Congress Passes 12-Month SGR Pay Patch

On March 27, the House passed the Protecting Access to Medicare Act of 2014 (H.R. 4302) to delay the anticipated SGR cut and maintain current rates until April 1, 2015. H.R. 4302 passed the House of Representatives by a voice vote despite strong opposition from the American Medical Association (AMA) and other stakeholders. On March 31, the measure passed the Senate by a vote of 64 — 35.

Other provisions of interest in the House SGR patch include:

- Work GPCI Floor of 1.0 extended to April 1, 2015 [cost: $300M over 10];
- Implementation of the ICD-10 diagnosis coding set delayed one year, until October 1, 2015 [cost: negligible];
- Annual targets of 0.5 percent in savings from misvalued Medicare physician payment schedule services would be established from 2017 through 2020 (if total RVUs for a service would otherwise be decreased by 20 percent or more, the effect is phased in over a 2-year period) [savings: $4.0B over 10];
- Revisions to the Medicare sequester in 2024 to frontload the cut so that all Medicare providers are cut by 4 percent during the first 6 months of 2024 [savings: $4.9B over 10].
- A requirement that not later than 18 months after the date of enactment of the bill that GAO shall submit to Congress a report that includes a description of the extent to which appropriate use criteria could be used for radiation therapy and clinical diagnostic laboratory services.

A link to the Congressional Budget Office (CBO) score is here.

Full SGR Repeal Measures Fails in the Congress

House SGR Repeal Bill

On March 11, House Ways and Means Chairman, David Camp (R-MI), introduced an amendment to offset the costs of H.R. 4015, the "SGR Repeal and Medicare Provider Payment Modernization Act of 2014," with a five-year delay in implementation of the Affordable Care Act’s tax penalties for individuals who do not purchase health insurance. The bill passed the House on March 14 by a 238-181 vote. Twelve House Democrats supported the House measure.

Senate Democrats and the White House expressed strong opposition to House passage of H.R. 4015. President Obama issued a Statement of Administration Policy on March 12 announcing he would veto the bill if it reached his desk.

The CBO scored the doc fix portion of the bill at $138 billion and the delay of the individual mandate at a $170 billion savings over 10 years.
Senate SGR Repeal Bill

On March 11, Senate Finance Chairman Wyden (D-OR) introduced the "Medicare SGR Repeal and Beneficiary Access Improvement Act" (S. 2110). This bill contained the bipartisan, bicameral language of H.R. 4015/ S. 2000, along with certain Medicare policy "extender" provisions (e.g., the floor on the geographic adjustment for physician work).

The CBO score of S. 2110 estimates the bill would cost $180.2 billion over 11 years.

On March 25, Senator Wyden introduced the "Commonsense Medicare SGR Repeal and Beneficiary Access Improvement Act of 2014" (S. 2157). This legislation is very similar to S. 2110, except for the inclusion of the so-called "Overseas Contingencies Operation" (OCO) offset. According to CBO, the cap to OCO spending under S. 2157 would limit discretionary appropriations for overseas contingency operations by $191.5 billion in outlays. However, CBO also sent a letter to House Budget Committee Chairman Ryan noting that CBO would not consider the establishment of caps on OCO funding as an "offset" to a proposed increase in direct spending because spending for OCO is "discretionary" and spending for Medicare is "direct spending" (or "mandatory"). As such, "Congressional scorekeeping procedures do not permit budgetary effects in those two categories to be combined."

Neither Senate bill passed the chamber.

Groups Urge Lawmakers to Support Permanent SGR Repeal

More than 600 organizations — primarily healthcare associations and professional societies — signed a letter to House Speaker John Boehner and House Minority Leader Nancy Pelosi urging Congress to pass legislation to permanently repeal the Sustainable Growth Rate (SGR) formula. The SGR Repeal and Medicare Provider Payment Modernization Act of 2014 (H.R. 4015/S. 2000) has bipartisan support and has passed through the three congressional committees of jurisdiction.

The groups urged House leaders to take advantage of the opportunity to pass a long-term solution to the Medicare physician payment system.

In a separate letter to Senate leaders, the American Medical Association expressed support for bipartisan Senate action to repeal the SGR before the current patch expires on March 31.

RTA Responds to CMS' Request for Alternative Models for Specialty Practitioner Payments

On March 25, the Radiation Therapy Alliance (RTA) submitted a letter to Administrator Marilyn Tavenner in response to the Centers for Medicare and Medicaid Services' (CMS) request for information (RFI) on innovative models of payment for specialty care. The CMS Innovation Center issued the RFI as part of an initiative to test new models of care that focus on specific diseases, patient populations, and specialty practitioners in the outpatient setting to incentivize quality care and reduce costs.

The RTA reiterated its support for the establishment of a new, episode-based bundled payment model to replace the existing fee-for-service structure, which creates uncertainty and volatility for the freestanding radiation oncology provider community. RTA urges CMS to seek payment reforms that incentivize quality outcomes instead of volume of care.
Obama Administration Releases Budget Proposal

On March 4, President Obama submitted his fiscal year 2015 budget proposal to Congress. The President's proposed budget contains his tax, spending and policy proposals for the coming fiscal year, including his proposed budget for the Department of Health and Human Services and the programs it manages, including Medicare.

Included in summary tables of the President's budget is a line-item to "Prevent reduction in Medicare physician payments" to override the upcoming April 1, 2014 Sustainable Growth Rate cut. The President's budget assumes overriding the SGR would cost $110 billion over 10 years.

The budget also assumes a number of Medicare and Medicaid savings options, which could be considered as part of legislation to permanently repeal the SGR, which are detailed in the HHS Budget Brief. In her testimony before the House Ways and Means Committee, Secretary Sebelius provided an overview of the department's proposed budget, which calls for $407 billion in Medicare savings over 10 years through payment reforms.

MedPAC Examines Setting Payment Rates Based on Clinical Evidence

On March 6, the Medicare Payment Advisory Commission (MedPAC) met to discuss the potential of improving the value of Medicare spending by linking Fee-for-service (FFS) payment policies to the comparative clinical effectiveness of health care services. The MedPAC staff presentation indicated that Medicare's payment systems today generally do not consider whether a new service results in better outcomes than alternatives. However, according to MedPAC, Medicare would need legislative authority to link payment to comparative clinical evidence.

New Report Estimates Practice Costs Associated with ICD-10 Transition

The American Medical Association (AMA) released a cost study conducted by Nachimson Advisory, which found that the mandated implementation of the ICD-10 code set will cost small practices anywhere between $56,639 to $226,105. The new estimates factor in the costs associated with purchasing new software to accommodate the new codes.

The AMA urged the Centers for Medicare and Medicaid Services to reconsider the ICD-10 mandate. In a letter to Health and Human Services Secretary, Kathleen Sebelius, the AMA recommended that CMS adopt a policy for Medicare that provides a two-year "implementation" period during which Medicare will not be allowed to deny payment based on the specificity of the ICD-10 code.

The transition to ICD-10 is occurring because ICD-9 produces limited data about patients' medical conditions and hospital inpatient procedures. ICD-9 is 30 years old, has outdated terms, and is inconsistent with current medical practice. Also, the structure of ICD-9 limits the number of new codes that can be created and many ICD-9 categories are full. ICD-10 codes allow for greater specificity in describing a patient's diagnosis and in classifying inpatient procedures. ICD-10 will also accommodate newly developed diagnoses and procedures. Implementing ICD-10 will result in a five-fold increase in diagnosis codes from the current 13,000 codes to 68,000 codes.

As noted earlier, H.R. 4302 delayed the ICD-10 coding transition until October 2015.
ASCO Report Details State of Cancer Care in America


The State of Cancer Care in America: 2014 report details demographic, economic, and oncology practice trends that will impact cancer care in the United States over the coming years. Key report findings include:

- Today, a record 13.7 million cancer survivors are living in the United States.
- The number of new cancer cases in the United States is projected to increase by as much as 42 percent by 2025.
- The total annual U.S. cost of cancer care is projected to reach $175 billion by 2020, an increase of 40 percent from 2010.
- The number of oncologists will likely grow by only 28 percent over the next decade, leaving a projected deficit of 1,487 physicians.

Specific to radiation therapy, the report finds that growth in the radiation oncologist subspecialties is relatively flat when compared to hematology/oncology and medical oncology workforce.

ASCO further provides recommendations for addressing cancer care delivery system concerns, including:

1. Develop and test new healthcare delivery and payment models that preserve the viability of small community practices while encouraging high-quality care.
2. End persistent financial threats to community practices caused by sequester-related cuts to Medicare physician payments, and by the Sustainable Growth Rate (SGR) formula, Medicare’s current reimbursement system that has become a source of tremendous instability within health care and a perennial threat to care for millions of seniors.
3. Embrace and support physician-led quality initiatives.

Patient Advocates, Provider Groups Urge Lawmakers to Preserve In-office Ancillary Services Exception

Patient groups and a coalition of healthcare stakeholder groups have voiced opposition to HR 2914, the Promoting Integrity in Medicare Act of 2013, which would limit patient access to in-office ancillary services that physicians are permitted to provide under the physician self-referral provision of the Stark law.

The National Patient Advocate Foundation issued a memo on March 12 urging Congress to reject HR 2914 citing concerns that the law goes far beyond the interests of the patient by interrupting the patient-provider relationship.

Approximately 30 healthcare stakeholder groups with The Coalition for Patient Centered Imaging sent letters to leaders of the Senate Finance, House Energy and Commerce, and House Ways and Means Committees also asking lawmakers to preserve the in-office ancillary services exception (IOASE) to the Stark law. The groups warn that limiting the IOASE for these services will hinder care coordination and increase healthcare costs to the patient.
CMS Considering Coverage for CT Screening for At-Risk Lung Cancer Beneficiaries

The Centers for Medicare and Medicaid Services (CMS) has initiated a National Coverage Analysis (NCA) on Lung Cancer Screening with Low Dose Computed Tomography (LDCT), which is recommended with a grade B by the U.S. Preventive Services Task Force (USPSTF) for individuals at high risk for lung cancer based on age and smoking history.

CMS is seeking evidence to inform the identification of patients eligible for screening; the appropriate frequency and duration of screening; facility and provider characteristics that predict benefit or harm; precise criteria for test positivity and the impact of false positive results and follow-up tests or treatments. CMS is soliciting input on the influence of these factors on patient education and informed consent among Medicare beneficiaries.

On April 30, CMS is convening a Medicare Evidence Development and Coverage Advisory Committee (MEDCAC) meeting to review the available evidence on the topic. Public comments for lung cancer screening with low dose computed tomography can be viewed here.

The proposed National Coverage Determination from CMS is due by November 10.

Community Oncologists Urge Congressional Leaders to Address Cancer Care Crisis

The US Oncology Network and Community Oncology Alliance (COA) sent a letter to House and Senate leadership on March 20 urging lawmakers to pass Medicare payment reform legislation to stabilize the nation’s cancer care delivery system. If reforms are not implemented, the groups warn that patients will be forced to seek care in higher cost settings. The letter details trends in community cancer care including clinic closings and consolidations. The groups also warn that policies included in the President’s FY 2015 budget proposal would further compromise cancer care and increase healthcare costs.

The US Oncology Network and COA encourage Congressional leaders to pass SGR and payment reform legislation now before the cancer care delivery system is destabilized any further.

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