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Congress Introduces Bipartisan Bill to Repeal SGR



Congressional leaders introduced long-awaited legislation (HR 1470) on March 19 regarding physician payments that would replace the flawed Medicare Sustainable Growth Rate (SGR) – yet only partially cover its cost – before the April 1 deadline.

The deal to replace SGR and extend other Medicare pay policies would cost an estimated \$213 billion, only \$70 billion of which Congress will assign offsets for in the proposed legislation. Half of the \$70 billion would come from provider cuts, and the other half would come from the policy changes that mostly affect beneficiaries – such as increased Part B and Part D premiums for high-income individuals. House Republicans stated, however, that “[r]emaining offsets would be accounted for in budget resolution,” in a bill summary, leaked to the press this week.

In addition to full repeal of SGR, the new proposal would:

- Ensure a 5-year period of annual updates of 0.5 percent each year
- Improve the existing fee-for-services system by rewarding value over volume
- Incentivize movement to alternate payment models
- Expand the use of Medicare data for transparency and quality improvement
- Extend the Children's Health Insurance Program (CHIP)
- Permanently fund the Medicare Qualifying Individual Program (QIP)
- Prolong typical Medicare and Medicaid extenders through FY 2017

Senate Democrats, however, are resisting the House-negotiated deal less than two weeks before a patch averting cuts to doctors is set to expire, including Senate Finance Committee Ranking Member Ron Wyden (D-OR), who came out in opposition on the bill this week.

On March 16, more than 750 organizations including the American Medical Association (AMA) sent a letter to Congress, calling on lawmakers to pass legislation to permanently eliminate the SGR formula and strengthen Medicare for America's seniors.

"It is our fervent hope that the bipartisan, bicameral policies developed by the previous Congress will be advanced and, under your leadership, enacted into law. We urge you and all members of the House and Senate to take the necessary steps to achieve this long standing goal," the groups wrote.

Others, including AARP, voiced concerns over some of the proposal's key tenets. AARP warned in a March 17 letter against shifting the cost burden to seniors, especially as the physician community was exempted from contributing financially to the fix.

"We are very concerned about the current construct of the package, which puts the financial burden on Medicare beneficiaries by asking them to pay for \$35 billion of the \$70 billion offset," wrote AARP. "Asking these Americans to pay more for Medigap policies – either through a deductible, restriction of first-dollar coverage or other avenues – amounts to a tax on seniors."

Since 2003, Congress has enacted multiple temporary solutions through delays or slight pay increases, known as a "doc-fix," to maintain the SGR. Without such patches, many believe that providers would back out of the Medicare program, leaving seniors with reduced access to care. Bipartisan supporters have long hoped that repeal would help ensure long-term stability, but have been previously unable to agree on pay-fors.

To view the legislation, [CLICK HERE](#).

To read the House talking points on the bill, [CLICK HERE](#).

To read the physician group letter, [CLICK HERE](#).

To read the AARP letter, [CLICK HERE](#).

MedPAC Once Again Recommends Site-Neutral Payment Reform



The Medicare Payment Advisory Commission (MedPAC) released its annual report to Congress on Medicare payment policy last week, which analyzed payment adequacy under Medicare's fee-for-service (FFS) payment system.

Similar to MedPAC's previous recommendations, the Commission called for site-neutral payment policies to equalize Medicare payments for the same services offered in different care settings.

MedPAC states, “We recommend site-neutral payments for certain select conditions between two post-acute care sectors: skilled nursing facilities and inpatient rehabilitation facilities. This recommendation builds on our past recommendations for site-neutral payments between hospital outpatient departments and physicians’ offices for certain services, and for consistent payment between acute care hospitals and long-term care hospitals for certain classes of patients. Medicare often pays different amounts for similar services across sectors. Site-neutral payments that base the payment rate on the less costly sector can save money for Medicare, reduce cost sharing for beneficiaries, and reduce the incentive to provide services in the higher paid sector, without compromising beneficiary access to care or health outcomes.”

In the report, MedPAC offers a number of other recommendations for annual rate adjustments under Medicare’s various FFS payment systems, including:

- Repeal the Medicare Sustainable Growth Rate (SGR) before the April 1 deadline
- Increase shared savings opportunities for physicians and health professionals in Accountable Care Organizations (ACOs);
- Update inpatient and outpatient hospital payment rates 3.25 percent for 2016;
- Identify overpriced fee-schedule services and reduce their relative value units (RVUs) accordingly.

For the full report, [CLICK HERE](#).

For the official fact sheet, [CLICK HERE](#).

Medicare to Publish Physician-Payment Data Next Month

Reports indicate the Centers for Medicare & Medicaid Services (CMS) plans to release the second round of Medicare physician payment data in April.

According to a [Wall Street Journal](#) report in February, a spokeswoman for CMS said the government has decided “to update the data annually” despite the concerns of doctors’ groups.

In April 2014, CMS released physician payment data for the first time, during which time the agency made detailed payments to 880,000 individuals and organizations totaling more than \$77 billion from the Medicare program in 2012, covering more than 5,000 different procedures, available to the public.

Several physician groups, including the [American Medical Association](#) (AMA), have expressed serious concerns regarding the data dump, urging CMS to offer more context for the services doctors performed specific to payment data. For instance, total payments might appear high for some physicians when several people from one office bill under a single provider number. Further, the data billed by a single physician doesn’t accurately represent what the doctor actually earned in income under Medicare.

U.S. Supreme Court Examines Health Insurance Subsidies in King v. Burwell

The Supreme Court heard oral arguments in King v. Burwell on March 4 – a case that could impact subsidies for low-income Americans purchasing health insurance on federally facilitated exchanges established through the Affordable Care Act (ACA).

Judges will now consider vague wording in the ACA, which authorizes premium tax credits for people in states with exchanges “established by the state.” Plaintiffs in the case have argued that the federal government does not have the authority to subsidize insurance premiums for Americans in the 37 states that did not create their own exchange. The court will likely issue a final decision in June.

Overall, the oral arguments offered few clues as to how the court will decide. For instance, Chief Justice Roberts – who many view as a potential swing vote in the case – did not ask any questions. However, Justices Kennedy, Ginsburg, and Alito raised three unexpected questions.

- Justice Kennedy – another potential swing vote – raised the idea of “federal coercion,” suggesting that by removing subsidies, “[t]he States are being told either create your own exchange, or we’ll send your insurance market into a death spiral.”
- Justice Alito raised the possibility that, in the event that the Supreme Court did rule against the health care law, it could maintain tax credits until the end of the year.
- Justice Ginsburg challenged the plaintiffs’ argument of whether the people challenging the ACA were actually being harmed by the law.

The Obama Administration, as well as many proponents of the ACA, worry that eliminating federal subsidies will threaten the viability and affordability of health plans selected by 8.6 million people in 37 states. The Department of Health and Human Services (HHS) estimated that if the Supreme Court were to rule in favor of the plaintiff, individual premiums would increase by an average of 256 percent.

For a full transcript of the oral arguments, [CLICK HERE](#).

CMS Considers Expansion of Coverage for PET Cancer Scans

Federal officials are considering the expansion of Medicare coverage for position emission tomography (PET) scans that utilize Sodium Fluoride F-18 (NaF-18) – a substance used to check for unusual growths in bones.

Currently the Centers for Medicare & Medicaid Services (CMS) only cover such tests for those participating in the National Oncologic PET Registry (NOPR), a requirement that

is part of the agency's "coverage with evidence development" approach to assessing medical procedures. However, NOPR's leaders are now calling for national Medicare coverage for the PET scans, which allowed participating physicians to avoid ordering additional noninvasive tests in 71 percent of cases and invasive procedures in 66 percent.

"The NOPR has been successful in meeting the goal for which it was established -- providing clear, extensive data on the previously little-researched question of whether there is a clinical benefit" of using the scans to identify bone metastasis, wrote Bruce E. Hillner, the chair of the NOPR with his co-chairs, Barry A. Siegel and Anthony F. Shields, in a Feb. 15 letter to CMS.

CMS will accept comments as part of the national coverage analysis (NCA) process through April 15. The agency will release an initial proposal on September 16. A final decision will then be issued by December 15.

To view the CMS Tracking Sheet for analysis of NaF-18 PET scans, [CLICK HERE](#).

To read the NOPR letter, [CLICK HERE](#).

HHS Unveils Next Generation Accountable Care Organization Model



The Department for Health & Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) introduced a new accountable care organization (ACO) model this month, as part of the Obama Administration's plan to further bolster quality of care, rather than quantity.

CMS says the new model – which will replace the previous “pioneer program” – will set “predictable financial targets,” enable “greater levels of financial risk so that providers have more opportunities to coordinate beneficiaries’ care,” and maintain “the highest of quality standards consistent with other Medicare programs and models.”

Specifically, the core principals of the Next Generation ACA Model are:

- Protecting Medicare FFS beneficiaries’ freedom to seek the services and providers of their choice;
- Creating a financial model with long-term sustainability;
- Utilizing a prospectively-set benchmark that: (1) rewards quality; (2) rewards both improvement and attainment of efficiency; and (3) ultimately transitions away from an ACO’s recent expenditures when setting and updating the benchmark;

- Engaging beneficiaries in their care through benefit enhancements that directly improve the patient experience and reward seeking care from ACOs;
- Mitigating fluctuations in aligned beneficiary populations and respecting beneficiary preferences through supplementing a prospective claims-based alignment process with a voluntary process; and
- Smoothing ACO cash flow and improving investment capabilities through alternative payment mechanisms.

“This model is part of our larger effort to set clear, measurable goals and a timeline to move the Medicare program -- and the health care system at large -- toward paying providers based on the quality, rather than the quantity of care they give patients,” said HHS Secretary Sylvia M. Burwell in a statement.

In the first year of the “pioneer program,” 118 ACOs saved Medicare \$705 million, while another 102 ACOs spent more than the program’s benchmark. ACOs were previously able to serve up to 5,000 patients, but will now be able to serve up to 10,000 in the Next Generation model.

For the official press release, [CLICK HERE](#).

For the CMS blog post, [CLICK HERE](#).

For the Next Generation ACO Model fact sheet, [CLICK HERE](#).

CDC Unveils Report on Invasive Cancer Incidence and Survival

A new report from the Centers for Disease Control (CDC) reveals that 65 percent of Americans with invasive cancers are living at least five years after their diagnosis.

The report, which focuses on data from 2011, cited “improvements in early detection and treatment of cancer” as the primary factor behind the number. The agency typically only provides estimates of cancer incidence, but provided statistics on survival for the first time in the report.

Survival rates were highest for prostate cancer (97 percent) and breast cancer (88 percent), and lowest for lung cancer (18 percent).

Overall, the CDC said a total of 1,532,066 invasive cancers were reported to cancer registries in the United States (excluding Nevada), for an annual incidence rate of 451 cases per 100,000 persons.

For the full study, [CLICK HERE](#).

Maryland Legislature Considers Law Allowing Integrated Cancer Care

Legislation has been introduced in the Maryland General Assembly (H.B. 944 and S.B. 539), which would exempt oncologists from the state's self-referral restrictions on radiation therapy and imaging services. Maryland is currently the only state in the country that prohibits physician offices from integrating medical oncology, imaging and radiation therapy services under the same roof.

Dr. David H. Smith – a practicing oncologist in Maryland who testified before Maryland lawmakers – argued that the integration of cancer care services would “improve the standard of care, enhance comfort and cut costs for cancer patients.”

Smith also penned an op-ed in *The Star Democrat*, in which he advocates for the policy change and highlights the law's potential impact on breast cancer patients he serves on the state's Eastern Shore.

“Breast conservation is undoubtedly the best option for patients and the standard of care in breast cancer treatment,” he wrote. “However . . . many of my patients face travel totaling 3,000 miles over a six-week course of radiation treatment, which many can't accommodate. As a result, many have opted for mastectomies instead of the inconvenience associated with conservation. Forcing patients to make this decision is disconcerting and unfair. Maryland patients deserve the best treatment, yet we limit access by preventing the integration of oncology services.”

The complementary bills were considered by lawmakers in two hearings this month – one in the Senate and one in the House of Delegates.

To read Dr. Smith's op-ed, [CLICK HERE](#).