ASTRO’s Legislative Priorities 2014

AMERICAN SOCIETY FOR RADIATION ONCOLOGY
ASTRO’s 2014 Legislative Priorities

ASTRO appreciates Congress’ support for radiation oncology and looks forward to working together to:

- Protect patients and the integrity of the Medicare program by ending physician self-referral abuse and supporting the Promoting Integrity in Medicare Act of 2013 (H.R. 2914);
- Stabilize Medicare physician payments and protect access to radiation oncology services;
- Increase investments in radiation oncology research by supporting sustainable and predictable funding; and
- Preserve and increase funding and residency slots for Graduate Medical Education.
ASTRO is concerned that physician self-referral is leading to certain doctors making clinical decisions based on increasing profits rather than providing the best care for patients. Along with the Alliance for Integrity in Medicare (AIM), we urge Congress to end self-referral abuses by supporting the Promoting Integrity in Medicare Act (H.R. 2914), which closes the in-office ancillary services (IOAS) exception loophole in current federal self-referral laws and limits its use to integrated and truly collaborative multi-specialty group practices.

The physician self-referral law, the Ethics in Patient Referrals Act, prohibits physicians from referring a patient to a medical facility in which he or she has a financial interest to ensure that medical decisions are made in the best interest of the patient without consideration of any financial gain. Unfortunately, a loophole — the IOAS exception — allows physicians to refer patients for radiation oncology treatments and certain other services in which they have a financial interest. Medicare is then billed for often more expensive services, regardless of whether or not these treatments are in the best interest of the patient. According to numerous independent reports, abuse of this IOAS exception has led to increased costs to patients and Medicare, as well as inappropriate use of diagnostic and therapeutic services. Often, the patient is not even aware that their physician has a financial interest in which treatment they choose.

Introduced by Rep. Jackie Speier (D-Calif.) and Rep. Jim McDermott (D-Wash.), the Promoting Integrity in Medicare Act of 2013 (PIMA) results in better care for patients and could save the Medicare program billions of dollars that could help offset the costs of repealing the Medicare sustainable growth rate (SGR) formula.

H.R. 2914 protects patients and reduces Medicare costs by closing the costly IOAS loophole and limits self-referral for certain complex services to restore the exception’s original intent.
Patient Care Suffers Under Self-referral Arrangements

Recent reports by the Government Accountability Office (GAO), in *The New England Journal of Medicine (NEJM)*, and from others consistently show that physician self-referral leads to increased utilization of services that may not be medically necessary, poses a potential risk of harm to patients and costs the health care system millions of dollars each year.

The GAO report on radiation therapy released in August 2013 concluded that financial incentives for self-referring providers—specifically those in limited specialty [urology] groups—were likely a major factor driving the increase in the percentage of prostate cancer patients referred for intensity modulated radiation therapy (IMRT), an effective, yet expensive form of cancer treatment, which may not always be the most appropriate treatment. A study published in the *NEJM* in October 2013 had similar results, finding that IMRT utilization among self-referring groups increased significantly once they acquired ownership of IMRT services.

Several notable bipartisan groups have endorsed closing the self-referral loophole, including the Bipartisan Policy Center, under the leadership of former Senate Majority Leaders Tom Daschle (D-S.D.) and Bill Frist (R-Tenn.), and the Moment of Truth Project, headed by Erskine Bowles and former Senator Alan Simpson (R-Wyo.).

Mainstream media has shined a harsh light on self-referral abuses, with publications such as *The Wall Street Journal, Washington Post, Baltimore Sun* and *Bloomberg News* reporting that physician self-referral, specifically urology-ownership of radiation therapy services, results in a detrimental impact on patient care and drives up health care costs in the Medicare program.

**Closing the self-referral loophole is not only the best way to protect cancer patients, but it would produce significant savings for the Medicare program.** Ending self-referral abuse is on several policy lists under consideration to help offset the cost of fixing the Medicare physician payment formula or other health care priorities. The President’s FY 2015 budget estimated more than $6 billion in savings by closing the self-referral loophole.

“Federal policy should drive doctors to make decisions based on quality of care, not financial relationships.”
— Senator Chuck Grassley (R-Iowa)

**ASTRO and its allies in the Alliance for Integrity in Medicare (AIM) urge Congress to end self-referral abuses by closing the IOAS loophole and limiting the use of the exception to robust, integrated and truly collaborative multi-specialty group practices.**
Key findings from the GAO and NEJM studies

**THE GAO REPORT FOUND FROM 2006 - 2010**

- IMRT utilization among self-referring groups **increased** by **356 percent**. Overall increases in IMRT utilization rates and spending were due entirely to services performed by limited-specialty urology groups. IMRT utilization among **non-self-referrers decreased by 5 percent**.

- The number of IMRT services performed by limited specialty urology groups **increased** by **509 percent**, while true multi-specialty groups’ IMRT use **decreased** by **3.8 percent**.

- IMRT spending by self-referral groups **increased** by approximately $138 million, compared to a **$91 million decrease** in the non-self-referral group.

- Self-referring centers referred **more than 50 percent** of men over the age of 75 for IMRT at self-referring centers. For these men, guidelines recommend active surveillance of their disease and the avoidance of aggressive treatment such as IMRT.

A STUDY PUBLISHED IN NEJM FOUND FROM 2008 - 2010

- Urologists who acquired ownership of IMRT services **increased** their use of IMRT **substantially** more than urologist, who did not own such services.

- IMRT utilization among self-referring groups **increased** from 13.1 percent to **32.3 percent** once they became self-referrers, an increase of 19.2 percentage points (146 percent).

- IMRT utilization among the subset of 11 self-referring urology practices near NCCN centers **increased** from 9 percent to **42 percent**, an increase of 33 percentage points (367 percent), from the pre-ownership to the ownership period, compared to an insignificant increase of 0.4 percentage points at NCCN centers.

- The data demonstrated decreases in utilization of other effective, less expensive treatment options by self-referring urologists. Use of **brachytherapy decreased** by **14.9 percentage points** to just 2.7 percent of patients receiving this treatment in self-referring urology practices.
ASTRO backs efforts to move toward a Medicare payment system driven by quality, rather than volume, and we support the bipartisan, bicameral legislation to permanently repeal the flawed Medicare sustainable growth rate (SGR) formula and provide a framework for physician payment reform.

**ASTRO encourages Congress to include provisions that would close the physician self-referral loophole as a way to offset the cost of the SGR repeal legislation.**

The inclusion of PIMA in an SGR payment package represents sound policy that protects patients and generates substantial savings to the Medicare program. Furthermore, we believe PIMA is consistent with the consensus SGR repeal legislation, as it would bridge the gap between the current fee-for-service system and the new payment system by ensuring that clinical decisions are not unduly influenced by financial gain. In addition, clarifying that only truly integrated, multi-specialty group practices participating in robust alternative payment models (APMs) would not be impacted by narrowing the exception is another way to encourage physicians to make the important move toward practicing within an APM.

Closing the IOAS loophole generates more than $6 billion in savings to the Medicare program, which could be used to offset the cost of repealing the SGR.

**Cost Difference Between Combined 10 Year Short-Term SGR fixes and Permanent SGR Fix**  
*[in billions of dollars]*

<table>
<thead>
<tr>
<th></th>
<th>Cost of 2014 bicameral, bipartisan permanent fix</th>
<th>Combined cost of short-term fixes since 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$170</td>
<td>$171</td>
</tr>
</tbody>
</table>

Since 2003, Congress has passed 16 short-term “doc fixes” to stabilize provider payments. These numbers combined represent roughly the same total amount estimated as needed to legislate a permanent fix.
ASTRO applauds Congress’ long-standing support for biomedical research and appreciates the role this funding has played in every major innovation in the fight against cancer, including significant advances in radiation oncology. This support has led to a decline in the overall number of cancer deaths in the United States. Now, thanks to advances in radiation oncology research and other cancer breakthroughs, more than two-thirds of cancer patients survive five years or longer after their cancer diagnosis.

The National Institutes of Health (NIH) and the National Cancer Institute (NCI) are central foundations for cancer research activities in the United States and abroad. However, despite many successes, additional progress in certain areas, including radiation oncology, has been hampered because funding has not kept pace with research needs. In a 2012 report to Congress, the NIH acknowledged that less than 1 percent of the total NIH budget in Fiscal Years 2010 and 2011 was spent on radiation oncology research, and just over 4 percent of NCI’s budget was spent on radiation oncology-specific projects in Fiscal Years 2010 and 2011. With more than two-thirds of cancer patients receiving radiation as a part of their treatment, the funding for radiation oncology research is not adequate to achieve new discoveries in the field. Sustainable and predictable funding for radiation oncology research in the fight against cancer is critical to the continued advancement of treatment and the quest for a cure.

Under sequestration, NIH funding was cut by an estimated $1.5 billion (5.1 percent), including more than $450 million from cancer research funding, with the FY 2014 omnibus spending bill only partially restoring funding to pre-sequestration levels, setting aside only $29.93 billion for next year. This amount is roughly $950 million less than the 2012 NIH appropriation.

A critical component for advancing cancer research is the ability to test promising new treatments in large, multicenter randomized studies. For more than five decades, NCI has funded large studies through its cooperative group program, which was recently rechristened as the National Clinical Trials Network (NCTN). Due to NCI budget cuts, enrollment in NCTN clinical trials will be reduced by 30 percent in FY 2014. Reducing patient enrollment impacts the progress of ongoing trials and slows the development of new cures. These are the studies that change the course of cancer care in the United States and internationally; a slow-down in development or accrual to these trials slows down the progress that we can make in the fight against cancer.
Restoring funding lost to sequestration and preventing further cuts to NIH research will drastically affect NIH’s and NCI’s ability to take advantage of new and emerging technologies. Sustained funding in the fight against cancer is critical to achieving long-term and permanent success.

ASTRO is asking Congress to provide sustainable and predictable funding in Fiscal Year 2015 by allocating $32 billion for NIH and $5.26 billion for NCI and direct additional funds to radiation oncology research.

Preserve and Increase Graduate Medical Education Funding

The Graduate Medical Education (GME) program supports graduated medical students’ progress to become competent practitioners in medicine, including radiation oncology. These programs allow trainees to develop the knowledge and skills needed for independent practice. GME plays a major role in addressing the nation’s physician workforce needs, as GME is the ultimate determinant of the output of physicians. The federal government contributes approximately $10 billion in Medicare funds to help fund GME annually.

While the need to develop the GME program grows, funding cuts continue to hinder the program. The President’s FY 2015 budget proposes to cut the program by approximately $14.6 billion over 10 years. Cutting these payments comes at a critical time when many hospitals currently have problems funding their current residents.

ASTRO urges Congress to preserve critical GME funding to support residency programs crucial for training the next generation of doctors treating cancer patients nationwide.
The Association of American Medical Colleges (AAMC) and others project a shortage of 91,500 doctors (including 46,100 specialists) by 2020; by 2025, the shortage will grow to 130,600 physicians (including 64,800 specialists). This year, several hundred U.S. medical students did not match to a first-year residency training program.

Increase the Number of GME Training Positions

This year, approximately 30 million individuals will begin to receive health care insurance, while physician shortages continue to increase. With proper cancer treatment and care being critical, ASTRO believes that educating and training a strong physician workforce is an important issue facing our health care system.

While the President’s FY 2015 budget proposes a new workforce initiative to expand residency training, existing caps on the number of Medicare-funded GME positions established in 1997 make it impossible to fund sufficient GME training positions to address the growing shortage of physicians. ASTRO supports legislation in the House and Senate that would increase the number of Medicare-supported training positions for medical residents. S. 577, H.R. 1180 and H.R. 1201 would provide for approximately 15,000 additional GME positions for medical residents and require at least 50 percent of the new positions to be allocated to specialties.
American Society for Radiation Oncology

ASTRO's mission is to advance the practice of radiation oncology by promoting excellence in patient care, providing opportunities for educational and professional development, promoting research and disseminating research results and representing radiation oncology in a rapidly evolving health care environment.

Radiation oncologists, radiation oncology nurses, medical physicists, radiation therapists, dosimetrists and biologists comprise ASTRO's **more than 10,000 members who treat more than 1 million cancer patients each year**. These medical professionals, found at hospitals and cancer treatment centers, make up the radiation therapy treatment teams that are critical in ensuring that patients receive safe and effective cancer care.

**Radiation oncologists use radiation to cure cancer, to control the growth of the cancer or to relieve pain and other cancer symptoms.** Radiation therapy works by damaging the DNA in cancer cells so that they cannot repair or reproduce. New technology and improved techniques allow radiation oncologists to better target radiation to eliminate cancer cells while protecting healthy cells, thereby reducing side effects while better controlling the cancer.

Radiation oncology services are a unique treatment option separate and apart from the medical process leading to the diagnosis of cancer. When a physician determines that radiation therapy may be a treatment option for a patient, a referral is made to a radiation oncologist. As highly trained specialists, radiation oncologists know the various forms of radiation therapy, their efficacy in specific cases and the potential side effects and risks.

Thanks to remarkable advances in radiation oncology and technology, doctors are able to treat breast cancer without removing the breast and brain tumors without having to open a person’s skull. With oral cancer, for example, radiation therapy allows doctors to treat a mouth tumor without disfiguring surgery. Radiation therapy is less invasive than many other cancer treatments, making it an attractive option for men and women, young and old, who want to maintain their lifestyles and careers while receiving treatment.

A culture of safety and quality control is woven into the fabric of the radiation oncology field, with checks and balances at every level to ensure that the safest and most effective care is delivered to patients. To improve safety and quality, ASTRO is launching **APEx – Accreditation Program for Excellence** to recognize high-quality radiation oncology clinics by objectively evaluating the radiation oncology team, the facility itself and its policies and procedures. APEx was created to ensure accountability in radiation therapy practices through standards of performance derived from evidence-based guidelines and consensus practice for radiation oncology.

In addition, ASTRO is using the framework and protections provided by Congress in the Patient Safety Act of 2005 to create **RO-ILS: Radiation Oncology Incident Learning System**, a first-of-its-kind national error reporting system for radiation oncology to help identify and learn from medical errors and near-misses to prevent future incidents.