USPSTF Gives PSA Test "D" Grade

On May 21 the U.S. Preventive Services Task Force (USPSTF) gave the prostate-specific antigen (PSA) test a grade of "D," essentially saying that the test may not be appropriate as it is being used currently. This recommendation runs counter to what has become common practice in many primary care, urology, and oncology offices across the country.

After reviewing two large studies, the USPSTF panel expressed its belief that PSA tests saved the life of just one man out of 1,000. In addition, the panel believes that for every man saved by PSA testing, another one will develop a blood clot, two will have heart attacks, and another 40 will develop incontinence or impotence due to unnecessary treatments.

Will the USPSTF recommendation change how the PSA test is given and how it is paid for? The answer to the first part is that practice will likely change very little due to this recommendation. Many men currently are given the option to take the PSA test, and many will opt for it. Men with lower risk factors may delay the test, perhaps; however, it is safe to say that the PSA test is not likely to disappear any time soon.

The second half of the question is harder to answer. Most insurers will not do anything right away to change their policies. Large insurers have already said that while they will review the data from the studies, they believe that PSA testing is still an important part of prevention of prostate cancer. Payers may eventually put some limitations on the test based on risk factors or age, but doing so will take some time.

Medicare coverage is also tricky. Because of the Affordable Care Act, patients can receive preventive tests at no cost if the tests have a positive recommendation from the USPSTF. With this change, it is possible that PSA tests will not be eligible for this coverage. Medicare will still likely cover the test, but the test would fall out of the preferred category. Only time and more studies will tell if this decision has a major impact on the practice of medicine. Stay tuned to ACCC for more information.

ACCC Submits Comments on Medication Non-Adherence and EHR Meaningful Use Criteria

On May 7 ACCC submitted comments to the Office of the Surgeon General regarding the causes, impact, and potential solutions for prescription medication non-adherence, which can increase costs to the patient, health plans, and society.

ACCC members identified four potential solutions for non-adherence:

1. Physicians or other members of a patient's healthcare team should contact the patient within 72 hours after prescribing a medication to ensure that the patient fills the prescription, understands how to take the medication, and understands potential side effects.
2. Pharmacists and/or insurers should educate patients and physicians about therapeutic substitutions and how they affect the dosing regimen prescribed by the physician.
3. Policymakers should develop an "electronic pill box" that explains the differences between medications and helps patients understand when to take their medications.
4. The Centers for Medicare & Medicaid Services (CMS) and other payers should continue to implement programs that help reduce patients' out-of-pocket costs for medications, such as the provisions in the Patient Protection and Affordable Care Act that close the Medicare Part D "donut hole."

On a separate issue, ACCC submitted comments to CMS on the proposed rule specifying Stage 2 electronic health record (EHR) meaningful use criteria and related matters for eligible professionals, eligible hospitals, and critical access hospitals.

IOM's CEO Checklist for High-Value Health Care

The Institute of Medicine (IOM) has developed a checklist of procedures and organizational tools that providers can use to deliver high-quality care at lower cost. The 10-item checklist is divided into four categories: foundation elements, infrastructure fundamentals, care delivery priorities, and reliability and feedback. The checklist includes the following as essential to delivery of high-quality, lower-cost care:

- Senior leadership committed to

continued on page 12

continued from page 6

this goal

- Organizational culture of continuous improvement
- Comprehensive IT systems in place
- Practice of evidence-based care
- Internal transparency regarding performance, outcomes, and costs.

The checklist is available at *www.iom.edu/Global/Perspectives/2012/CEOChecklist.aspx*.

Major Health Insurers to Keep Some Health Reform Measures, Regardless of Supreme Court's Decision

On June 11 three major health insurers announced their intention to keep some provisions of the health reform law, regardless of the U.S. Supreme Court's ruling, according to *BNA Health Care Daily Report*.

UnitedHealthcare and Humana Inc., announced they will keep five health insurance reform provisions already in effect. Aetna, Inc., said it will keep at least three provisions currently in effect.

The UnitedHealthcare and Humana provisions being retained are:

- Preventive health services without copayments.
- Dependent coverage up to age 26. Coverage will be offered on parents' plans, regardless of young adults' eligibility for other insurance coverage, whether they are in school, or whether they are married.
- Elimination of lifetime coverage limits.
- No rescissions of health coverage, except for in cases of fraud or intentional misrepresentation of material facts.
- Provision of what Humana terms "a clear and simple process for appeals claims decisions," as well as the option to have cases reviewed by independent organizations.

For updates on the Supreme Court decision visit *acccbuzz.wordpress.com*.

ACCC Medical Home Survey Results

An ACCC survey of 217 administrators, oncologists and oncology nurses—63 percent of whom work in a hospital-based cancer program—showed that a majority are familiar with the medical home concept and most believe the oncology home model could work in their practice or hospital cancer service line.

In fact, the great majority of respondents believe that within five years they will be practicing as part of an ACO and/or a medical home. By 2017 only 25 percent of respondents believe their facility will keep its current staffing and billing structure. Thirty-two percent envision their practice or hospital being part of both an ACO and medical home, 26 percent believe their facility will join or become an ACO, and 18 percent anticipate becoming a medical home. Forty-six respondents said they believe a medical home could provide better-quality, collaborative care at lower costs, and they would consider applying for recognition from the National Committee for Quality Assurance (NCQA).

At the same time, the survey revealed concerns. Most respondents (more than 90 percent) say they are concerned about medical home and ACO start-up costs and payer negotiations.

Responses were mixed on whether these changes will be favorable. While 45 percent believe moving away from the buy-and-bill model will result in better patient care, 15 percent believe it won't. And 33 percent of respondents said the change will negatively impact providers.

The survey was conducted as part of the oncology medical home theme of ACCC Immediate Past-President Thomas Whittaker, MD, FACP.

PCORI Update

In a recently released preliminary draft report, the Patient-Centered Outcomes Research Institute (PCORI) indicated that it might include electronic health records in future comparative effectiveness research (CER) efforts. The draft report, generated by PCORI's Methodology Committee, is provided as a resource for use by applicants for PCORI funding announcements. The draft suggests that PCORI will eventually recommend how to use the millions of electronic medical records from doctor and hospital visits each year—that are not currently useable—for comparative effectiveness research. But first PCORI must tackle the medical, financial, and political hurdles that prevent widespread use of electronic records.

The full draft report, which sets out 60 standards to guide patient-centered outcomes research, is available at *www.pcori.org/assets/Preliminary-Draft-Methodology-Report.pdf*.

A public comment period on an updated form of the report starts in July. OI

CMS Reports Healthcare Spending Grew 3.9 Percent in 2011

According to new estimates released from CMS on June 12, healthcare spending in the U.S. grew 3.9 percent in 2011, the same rate recorded in 2010, and close to the historically low 3.8 percent growth in 2009.

Projections are for health spending to continue slow growth until 2014, when coverage expansion mandated under the ACA goes into effect.

The report, "National Health Expenditure Projections: Modest Annual Growth Until Coverage Expands and Economic Growth Accelerates," can be accessed from *Health Affairs* at *http://content.healthaffairs.org/content/early/2012/06/11/hlthaff.2012.0404*.