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US House Passes Bipartisan Bill to Repeal SGR

On March 26, the US House of Representatives passed the Medicare Access and CHIP Reauthorization Act (HR 2) to permanently replace the Medicare Sustainable Growth Rate (SGR) formula. The measure passed by a vote of 392 to 37.

Key provisions of the bull include:

- **Repeal and Replace Medicare Physician Payment System:** The legislation repeals the flawed SGR formula and replaces it with the bicameral, bipartisan agreement that moves the Medicare payment system toward improved value and returns stability to physician payments. Under the law, providers will receive an annual update of 0.5 percent in each of the years 2015 through 2019. The rates in 2019 will be maintained through 2025, while providing professionals with the opportunity to receive additional payment adjustments through the Merit-Based Incentive Payment System (MIPS). In 2026 and subsequent years, professionals participating in alternative payment models (APMs) that meet certain criteria would receive annual updates of one percent, while all other professionals would receive annual updates of 0.5 percent.
- **Funds the Children's Health Insurance Program (CHIP):** The legislation preserves and extends CHIP, fully funding the program through September 30, 2017.
- **Extends Medicare, Medicaid, and Other Health Extenders**: The legislation extends all of the extenders included in the Protecting Access to Medicare Act of 2014.
- **Medicare Reforms**: This legislation includes other Medicare reforms, including the Protecting Integrity in Medicare Act (HR 1021), which strengthens Medicare's ability to fight fraud and builds on existing program integrity policies.

The estimated $70 billion in pay-fors in the legislation are achieved by both reductions in Medicare payments to providers as well as increased out-of-pocket costs for higher-income beneficiaries and an increase in Part B deductibles for Medigap plans.

According to the House Republican's summary, HR 2 contains a number of policies that reduce its cost, including:

- **Medigap Reform:** This legislation limits first dollar coverage on certain Medigap plans by prohibiting plans from covering the Part B deductible. Under current law, some Medigap plans provide first-dollar coverage for beneficiaries, meaning that the plan pays both the deductibles and the copayments. The change in law proposed by H.R. 2 would take effect to any plans sold to new beneficiaries starting in 2020.
- **Income-Related Premium Adjustment:** This legislation would, starting in 2018, increase the percentage that beneficiaries pay toward their Part B and D premiums in two income brackets (approximately 2 percent of beneficiaries): for individuals with income between $133,500 and $160,000 ($267,000-$320,000 for a couple), the percent of premium paid increases from 50 percent to 65 percent; for individuals with income between $160,000 and $214,000 ($320,000-$428,000 for a couple), the percent of premium paid increases from 75 percent to 80 percent.

- **Market Basket Update:** HR 2 replaces the market basket update in 2018 with a one percent update for long-term care hospitals (LTCHs), skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), home health provides (HH), and hospice providers.
- **Medicaid Disproportionate Share Hospitals (DSH):** Currently, reductions in state DSH allotments are scheduled to begin in FY2017. This policy would delay Medicaid DSH changes until FY2018 and extend the policy through 2025.
- **Levy on Medicare Providers for Nonpayment of Taxes**: This provision permits the IRS to impose a levy of up to 100 percent on tax delinquent Medicare service providers.
- **Adjustments to Inpatient Hospital Payment Rates:** Under current law, hospitals will receive a 3.2 percentage point adjustment in addition to their base payment rate in FY18. These policies would phase-in this update incrementally and prohibit CMS from collecting a recoupment from 2010.

The nonpartisan Congressional Budget Office (CBO) released an estimate predicting the House SGR deal would cost $141 billion over 10 years.

CBO analyses also found that enacting HR 2 would raise federal costs relative to current law during the decade after 2025. However, compared with the costs of freezing Medicare's payment rates for physicians' services, the CBO predicts the legislation could represent a small net savings.

The White House officially endorsed the House's SGR-CHIP measure. "The Administration supports House passage of HR 2 because it would reform the flawed Medicare physician payment system to incentivize quality and value (a proposal called for in the President's Fiscal Year 2016 Budget), would make reforms that could help slow health care cost growth, and would extend other important programs such as health care coverage for children," according to a White House policy report.

The US Senate adjourned on March 27 for recess and returns to Washington on April 13, at which time the upper chamber will take up debate on HR 2.

The current SGR patch expired on April 1. However, CMS has the ability to hold claims for two weeks in order to give the Senate time to act before impacting physician rates.

To view the Medicare Access and CHIP Reauthorization Act, click here.

To read the bill's section-by-section summary, click here.

Senate, House Pass Budget Resolutions

Senate Budget Resolution

The US Senate approved its Budget Resolution for FY 2016 on March 27 by a 52-46 vote.

The Senate budget resolution calls for $430 billion in unspecified savings from Medicare as part of a plan to cut $5.1 trillion in spending, and balance the budget in 10 years without

raising taxes. The Senate proposal also assumes $2 trillion in savings from a full repeal of the Affordable Care Act.

The Senate budget resolution will boost the nation's economic growth by more than $500 billion over the next ten years, according to the non-partisan Congressional Budget Office (CBO) estimate.

House Budget Resolution

The US House passed its Budget Resolution by a vote of 228 -199 on March 25.

According to the House Budget Committee's summary, the House resolution:

- Balances the budget in less than 10 years without raising taxes
- Cuts $5.5 trillion in spending
- Calls for a fairer, simpler tax code to promote job creation and a healthy economy
- Repeals Obamacare in full – including all of its taxes, regulations and mandates
- Eliminates IPAB

The two chambers of Congress will negotiate a compromise budget in mid-April when they return from recess.

House Energy and Commerce Committee Examines 340B Program

The House Energy and Commerce Health Subcommittee assessed the state of the 340B drug discount program at a hearing on March 26, as lawmakers mulled possible reform.

At the hearing, discussion centered around two central ideas. First, lawmakers examined the use of 340B funds in hospital settings. Second, the committee considered an expanded federal regulation of the program. In the end, both Democrats and Republicans concluded that 340B requires greater oversight and transparency.

- ***Transparency****:* While most health providers participating in the 340B program must demonstrate they serve a vulnerable population and reinvest resources directly into services for those populations, hospitals aren't required to track how funding is used. Therefore, a number of lawmakers asked for more information regarding hospitals' use of 340B funds.

- ***Oversight***: Following a 2014 court ruling, HRSA's rulemaking authority was limited to three areas: ceiling prices, dispute resolution and civil monetary penalties. Therefore, instead of overarching regulation, the agency plans to write rules only for those three areas and write guidance for other aspects of the program. At the hearing, however, lawmakers considered a change. For instance, Rep. Morgan Griffith (R-VA) asserted that Congress has the authority to grant HRSA the rule making authority over additional aspects of law, such as "patient eligibility."

According to news reports, many stakeholders and lobbyists believe the hearing may serve as a precursor to legislation that monitors the use the savings from the 340B drug discount program in hospitals and clarifies which patients for whom hospitals may claim discounts.

The full list of witnesses included:

- Diana Espinosa, Deputy Administrator for Health Resources and Services Administration (HRSA)
- Debbie Draper, Health Care Director at the Government Accountability Office (GAO)
- Ann Maxwell, Assistant Inspector General for Evaluation and Inspection at the Office of Inspector General

The 340B Program – which intends to make care more accessible and affordable for America's most vulnerable patient populations – offers eligible safety net providers discounts for medications. However, since its inception, the program has garnered criticism from stakeholders and lawmakers alike who are concerned that the program lacks oversight and is being used to garner profits opposed to help underserved patients.

To watch the full hearing, CLICK HERE.

New Study Refutes Claims that Self-Referral Encourages Inappropriate Utilization or Increased Medicare Spending

The American Medical Association (AMA) released a study this week completed by independent actuarial firm Milliman, Inc., which analyzes Medicare claims data for specific self-referred services provided under the in-office ancillary services exception (IOASE) to the Stark Law including advanced imaging and intensity-modulated radiation therapy (IMRT).

In the study, "Outpatient ancillary trends in the Medicare fee-for-service population: 2008-2012," Milliman reviewed Medicare claims from 2008 to 2012 from a five percent sample of Medicare fee-for-service enrollees to examine changes in spending and utilization for select services.

Specific to IMRT, the study finds lower growth of utilization and expenditures in physician offices, which has led to a decline in the share of spending in physicians' offices. The in-office share of total spending for IMRT showed a decline from 59 percent in 2008 to 53 percent in 2012.

Key study findings include:

- For most of the ancillary services, the proportion provided in physician offices compared to hospital settings is relatively small, suggesting that imposing pay cuts or self-referral restrictions on these services will not produce significant savings.
- In general, five-year annualized utilization and spending trends for these services show declining and even negative growth rates in office settings.
- These trends indicate that concerns about potential cost and utilization related to physician ownership are unwarranted.

- By the end of the study period, utilization growth in hospital outpatient departments was outpacing growth in physician offices for all four categories of ancillary services examined.
- There is a real risk that policies intended to preclude or discourage physician investment in ancillary services could backfire by accelerating their movement out of physicians' offices where Medicare and its beneficiaries often pay less than when the identical services are provided in the hospital.

According to the AMA summary, "As shown in this analysis, the cost and utilization trends for the services in question do not support arguments that physician ownership of the services leads to overutilization and increases Medicare spending. In fact, they suggest that to the contrary, efforts to discourage availability of these services in physician's office could actually increase costs to Medicare and its beneficiaries."

To read more from the AMA, CLICK HERE.

To download the AMA report summary, CLICK HERE.

To download the full study, CLICK HERE.

GAO Analyzes Medicare Payments to Certain Cancer Hospitals

The U.S. Government Accountability Office (GAO) released a new report on March 23, comparing average payments for services in PPS-exempt cancer hospitals (PCH) and teaching hospitals paid under Medicare's prospective payment systems (PPS).

The report, entitled "Payment Methods for Certain Cancer Hospitals Should Be Revised to Promote Efficiency," centers on payment differentials for both inpatient and outpatient services in PCHs and PPS teaching hospitals. Specifically, it examines:

- Characteristics of PCHs with those of PPS teaching hospitals;
- Inpatient and outpatient methodologies Medicare uses to pay PCHs and PPS teaching hospitals; and
- Medicare payments to PCHs with payments to PPS teaching hospitals.

The GAO concluded that Medicare payments – in both inpatient and outpatient settings – were substantially higher at PCHs than at PPS teaching hospitals in the same geographic area for beneficiaries with the same diagnoses or services, based on 2012 data used in the study. In fact, PCHs received an average of about 42 percent more in Medicare inpatient payments and 37 percent more in outpatient payments than comparable PPS teaching hospitals.

According to the report, flawed incentives may have driven the vast cost discrepancies. The GAO states that "compared with how PPS teaching hospitals are paid, the methodologies for paying PCHs provide little incentive for efficiency."

Ultimately, GAO recommends that "Congress should consider requiring Medicare to pay PCHs as it pays PPS teaching hospitals, or provide the Secretary of Health and Human Services (HHS) with the authority to otherwise modify how Medicare pays PCHs. In doing so, Congress should provide that all forgone outpatient payments be returned to the Trust Fund."

For the full GAO report, CLICK HERE.