Alan Nunnelee</td>
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<td>Rich Nugent</td>
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<td>Reid Ribble</td>
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<td>Tom Latham</td>
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<td>Dan Burton</td>
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<td>Elton Gallegly</td>
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<td>Mike Simpson</td>
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<td>Walter B. Jones</td>
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<td>Lee Terry</td>
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<td>Tim Murphy</td>
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<td>Mario Diaz-Balart</td>
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<td>Mac Thornberry</td>
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<td>Nan Hayworth</td>
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<td>Austin Scott</td>
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<td>Dave Richert</td>
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Comment Letters Submitted to 2013 Physician Fee Schedule Proposed Rule

Several comment letters were submitted to CMS objecting to the 2013 Physician Fee Schedule Proposed Rule's cuts to radiation therapy. Letters were submitted from the RTA, specialty societies (ACRO, ASTRO), patient groups and others. These letters made several important points:

Need for a Holistic Approach in Valuing Radiation Therapy Codes. The RTA and ACRO comment letters urged CMS to take a holistic approach to valuing radiation therapy codes. In particular, the RTA comment letter provided 140 recent paid invoices indicating that the equipment used to value key radiation therapy services was either outmoded or missing altogether.

Updated Procedure Time Estimates. The ASTRO comment letter conducted its own consensus panel to update the procedure time assumptions for key radiation therapy services.

Objection to Use of Patient Fact Sheets to Guide Reimbursement Decisions. The Cancer Leadership Council indicated that patient education materials are "intended to serve patients" and "not designed to reflect or describe the time necessary to deliver professional services, including the technical requirements of the services that may be undertaken before and after the patient experience."

Hill passes Continuing Resolution (CR)

On September 28, the President signed H. J. Res. 117, the Continuing Appropriations Resolution. The measure provides stopgap funding for so-called "discretionary spending" programs through March 27, 2013. Although the measure does not address so-called "mandatory spending" (including Medicare spending), it is an important measure to prevent a government shutdown of federal agencies and a possible calendar benchmark for other stopgap measures necessary to extend Medicare physician payments and other expiring provisions.

White House Sequester report

As we reported previously, upon signing the Sequestration Transparency Act, President Obama was required to provide a sequestration report within 30 days of enactment of the act. On September 14, the White House Office of Management and Budget (OMB) released its report detailing the $1.2 trillion in automatic funding cuts that will take effect on January 2, 2013. The report confirmed that sequestration will cut Medicare reimbursement rates by 2 percent, or $11.1 billion.

Separately, on September 21, House Budget Committee Democrats released an updated FAQ on the sequestration required under the Budget Control Act. According to the report, "Most of Medicare payments to providers are subject to sequestration but limited to a 2 percent reduction."

Center for American Progress Reports on Alternatives to Fee-for-Service Payments

Alternatives to Fee-for-Service Payments in Health Care, a paper from Center for American Progress, reports that the predominance of fee-for-service payments drives up health care costs and potentially lowers the value of care for two reasons: (1) it encourages quantity over quality (especially for high-cost services) and (2) it results in misalignment of financial incentives between providers. As a result, patients receive care they don't want and premiums, deductibles, and cost-sharing increases for all health care consumers.
The paper examines payment and delivery system reforms, including bundled payments, designed to control costs and improve care by compiling recent data from organizations that have tested these reforms. According to the report, bundled payments offer the following benefits for payers, providers and patients:

- More coordinated patient care for improved health outcomes and lower costs
- Reduced variation in spending and clinical treatments to reduce costs
- Greater transparency and accountability on price and quality
- Allow providers to transition to wider-scale payment reforms.

According to the report, implementation challenges include determining which services to include in the bundle, the duration of the bundle, pricing of the bundle, and which patients will be eligible for the payment. Two keys to success in bundled payments are strong physician leadership and investments in organizational capacity.

The report specifically examined UnitedHealthcare’s use of episodic payments for chemotherapy through a pilot program that pays for 19 clinical episodes in breast, colon, and lung cancers, and differentiates between regimens intended to cure patients and those used for palliative care.

Institute of Medicine Report Released

On September 6, the Institute of Medicine released *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*, a 382-page report stating that America's healthcare system has become too complex and costly to continue. According to the report, recent advances in science and technology will be important in addressing an increasingly complicated healthcare system plagued by inefficiency, high costs and poor quality. Eighteen panel members from the Committee on the Learning Health Care System in America argue for improvement strategies to make information more accessible, engage patients and their families and make care more equitable. These changes will include increased use of health information technology, increase connectivity, use of new payment models and a re-engineering of healthcare systems.

The panel calculated that about 30 percent of health spending in 2009 -- roughly $750 billion -- was wasted on unnecessary services, excessive administrative costs, fraud, and other problems. Moreover, they state that inefficiencies cause needless suffering. According to the report, roughly 75,000 deaths might have been averted in 2005 if every state had delivered care at the quality level of the best performing state.

Among the "list of payment policies and delivery system reforms that change the method for recognizing high-value care" is the bundled payment option. The paper reviews bundling and registry initiatives currently underway in the oncology sector.

MedPAC Reviews Geographic Practice Cost Index under Medicare Physician Payment Formula

On September 6, the Medicare Payment Advisory Commission (MedPAC) met to discuss a report required by H.R. 3630, the Middle Class Tax Relief and Job Creation Act of 2012. Pursuant to the act, not later than June 15, 2013, the MedPAC must submit to the Congress a report that assesses whether the geographic practice cost index (GPCI) is appropriate and, if so, where it should be applied and to what extent. The act also requires MedPAC to assess the extent to which the current GPCI floor impacts access to care. Pursuant to the act, the work GPCI floor was extended through 2012.
During the meeting, MedPAC discussed the pros and cons of geographic adjustments and policy options. Arguments in favor of the work GPCI included: (1) compensation for cost of living, (2) beneficiary access in high-cost areas, (3) work as input to production of services, and (4) consistency with Medicare's other geographic payment adjustments. Arguments against the work GPCI included: (1) the argument that "work is work" regardless of geography, (2) inadequacy of earnings data, (3) Social Security and other payments are not geographically adjusted, and (4) research suggests that rural physicians have higher earnings than urban physicians. MedPAC listed as policy options to: (1) retain Â¼ of the work GPCI and eliminate the floor or (2) eliminate the work GCPI altogether.

**State-Level Projections of Cancer-Related Medical Care Costs: 2010 to 2020**

On September 25, the American Journal of Managed Care published a study projecting cancer-related medical costs by state from 2010 through 2020. The study projected percentage increases in cancer care costs between 2010 and 2020 ranged from 34% in the District of Columbia to 115% in Arizona (median = 72%). Projected actual increases in costs ranged from $347 million in the District of Columbia to $28.3 billion in California (median, $3.7 billion). States with the largest projected increases in the number of people treated for cancer were Florida (353,000), California (351,000), and Texas (249,000).

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