House of Representatives Passes SGR Repeal Legislation

The US House of Representatives on March 26 passed the Medicare Access and CHIP Reauthorization Act (H.R. 2) to repeal the Medicare Sustainable Growth Rate (SGR) formula by a vote of 392 to 37.

Key provisions of the bill include:

- **SGR Repeal and Medicare Provider Payment Modernization:**
  - **Fee Updates:**
    - The SGR mechanism is permanently repealed, averting a 21 percent SGR-induced cut scheduled for April 1, 2015.
    - Physicians 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 physicians with the opportunity to receive additional payment adjustments through the Merit-Based Incentive Payment System (MIPS).
    - In 2026 and subsequent years, physicians participating in APMs that meet certain criteria would receive annual updates of 0.75 percent, while all other physicians would receive annual updates of 0.25 percent.
  - **Merit-Based Incentive Payment System:**
    - The MIPS streamlines and improves on the three distinct current law incentive programs: (1) the Physician Quality Reporting System (PQRS) that incentivizes professionals to report on quality of care measures; (2) the Value-Based Modifier (VBM) that adjusts payment based on quality and resource use in a budget-neutral manner; and (3) Meaningful use of EHRs (EHR MU) that entails meeting certain requirements in the use of certified EHR systems.
    - The payment implications associated with the current law incentive program penalties are sunset at the end of 2018, including the 2 percent penalty for failure to report PQRS quality measures and the 3 percent (increasing to 5 percent in 2019) penalty for failure to meet EHR MU requirements.
    - Physicians will receive a composite performance score of 0-100 based on their performance in the MIPS. Each eligible professional's composite score will be compared to a performance threshold (i.e. the mean or median of the composite performance scores for all MIPS-eligible professionals during a period prior to the performance period).
    - Eligible professionals whose composite performance scores fall above the threshold will receive positive payment adjustments and eligible professionals whose composite performance scores fall below the threshold will receive negative payment adjustments.
    - Professionals who treat few Medicare patients, as well as professionals who receive a significant portion of their revenues from eligible APM(s), will be excluded from the MIPS.
**Alternative Payment Models:**
- Professionals who receive a significant share of their revenues through an APM(s) that involves risk of financial losses and a quality measurement component will receive a five percent bonus each year from 2019-2024.

**Development of "Physician-Focused Payment Models"**
- **180 Days After Enactment of H.R. 2**
  - The bill establishes a "Physician-Focused Payment Model Technical Advisory Committee" 180 days after the enactment of H.R. 2 to provide comments and recommendations to the Secretary on physician-focused payment models.
  - **Not later than November 1, 2016**
    - The Secretary shall, through notice and comment rulemaking, following a request for information, establish criteria for physician-focused payment models, including models for specialist physicians, that could be used by the Physician-Focused Payment Model Technical Advisory Committee for making comments and recommendations.

**On an Ongoing Basis**
- Individuals and stakeholder entities may submit to the Physician-Focused Payment Model Technical Advisory Committee proposals for physician-focused payment models. The Committee shall, on a periodic basis, review models submitted by stakeholders and advise whether such models meet criteria established by the Secretary. The Secretary will review the Committee’s advice and provide detailed responses.

**Development of Care Episode and Patient Condition Groups and Classification Groups and Classification Codes**
- **180 Days After Enactment of H.R. 2**
  - The Secretary shall post on the CMS website a list of episode groups that have been developed thus far.
  - **For 120 days after the date of the aforementioned posting on the CMS website**
    - The Secretary shall accept (1) suggestions from physician specialty societies, applicable practitioner organizations, and other stakeholders for episode groups in addition to those already posted and (2) specific clinical criteria and patient characteristics to classify patients into (a) care episode groups and (b) patient condition groups.
  - **Not later than 270 days after the end of the aforementioned comment period**
    - The Secretary shall post on the CMS website a draft list of episode and patient condition codes.
  - **For 120 days after the date of the aforementioned posting on the CMS website**
    - The Secretary shall seek comments from physician specialty societies, applicable practitioner organizations, and other stakeholders regarding the aforementioned list of episode and patient condition codes.
  - **Not later than 270 days after the end of the aforementioned comment period**
    - The Secretary shall post on the CMS website an operational list of care episodes and patient condition codes.
  - **Not later than November 1 of each year (beginning with 2018)**
    - The Secretary shall, through rulemaking, make revisions to the operational lists of care episode and patient condition codes as the Secretary determines may be appropriate.
• Attribution of Patients to Physicians
  • Not later than one year after the enactment of H.R. 2:
    • The Secretary shall post on the CMS website a draft list of patient relationship categories and codes in order to facilitate the attribution of patients and episodes to one or more physicians.
  • For 120 days after the date of the aforementioned posting on the CMS website
    • The Secretary shall seek comments from physician specialty societies, applicable practitioner organizations, and other stakeholders regarding the aforementioned patient relationship categories and codes.
  • Not later than 240 days after the end of the aforementioned comment period
    • The Secretary shall post on the CMS website an operation list of patient relationship categories and codes.
  • Not later than November 1 of each year (beginning with 2018)
    • The Secretary shall, through rulemaking, make revisions to the operational list of patient relationship categories and codes.

• Medicare Extenders: The legislation contains a number of "extender" provisions, including the extension of work Geographic Practice Cost Index (GPCI) floor. The GPCI increases payments for the work component of physician fees in areas where labor cost is lower than the national average. The provision in H.R. 2 would extend the existing 1.0 floor on the "physician work" cost index until January 1, 2018.

• Children's Health Insurance Program (CHIP): The legislation extends CHIP through September 30, 2017.

• Select Offsets:
  • 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: H.R. 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 providers (HH), and hospice providers.
  • The Congressional Budget Office (CBO) released an estimate predicting the House SGR deal would cost $141 billion over 10 years.

To read a section-by-section summary of the SGR repeal and Medicare Provider Payment Modernization provisions, click here.

To read section-by-section of the overall bill, click here.
House, Senate Approve Budget Blueprint

House Budget Proposal

On March 25, the House passed H. Con. Res. 27, the House Budget Resolution, by a vote of 228 – 199.

According to the House Budget Resolution Committee Report, the House Budget Resolution would:

- Save $148 billion over 10 years by strengthening Medicare and transitioning to a premium support model.
- Achieve another $913 billion in health savings, partly by allowing greater State flexibility in Medicaid.
- Saves $1.1 trillion in other direct spending.

The House Budget Resolution also contains reconciliation instructions to various committees, including the House Energy and Commerce and Ways and Means Committees. The House Budget Resolution directs the aforementioned committees to submit, not later than July 15, 2015, changes in laws within its jurisdiction sufficient to reduce the deficit by $1,000,000,000 over a 10-year period. The resolution states that committees should note the policies described in their submission that repeal the Affordable Care Act. The resolution notes elsewhere that, "The amounts reconciled are intended to serve as a floor on required savings, not a ceiling. The targets are for the total of the ten-year period of fiscal year 2016 through 2025. These targets will provide the committees maximum flexibility in their savings while ensuring the budget is balanced within the ten-year window."

Senate Budget Proposal

On March 27, the Senate passed S. Con. Res. 11, the Senate Budget Resolution, by a vote of 52 – 46.

The Senate Budget Resolution contains reconciliation instructions to the Finance and Health, Education, Labor and Pensions Committees. The Senate Budget Resolution directs the aforementioned committees to submit, not later than July 31, 2015, changes in laws within its jurisdiction to reduce the deficit by $1,000,000,000 over a 10-year period.

Oral Arguments Heard in King vs. Burwell

On March 4, the Supreme Court of the United States heard the oral arguments in the King v. Burwell case. While the oral arguments offered few clues as to how the court will decide, Justices Kennedy, Ginsburg, and Alito all raised questions. Chief Justice Roberts, a potential swing vote, did not raise any questions.

Among the questions raised, the Justice Kennedy questioned the potential consequences for states that choose not to establish their own exchanges under the petitioners' reading of the statute – that is, that citizens of those states would receive no subsidy and no resulting mandate tax penalty.

"It does seem to me that if petitioners' argument is correct, this is just not a rational choice for the states to make and that they're being coerced," Kennedy said. "You then have to invoke the standard of constitutional avoidance."

Justice Alito said it isn't too late for a state to make its own exchange if the court rules against the administration and suggested that the court could stay the mandate until the end of the current tax year, as in past cases that could have had "very disruptive consequences."
Justice Scalia stated that he expects lawmakers would pass a fix to protect Americans if the justices strike down subsidies. It is not up to the court to twist words in parts of the law so they make sense "even if it has untoward consequences for the rest of the statute," he said. While this may not be the statute Congress intended, Scalia said, the question is whether it is the statute they wrote.

The plaintiffs are a group of Virginia residents who, without the tax credits, would fall under the unaffordability exception in the Affordable Care Act (ACA) and be exempt from having to purchase health insurance. Although the legislative language of the ACA only referred to the exchanges established by the states, the Internal Revenue Service (IRS) created a regulation that made the tax credits available to those enrolled in plans through federal as well as state exchanges. They argue that the IRS regulation exceeds the agency's statutory authority, is arbitrary and capricious, and is contrary to the law in violation of the Administrative Procedure Act. The district court granted the defendants' motion to dismiss, and the U.S. Court of Appeals for the Fourth Circuit affirmed.

To download a transcript of the oral arguments, [click here](#).

**Congressional Budget Office Releases Analysis of President's FY 2016 Budget**

The Congressional Budget Office (CBO) released estimates for the health care policies in the Obama administration's FY 2016 Budget. According to the CBO analysis, "Taken together, the proposed changes to Medicare in the President's budget (excluding those related to repealing the automatic enforcement procedures known as sequestration) would decrease federal spending by $240 billion over the 10-year projection period. The President's proposal to increase payment rates for physicians (which, under current law, are scheduled to be lowered in 2015) would boost outlays by $6 billion in 2015 and by $168 billion between 2016 and 2025. However, the President’s other proposals affecting Medicare would reduce outlays by $408 billion."

To view the CBO estimate, [click here](#).

**CMS Releases Value-Based Modifier Program Report**

The Centers for Medicare and Medicaid Services (CMS) announced in March physician payment adjustments based on results from the first year of the value-based payment modifier (VM) program. The VM is based on the quality of care provided compared to cost of care. Groups receiving additional money either provided above-average care at average costs or provided average quality care at low costs.

Of 127 large group practices participating in the "quality tiering" program – which was only eligible to groups employing at least 100 doctors – 14 will receive an increase in payments next year. Eleven groups will see a decrease in payments in 2015, while the remaining 102 will not experience a change.

The "quality tiering" program is part of the Affordable Care Act’s physician quality reporting system (PQRS). Last year, all physician groups with at least 100 employees were asked to self-nominate for the PQRS or take on a one percent payment reduction. In 2016, physicians in smaller groups of 10 or more will also be subject to the VM based on their 2014 performance. In 2017, CMS will begin applying the value modifier to all physicians, including solo practitioners.

According to CMS, the program is meant to improve the Medicare program and will provide "meaningful and actionable information to physicians so they can improve the care they deliver" as the agency moves "toward physician payment that rewards value rather than volume."

For the 2015 Value Modifier Results, [click here](#).
CMS Announces the Next Generation ACO Model

The Centers for Medicare & Medicaid Services (CMS) announced the Next Generation Accountable Care Organization (ACO) Model, which offers a new opportunity in accountable care—one that sets predictable financial targets, enables providers and beneficiaries greater opportunities to coordinate care, and aims to attain the highest quality standards of care. The Next Generation ACO Model was designed based upon CMS’ experience from the Pioneer ACO Model and the Medicare Shared Savings Program (Shared Savings Program).

The Next Generation ACO Model will test whether strong financial incentives for ACOs can improve health outcomes and reduce expenditures for Medicare fee-for-service (FFS) beneficiaries. The Model offers financial arrangements with higher levels of risk and reward than current Medicare ACO initiatives, using refined benchmarking methods that:

- Reward quality performance
- Reward both attainment of and improvement in cost containment
- Transition away from reference to ACO historical expenditures.

The Model additionally offers a selection of alternative payment mechanisms to enable a graduation from FFS reimbursements to capitation. Also central to the Next Generation Model are several tools to help ACOs improve engagement with beneficiaries, including:

- Enhanced access to home visits, telehealth services, and skilled nursing facilities
- A reward payment for receiving care from the ACO
- A process that gives beneficiaries a decision in their alignment with ACOs
- Collaboration between CMS and ACOs to clearly communicate to beneficiaries the characteristics and potential benefits of ACOs in relation to their care.

Eligible providers and suppliers include:

- Physicians or other practitioners in group practice arrangements
- Networks of individual practices of physicians or other practitioners
- Hospitals employing physicians or other practitioners
- Partnerships or joint venture arrangements between hospitals and physicians or other practitioners
- Rural Health Clinics (RHCs)
- Critical Access Hospitals (CAHs).

CMS will accept ACOs into the Next Generation ACO Model through two rounds of applications in 2015 and 2016, with participation expected to last up to five years. For round one consideration, interested organizations must submit a Letter of Intent by May 1, 2015. Round one applications must be submitted electronically no later than June 1, 2015.

To file an LOI and complete the online application, interested organizations may access the electronic submission portal.

To read more on the Next Generation ACO Model, click here.
MedPAC Issues March 2015 Report to the Congress

On March 13, the Medicare Payment Advisory Commission (MedPAC) released its March 2015 Report to the Congress: Medicare Payment Policy. Specific to the Medicare SGR formula, MedPAC recommends a full repeal. The report reads:

"Because this year’s payment adequacy findings are largely similar to the findings from prior years, the Commission reiterates its long-standing position that the SGR should be repealed. The budgetary cost of repeal remains near historic lows, providing a clear opportunity. Our recommendations for SGR reform are as follows:

- Repeal the SGR and replace it with a 10-year path of legislated updates, with higher updates for primary care services than for other services.
- Collect data to improve the relative valuation of services.
- Identify overpriced services and rebalance payments.
- Encourage accountable care organizations by creating greater opportunities for shared savings."

MedPAC recommends Congress to direct the Secretary of Health and Human Services to reduce or eliminate differences in payment rates between outpatient departments and physician offices for selected ambulatory services.

To download the MedPAC recommendations on physician services, click here.

To download the MedPAC Report to Congress, click here.

GAO Report Examines Payment Methods to Certain Cancer Hospitals

The U.S. Government Accountability Office (GAO) released a new report, "Payment Methods for Certain Cancer Hospitals Should Be Revised to Promote Efficiency" on March 23, which analyzes CMS claims and cost report data for 2012 to determine various characteristics, estimate inpatient payment differentials for comparable beneficiaries, and calculate the average payment differences for outpatient services in PPS-exempt cancer hospitals (PCH) and teaching hospitals paid under Medicare’s prospective payment systems (PPS). The report compares:

- 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 report found that Medicare payments – in both inpatient and outpatient – were substantially higher at PCHs than at PPS teaching hospitals in the same geographic area for beneficiaries with the same diagnoses or services. GAO estimates that PCHs received, on average, about 42 percent more in Medicare inpatient payments per discharge than what Medicare would have paid a local PPS teaching hospital to treat cancer beneficiaries with the same level of complexity.

The GAO recommends Congress 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. To generate cost savings from any reduction in outpatient payments to PCHs, Congress should also provide that all forgone outpatient payment adjustment amounts be returned to the Supplementary Medical Insurance Trust Fund.

To download the full GAO report, click here.

To read the report highlights, click here.
CDC Report Finds Cancer Patients Living Longer Following Diagnosis

Data released from the Centers for Disease Control (CDC) show that 65 percent of Americans with invasive cancers are living at least five years after their diagnosis. Overall, though, "improvements in early detection and treatment of cancer" are leading to increased survival, CDC says. Its report shows that, based on cases diagnosed from 2003-2010 with follow-up through 2010, 65 percent of both men and women were alive five years post-diagnosis. The numbers were highest for prostate cancer (97 percent) and breast cancer (88 percent) and lowest for lung cancer (18 percent).

To download the CDC report, click here.

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