President Obama Addresses Nation in State of the Union

On Tuesday, January 28, President Barack Obama gave his sixth State of the Union Address to Congress and the American public.

Specific to healthcare, the President did not offer any new policy proposals. He highlighted some achievements of the Affordable Care Act – coverage for individuals with pre-existing conditions – and encouraged more Americans to sign up for healthcare coverage under the exchange before the March 31 deadline. The President also called on Republicans to cease efforts to repeal the healthcare reform law.

CBO Releases Cost Estimates for SGR Repeal Bills

- **CBO score of H.R. 2810**, SGR Repeal and Medicare Beneficiary Access Act of 2013: The Congressional Budget Office (CBO) estimates the House Ways and Means bill would cost $121 billion over 10 years.

- The CBO also reduced its estimate of the House Energy and Commerce SGR bill from $175 billion to $146 billion.

- **CBO score of S. 1871**, SGR Repeal and Medicare Beneficiary Improvement Act of 2013: CBO estimates that enacting S. 1871 would increase direct spending by $150.4 billion over the 2014-2023 period.

The American Medical Association has released a chart outlining how the three SGR repeal bills would change current law.

On January 30, a list of potential offsets was circulated on Capitol Hill, however, the menu of offsets was not formally released or endorsed by any Committee. Categories of the potential offsets relating to:

- Low-income Beneficiaries
- High-income Beneficiaries
- Finance & Tax
- Medical Education & Physicians
- Prescription Drugs & Manufacturers
- Providers or Facilities
- Medicare Part B and Part D
- Medicaid
- Medicare

The options included in the list were sourced to (1) the President's Budget, (2) the Congressional Budget Office, and (3) the Bipartisan Policy Center.
MedPAC Votes to Equalize Site Payments

The Medicare Payment Advisory Commission (MedPAC) presented 2015 payment recommendations for updating Medicare payment policies in January, which included a recommendation to align Medicare payments for patient services provided in hospital outpatient departments (HOPD) and freestanding settings.

MedPAC recommends adjusting payment rates in 66 Ambulatory Payment Classifications (APCs) for hospital payments, which MedPAC projects will reduce hospitals' Medicare revenue by 0.6 percent.

MedPAC supports payment reductions for services provided in the HOPD so that the total payment for HOPD services does not exceed total Medicare payments where the services are provided in the freestanding setting. MedPAC estimates that aligning payment rates across settings will reduce Medicare hospital and beneficiary spending by $1.1 billion annually.

The Commission's recommendations will likely be included in MedPAC's report to Congress due in March.

CMS to Release Physician Payment Data

The Centers for Medicare and Medicaid Services (CMS) will consider individual requests for obtaining physician information on Medicare payments, CMS announced on January 17.

Under the new policy, CMS will assess requests for releasing amounts paid to a physician under Medicare. CMS will determine on a case-by-case basis if the request meets the standards for releasing information under exemption 6 of the Freedom of Information Act. This provision requires balanced consideration of the physician's privacy and the public interest.

In addition to releasing payment data for individual physicians participating in the Medicare program, CMS announced it will make public aggregate data sets on Medicare physician services.

CMS Principle Deputy Administrator Jonathan Blum cited specific benefits of making physician payment data available to the public as offered in comments by organizations during the comment period, including:

- Providers to collaborate on improved care management and the delivery of healthcare at lower costs;
- Consumers to gain broader, more reliable measures of provider quality and performance which drives innovation and competition while informing consumer choice; and
- Journalists and others to identify waste, fraud, and abuse as well as unsafe practices.

The new policy will become effective on March 18, 2014.

MedPAC Chairman Addresses Extension of Work GCPI in SGR Repeal

Within his testimony, Chairman Hackbarth reported that, while there is evidence for the need for geographic adjustments for fee schedule payments, the Commission finds the current work GPCI to be flawed due to a lack of quality data on physician and health professional earnings.

The Commission recommendations are:

- Medicare payments for the work effort of physicians and other health professionals to be geographically adjusted. The adjustment should reflect geographic differences in cost per unit of output across labor markets for physicians and other health professionals.
- The Congress should allow the GPCI floor to expire as current law requires (March 31, 2014) and adjust payments for the work of physicians and other health professionals only by the current one-fourth GPCI (because of uncertainty in the data) while the Secretary develops an adjuster to replace it.

**Health Affairs Report Claims Slow U.S. Healthcare Spending Growth**

The Office of the Actuary of the Centers for Medicare and Medicaid Services (CMS) released a new analysis in the January 2014 issue of *Health Affairs* reporting slowed growth in United States’ healthcare spending. Data presented in the analysis illustrates a trend in lower post-recession healthcare spending growth in Medicare and Medicaid as well as private payers over the last four years.

Key findings of the report include:

- U.S healthcare spending grew at a rate of 3.7 percent in 2012 to $2.8 trillion
- Healthcare expenditures in the overall economy fell slightly from 17.3 percent in 2011 to 17.2 percent in 2012
- Physician and clinical services spending growth increased from 4.1 percent in 2011 to 4.6 percent in 2012
- Physician services spending growth increased from 3.5 percent in 2011 to 4.0 percent in 2012
- Medicare spending growth slowed from 5.0 percent growth in 2011 to 4.8 percent in 2012
- Medicare fee-for-service expenditures slowed from 4.3 percent in 2011 to 2.7 percent in 2012
- Total Medicare enrollment jumped 4.1 percent in 2012

The report attributes slow growth to prescription drug, skilled nursing facility, private health insurance, and Medicare expenditures. It found that the Affordable Care Act only had a 0.1 percent impact on total healthcare spending between 2010 and 2012.

The report also projects increased healthcare spending in 2014 due to newly insured people entering the marketplace and expanded Medicaid programs under the Affordable Care Act.

**OIG Finds Local Medicare Coverage Determinations Create Inconsistencies**

On January 14, the Office of the Inspector General (OIG) released a report focused on the variation in coverage of Part B items and services as a result of Local Coverage Determinations (LCDs). Medicare claims processing contractors and CMS develop coverage policies for Medicare coverage of specific items and services. Contractors issue local policies—called LCDs—that apply to the States in their jurisdictions. CMS develops national policies—called National Coverage Determinations (NCDs)—that apply to all beneficiaries across the country.
Key findings from the report include:

- In October 2011, over half of Part B procedure codes were subject to an LCD in one or more States.
  - LCDs most often addressed medical procedures.
  - The presence of LCDs was unrelated to the cost or utilization of Part B items and services.
- LCDs limited coverage for these procedure codes differently across States.
  - LCDs prohibited coverage for some procedure codes—often those for new technology—in some States and not in others.
  - LCDs limited coverage for many Part B items and services in some States and few items and services in others.
- LCDs defined similar clinical topics inconsistently.
- CMS has taken steps to increase consistency among LCDs, but it lacks a plan to evaluate new LCDs for national coverage as called for by the Medicare Modernization Act (MMA).

OIG Recommendations include:

- Establish a plan to evaluate new LCDs for national coverage consistent with MMA requirements.
- Continue efforts to increase consistency among existing LCDs.
- Consider requiring MACs to jointly develop a single set of coverage policies.

Improved Survival Using Intensity-Modulated Radiation Therapy in Head and Neck Cancers

A newly published study in the January edition of Cancer, reports improved survival rates for patients receiving intensity-modulated radiation therapy (IMRT) to treat head and neck cancers.

Researchers from the University of Texas MD Anderson Cancer Center analyzed Medicare records and survival rates for 3,172 head and neck cancer patients who received IMRT and conventional radiation treatments and concluded that patients with treated with IMRT are significantly less likely to die from the tumors within 40 months than those who receive conventional radiation treatments.

Researchers found a 38.9 percent survival rate for patients treated with IMRT and an 18.9 percent survival rate for those receiving more conventional treatments.

COA and ASCO Release Principles for Payment System Reform

Community Oncology Alliance (COA) and American Society of Clinical Oncology (ASCO) have released a set of guidelines the groups say will guide organizations’ efforts to achieve payment reform in the delivery of oncology care, entitled, Principles to Guide the Evolution of Health Care Payment Systems that Support High Quality, High Value Cancer. The guidelines were developed in coordination with AmerisourceBergen/ION and McKesson/US Oncology.

Among their guiding principles, COA and ASCO recommend that future payment reform models should:

- Promote access to evidence based care, improve quality, support the efficient use of resources, and help control the overall growth of health care;
- Ensure adequate financial, administrative and data support for oncology providers to engage in new approaches that reduce the frequency and severity of clinical complications;
- Improve clinical outcomes and reduce overall costs in oncology care;
• Measure the quality of oncology care in meaningful ways; and
• Cover the costs and risks of purchasing and maintaining an inventory of cancer drugs.
To view the COA announcement, click here.

To view the ASCO announcement, click here.

**CMS Releases Findings on Delivery System Reform Initiatives**

On January 30, the Centers for Medicare and Medicaid Services (CMS) released findings on a number of initiatives to reform the healthcare system, including Medicare Accountable Care Organizations (ACOS) and CMS' Bundled Payments for Care Improvement Initiative.

In a fact sheet entitled, "Lower Costs, Better Care: Reforming Our Healthcare Delivery System," CMS outlines several areas of "significant progress" in building a healthcare system to ensure the delivery of quality healthcare. The fact sheet specifically connects the listed improvements to the Affordable Care Act.

CMS reports that nearly half (54 out of 114) of the ACOs in the Medicare Shared Savings Program ACOs that started program operations in 2012 reported lower expenditures than projected. CMS also reports that ACOs participating in the program have generated $128 million in net settings for the Medicare trust fund to date.

CMS further reports that a preliminary evaluation of the Pioneer ACOs finds they have generated gross savings of $147 million in their first year. CMS' analysis showed that of the 23 Pioneer ACOs, nine had significantly lower spending growth relative to Medicare fee for service while exceeding quality reporting requirements.

CMS also released a fact sheet on the Bundled Payments for Care Improvement Initiative, which is currently testing how bundled payments for episodes of care can lead to increased patient care coordination and decreased Medicare spending. To date, 232 acute care hospitals, skilled nursing homes, physician group practices, long-term care hospitals, and home health agencies have entered into agreements to participate in the Bundled Payments for Care Improvement initiative.

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