ACCC Submits Comments to Proposed ACO Rule

In early June, the Association of Community Cancer Centers (ACCC) submitted comments (*http://www.accc-cancer.org/advocacy/pdf/2011-ACO-comments.pdf*) to the Centers for Medicare & Medicaid Services (CMS) on the Medicare Shared Savings Program: Accountable Care Organizations proposed rule.

The comments expressed ACCC's recommendations to protect beneficiary access to cancer care by requiring ACOs to include specialists in the leadership and management structures and by establishing additional protections for access to specialty care and clinical trials. ACCC asked CMS to consider the creation of oncology-centered ACOs under the Center for Medicare and Medicaid Innovation (*http://innovations.cms.gov*) and reduce barriers to community cancer centers' participation in ACOs by creating an option to participate under the one-sided risk model for all three years.

For more, read the ACCCBuzz blog post, "Over-burdensome and Under-rewarding: ACCC Says Whoa to ACO Proposed Rule" (*http://acccbuzz.wordpress.com/2011/06/09/over-burdensome-and-under-rewarding-accc-says-whoa-to-aco-proposed-rule*).

ACO Initiatives from CMS

On May 17 CMS announced three ACO-related initiatives under the Affordable Care Act's Center for Medicare and Medicaid Innovation:

1. The Pioneer ACO model (*http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/pioneer-aco*), which provides an accelerated ACO path for advanced organizations ready to move more rapidly from a shared savings payment model to a population-based payment model. ACOs can participate in either the shared savings program or in the Pioneer model, but not in both concurrently, the agency said.
2. Consideration of an Advance Payment Initiative (*http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/advance-payment)* for ACOs going into the Medicare Shared Savings Program to test if pre-paying a portion of future shared savings could increase participation.
3. Four ACO Accelerated Development Learning Sessions (*http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/acolearningsession*), with the initial three-day session scheduled for June 20. Each will include a focused curriculum on care competencies for ACO development. Sessions will not discuss elements of or specific requirements for participation in any CMS ACO program.

For more information and updates, visit CMS's Center for Medicare and Medicaid Innovation at: *http://innovations.cms.gov/*.

ACO Resources on ACCC's Website

In April ACCC hosted an overview presentation on the proposed ACO rule, "The Medicare Shared Savings Program: The Accountable Care Organization (ACO) Proposed Rule." A follow-up conference call on "Tax and Legal Implications in the Proposed ACO Rule" was held in May. These calls and the accompanying slides are available on the Members-Only section of ACCC's website at: *www.accc-cancer.org*. To access these archived presentations, log in to the members-only section and click on "members-only content."

…comments expressed ACCC's recommendations to protect beneficiary access to cancer care…

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Update on HHS's Pre-Existing Condition Insurance Plan

On May 31 the U.S. Department of Health and Human Services (HHS) announced new steps to reduce premiums and make it easier for Americans to enroll in the Pre-Existing Condition Insurance Plan (PCIP). Premiums for the federally administered PCIP will drop as much as 40 percent in 18 states, and eligibility standards will be eased in 23 states and the District of Columbia to ensure more Americans with pre-existing conditions have access to affordable health insurance. PCIP was created under the Affordable Care Act and serves as a bridge to 2014 when insurers will no longer be allowed to deny coverage to people with any pre-existing condition such as cancer, diabetes, and asthma.

Eligibility for the PCIP has been simplified. Starting July 1, 2011, people applying for coverage in the federally administered program can demonstrate eligibility for PCIP simply by providing a letter from a doctor, physician assistant, or nurse practitioner dated within the past 12 months stating that he or she has, or at any time in the past, had a medical condition, disability, or illness. To apply for coverage, individuals must be U.S. citizens or reside in the U.S. legally and have been without health coverage for at least 6 months.

Information on eligibility, plan benefits and rates, and how to apply is available at: *www.pcip.gov*. View a chart showing PCIP premiums in states with federally administered PCIP programs at: *www.HealthCare.gov/news/factsheets/pcip05312011a.html*. The PCIP Call Center is open 8 am to 11 pm EST, call toll-free 1.866.717.5826 (TTY 1.866.561.1604).

CMS EHR Incentive Program Payments Issued

On May 19 the Medicare EHR Incentive Program (*http://www.cms.gov/ehrincentiveprograms*) issued the first round of payments totaling $75 million to providers who signed up in the first two weeks of the program.

In April CMS opened a secure website through which eligible professionals (EPs), eligible hospitals, and critical access hospitals can demonstrate meaningful use of certified EHR technology to CMS by "attesting" to their compliance with program requirements for a continuous 90-day reporting period for their first year of participating in the Medicare EHR Incentive Program. In their second and subsequent years of participation, providers must demonstrate meaningful use on a full-year reporting period. Information on attestation is available at: *http://www.cms.gov/EHRIncentivePrograms/32_Attestation.asp#TopOfPage*.

Under the Medicaid EHR Incentive Program, EPs can receive incentive payments in their first year of participation by successfully registering through CMS's web-based registration system and then demonstrating to their state that they are eligible and have adopted, implemented, or updated certified EHR technology. Medicaid EPs and eligible hospitals do not need to demonstrate that they have met meaningful use criteria in the first year. In subsequent years of the program, they will need to demonstrate meaningful use. A schedule of state launch dates for the Medicaid EHR Incentive Program is available at: *www.cms.gov/apps/files/medicaid-HIT-sites*.

CMS Proposes Some Flexibility for eRx Incentive

On May 26 CMS announced proposals for new flexibilities to help providers phase in use of electronic prescription technology. The eRx Incentive Program (*http://www.cms.gov/ERxIncentive*) provides financial incentives, including payment adjustments beginning Jan. 1, 2012, for eligible providers to encourage electronic prescribing. CMS's proposed rule would provide exemptions from payment adjustments for providers who plan to participate in the program but face certain barriers to using electronic prescribing systems or meeting program requirements that may be beyond their control. The proposed rule is available online at: *http://www.ofr.gov/OFRUpload/OFRData/2011-13463_PI.pdf*. The comment period on the proposed rule closes on July 25, 2011.


The eRx Incentive Program provides financial incentives…to encourage electronic prescribing.

ISSUES

HOT TOPIC

SGR Showdown?

by Sydney Abbott, JD

Everyone agrees that physician reimbursement reform isn't easy and the Sustainable Growth Rate (SGR) has long been a target of harsh criticism. For the last 10 years, it's been patch, patch, patch with Congress repeatedly coming to the rescue with a "doc fix" to scheduled physician reimbursement cuts. The crisis seemed to come to a head last year when Congress scrambled to avoid making a 21 percent cut with a series of short-term fixes—some as brief as one-month extensions. The uncertainty drove providers to the brink. Eventually, Congress passed yet another stop-gap "fix" through the end of 2011. And now once again the physician community is facing increased cuts and more uncertainty. At the end of this year, the SGR is threatening a 30 percent cut for physicians. But the 2011 outcome may be different. Two congressional committees are finally looking at sustainable alternatives to the SGR.

The House Committee on Energy and Commerce recently requested input from 50 medical organizations for alternatives to the Medicare Sustainable Growth Rate SGR formula, and on May 5, the committee held a hearing to discuss alternative physician payment plans to the SGR. Also in May, the House Ways and Means Committee, which shares jurisdiction with Energy and Commerce over health payment issues, scheduled a hearing to identify additional solutions.

The yearly "doc fix" to the SGR problem is not sustainable. If Congress is serious about improving healthcare, it cannot leave physicians and other providers in annual limbo as to whether they will be appropriately reimbursed. Various solutions to the SGR have been suggested, but three seem to garner the most support: medical malpractice reform, balanced billing, and full repeal of the SGR.

Medical Malpractice Reform

The American Hospital Association (AHA) believes an SGR fix could be funded by eliminating the need to carry substantial insurance against—and the time, money, and effort associated in the defense of—medical malpractice lawsuits. AHA supports the removal of negligence-based claims from the court system and the implementation of an administrative compensation system, or "health-court," where a patient could submit a claimed injury to an administrative panel, which would use national standards to make a decision on whether the injury is eligible for compensation. The panels would be state administered and would only handle claims for injury (during care) that were unintentional and did not rise to the threshold of criminal acts. AHA suggests that the negligence standard currently used in courts not apply under this system. A patient disagreeing with the panel's decision could appeal to an expert panel or administrative law judge. Opponents, however, warn of the inefficiency and high cost associated with establishing health courts.

Balanced Billing

The Coalition of State Medical and National Specialty Societies, along with other provider advocate organizations including the American Medical Association (AMA), take a slightly different approach to the SGR problem and propose balanced billing as a solution. Under this system, any physician could contract with any Medicare patient to charge more than Medicare rates, with the patient paying the balance. Supporters feel this solution will lead to wiser and more informed health decisions by beneficiaries, while ensuring providers receive appropriate compensation for their services. However, opponents to this plan worry that it will create too high a burden for the severely ill and cause some patients to forgo needed treatment. Balanced billing is generally not popular on Capitol Hill and will probably be difficult to pass through Congress, no matter which party is in charge.

Repealing SGR

AMA goes as far as calling for the immediate repeal of the SGR with five years to try new models. The Association proposes expansion of gainsharing demonstration grants similar to the Shared Savings Program we could see in accountable care organizations (ACOs). Gainsharing programs test ways hospitals and providers, working together, can save money through improving quality and efficiency. These hospitals and providers then share in the savings realized. To be effective, these programs will require regulatory waivers by Congress for Stark and anti-kickback laws. The gainsharing program, which was established in the 2005 Deficit Reduction Act, is scheduled to end this June. AHA estimated that physicians received an additional $5,000 in the first year of participation in the program. Without congressional action, after June such arrangements will be prohibited by monetary penalty anti-referral laws.

Looking to the Future

Across the board, proposals seem to support stable payments for physicians during the transition period to a new payment model. Both House committees agree on two things: there will not be a one-size-fits-all approach to replacing the SGR, and a solution could take years to effectively implement. Both committees, however, anticipate identifying a solution before the next "doc fix" showdown later this year.

ACCC will continue to follow this issue and keep membership informed.

Sydney Abbott, JD, is policy coordinator for the Association of Community Cancer Centers.

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