

Washington Update

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Today's Topics

- Health Care Reform Law
- Medicare Sustainable Growth Rate
- 2011 Proposed Fee Schedule
 - Imaging
 - Self Referral
 - Drug and Administration Payments
- Competitive Acquisition Program
- Off Label Uses
- Clinical Trials
- PQRI
- NIH Appropriations

The Patient Protection and Affordable Care Act (ACA)

- Signed by President Obama in March
- Will be implemented over many years
- Law is over 2000 pages
- Implementation is critical

Some of the ACA provisions affecting people with cancer

- Mandated coverage of routine patient care in clinical trials
- Potential demonstration project on treatment planning
- Ban on pre-existing condition exclusions
- Elimination of lifetime caps
- Prohibition on rescissions
- Extension of coverage under parents' health insurance for children up to age 26
- Waiver of copayment for colorectal screening

ACA Provisions in 2010

- 2010
 - Immediate access to insurance for the uninsured and individuals with pre-existing conditions (including children)
 - Rebates for Medicare Part D “Donut Hole”
 - Prohibition on rescissions
 - Elimination of lifetime limits and regulations on annual caps
 - Extending coverage to age 26 for young adults on parent’s policy
 - Establishes Patient Centered Outcomes Research Institute to compare the effectiveness of different interventions
 - Establishes National Health Care Workforce Commission

ACA Provisions in 2011 & 2012

- 2011
 - Discounts in Part D “Donut Hole”
 - Free annual wellness and prevention services with no cost sharing
 - PQRI: 1% bonus in 2011 and 0.5% bonus in subsequent years
 - Restriction on Physician Ownership of Specialty Hospitals
- 2012
 - Establishes hospital value-based purchasing program. Secretary to submit plan to Congress by 2012 to move home health and nursing home providers into value-based purchasing

ACA Provisions in 2013 & 2014

- 2013
 - Incentives for Medicaid programs to cover evidence-based preventive services with no cost sharing
 - Public reporting of physician performance
- 2014
 - Eliminate Annual Limits on insurance coverage
 - Coverage for routine care costs associated with a clinical trial
 - Quality Reporting for certain providers
 - Quality reporting measures and pilot programs for PPS Exempt Cancer Hospitals

ACA Provisions in 2015 & 2016

- 2015
 - Independent Payment Advisory Board
 - First recommendations to Congress to lower costs, extend Medicare solvency, improve patient outcomes, promote quality, efficiency, expand access to evidence-based care
 - Physician payment linked to outcomes
 - Value-based payment program to improve quality of care
 - PQRI penalties will be assessed beginning in 2015 (1.5%) and 2% in subsequent years
- 2016
 - Purchase Insurance Across State Lines

ACA Provisions of Concern

- Independent Payment Advisory Board
- Patient Centered Outcomes Research Institute
- Medicaid Expansion
- Minimum Benefits
- National Health Care Workforce Commission

Sustainable Growth Rate (SGR)

- SGR is part of a formula and a Medicare target for spending on physician services – if actual expenditures exceed SGR, physician's payments are cut
- Temporary patches are added on to subsequent years which is why annual proposed cut getting larger (21.3% for 2010)
- ASCO working with the AMA and other medical specialty societies to permanently repeal the SGR formula
- Congress patched with a 2.2% increase through end of November 2010
- Unclear what will happen on December 1st

SGR: A History

<u>Year</u>	<u>Scheduled Cut</u>	<u>Congressional Action</u>
• 2002	5.4%	No Congressional Action
• 2003	4.4%	1.6% increase
• 2004	4.5%	1.5% increase
• 2005	3.3%	1.5% increase
• 2006	4.4%	Freeze at 2005 level
• 2007	5%	Freeze at 2005 level
• 2008	10.1%	0.5% increase
• 2009	15%	1.1% increase
• 2010	21.3%	2.2% increase to November

2011 Proposed Fee Schedule

- CMS projects an additional 6.1% cut to the conversion factor affecting all physicians in addition to the estimated SGR cut
 - 6.1 + 21.2 = approx 28% cut to all physicians for Medicare
- 2010 final fee schedule estimated total oncology payments will go down 6% over 4 years. CMS now estimates that cut will be 4% by 2014
- For 2011, drug administration codes slightly increase overall, E&M codes slightly increase
 - Drug administration codes down by double digits by 2013
- Changes to Bone Density Test Payments

2011 PPFS - Imaging

- Implementing provisions from the ACA
- Change Equipment Usage Assumption to 75%
 - Prior to 2010 was 50%; partially implemented 90% in 2010
- Multiple Procedure Payment Reduction Policy: Payment for subsequent imaging services will drop from 75% to 50% of the normal payment amount. CMS expanding across imaging families.
- ASCO Member of the Access to Medical Imaging Coalition

2011 PPFS – Self-Referral

- Provision in ACA
- Disclosure requirement for in-office ancillary services exception to prohibition on physician self-referral
- For MRI, CT and PET the referring physician must inform patient in writing at time of referral that patient may obtain the service from someone other than referring physician
- Must give list of 10 suppliers in 25 mile radius (or as many as exist in 25 mile radius)

Drug Payments in Office

- CMS to substitute drug payment method based on WAMP or 103% of AMP, instead of 106% of ASP, if ASP exceeds the AMP or WAMP by 5%
- “Underwater” drugs still pose significant problem
 - Some drugs not available to some physicians at Medicare rate
 - Prompt pay discounts included in calculation but not passed on to physician
 - No exceptions process for particular drugs
 - 2-quarter delay in adjusting payments to reflect price increases

Competitive Acquisition Program (CAP)

- Program was on hold for 2010, but CMS sought input on how to make it better, including:
 - Updating payment amounts quarterly
 - Limiting drugs available through CAP
 - Allowing physicians to maintain small quantities of CAP vendor’s drugs in office
 - Allow physicians to transport CAP drugs between practice offices
- No mention of CAP for drugs in 2011 fee schedule
- Congressional Interest in CAP Program

Consultations

- CMS eliminated payment for consultation codes in 2010
- Not reintroduced in 2011 PFS
- AMA, ASCO, and other specialties still attempting to overturn this decision
- AMA has estimated a loss of \$50 million to physicians due to “subsequent hospital visit” billing in the inpatient setting

Off-Label Coverage

- Recognized compendia for Medicare:
 - Thomson DrugDex
 - NCCN Drugs & Biologics Compendium
 - AHFS Drug Information
 - Clinical Pharmacology
 - Or uses supported by evidence published in one or more of 26 specified peer-reviewed journals
- Requirements for Compendia
 - Publically transparent process for evaluation therapies
 - A process in place for identifying conflicts of interest

FDA Approves REMS for ESAs

- Extensive REMS including Elements to Assure Safe Use (ETASU) and an implementation plan
- ASCO is engaging the FDA through different channels, including the Public Safety Initiative, on REMS in general
- FDA holding new public meetings on REMS, receptive to public input

Clinical Trials Coverage

- Health Care Reform law requires coverage of routine costs associated with clinical trials
 - Beginning in 2014
 - Applies to ERISA –covered plans
 - Issue with Grandfathered plans
- 2011 Medicare Advantage payment policies require MAOs to reimburse patients for the difference between the FFS rates they are charged for being in clinical trials and what they would have paid for a similar service in-network.

Medicare E-Prescribing

- Incentive program launched January 1, 2009 for physicians who e-prescribe :
 - 2% payment increase in 2009-2010
 - 1% payment increase in 2011-2012
 - 0.5% payment increase in 2013
- New with ACA: Penalties will be assessed for non-participating physicians beginning in 2012 based on 2011 non-participation
 - Must e-prescribe at least 10 times in first 6 months of 2011 to avoid 2012 penalty of 1%
- Successful reporting initially defined as reporting for at least 50% of eligible patients – now changed to 25 unique visits only

ARRA Incentive

- Stimulus bill (ARRA) provides \$19 billion to encourage physicians to adopt and use qualifying electronic health records (EHRs) in a meaningful way
- HHS must adopt an initial set of standards by December 31, 2009, for qualifying EHRs
- ASCO has made comment on both the measures and certification proposals.
- Initial measures released on “meaningful use”
 - Some clinical quality measures relevant to oncology: inappropriate overuse of imaging in early-stage prostate cancer, treatment of stage III colon cancer and hormonal therapy in breast cancer.
 - Oncology has special functional requirements for an EHR.

PQRI – Medicare Quality Reporting in 2010 and Beyond

- PQRI incentive:
 - 2% in 2010
 - 1% in 2011
 - .5% in 2012-2014
- CMS proposing to lower threshold for reporting of individual measures from 80% to 50% for claims-based reporting; registry- and EHR-based reporting is still 80%
- CMS required to set up appeals process
- In 2011, CMS has proposed lowering the threshold for a “group practice” from 200 to as few as 2

Funding for NIH

- Congress has passed an omnibus spending bill for remainder of FY 2010, which funds NIH at 31.3 billion.
- Stimulus bill included \$10.4 billion for National Institutes of Health for FY 2009 and FY 2010
- Obama budget proposal included \$6 billion for “cancer research”
- Stimulus funds are not included in the base of the FY 2010 NIH funding bills.
- Continuing Resolution likely for 2011.

What is ASCO Doing?

- Fighting to address “underwater” drugs:
 - Would remove wholesaler discounts from the Average Sales Price (ASP) methodology
 - Coalition of Cancer Community Groups
 - Attempted inclusion in health reform
- Advocating for coverage of treatment planning and treatment summaries
 - Legislation
 - Potential demonstration project

What is ASCO Doing?

- Lobbying for repeal of the SGR
 - Hundreds of visits on Capitol Hill
 - Grassroots campaign – we need your voice!
 - Editorials and newspaper stories
- Engaging in Health Reform
 - Commenting on implementing regulations
 - Nominating oncologists to Boards
 - Meeting with CMS, HHS, FDA, NIH, NCI, Administration

What is ASCO Doing?

- Addressing Workforce Shortage
 - Demand outpacing supply due to aging Medicare population and other factors
 - Competitive grants to study innovative practice arrangements
 - Pilot projects to test innovative practice models
 - Partnerships with other health professionals
 - Number and funding for training slots and recommendations for expansion
 - Exposure to outpatient oncology during training
 - Workforce information database and health of the workforce report

What is ASCO Doing?

- Developing plans to facilitate registry-reporting to PQRI that is coordinated with the Quality Oncology Practice Initiative (QOPI)
- Working on implementation of clinical trials provision
- Advocating for additional funding for NIH
- Supporting doubling of cooperative group budget

Questions?

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