Energy & Commerce Committee Passes 21st Century Cures Legislation

The House Energy & Commerce Committee unanimously passed the "21st Century Cures Act" on May 21 by a vote of 51-0.

Among other things, an objective of the legislation is to accelerate the discovery, development, and delivery of promising new treatments and cures. The bill also includes changes specific to Medicare, including the following:

- **SECTION 3081: IMPROVEMENTS IN THE MEDICARE LOCAL COVERAGE DETERMINATION PROCESS.** Section 3061 would increase transparency around the LCD process.
- **SECTION 3121: MEDICARE SITE-OF-SERVICE TRANSPARENCY.** Section 3121 would require the Secretary of HHS, for 2017 and each year thereafter, to make available to the public via a searchable website the estimated payment amount and beneficiary liability for certain items and services under the hospital outpatient fee schedule and the ambulatory surgical center fee schedule.

To read the legislative text of H.R. 6, click here.

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

At the committee markup, a Manager's amendment to the legislation also was adopted by voice vote. Among the provisions was a policy to accelerate the modernization of x-ray imaging and improve patient safety by reforming the Medicare reimbursement system for outdated film x-ray imaging services.

To read the Manager's amendment, click here.

To read the Manager's amendment section-by-section, click here.

Trade Bill Contains Medicare Sequestration Offset

On May 22, the Senate passed the Trade Act of 2015. Among the offsets contained within the bill are offsets to (1) modify the Medicare sequester for fiscal year 2024 and (2) change coverage and payment for renal dialysis services for individuals with acute kidney injury.

With respect to the Medicare sequestration provision, the bill would modify sequestration of Medicare spending for fiscal year 2024. Under current law, the Medicare sequestration for fiscal year 2024 is -4.0 percent for April 2024 through September 2024 and zero percent for October 2024 through March 2025. The bill would change the second half of the fiscal year 2024 sequestration (October 2024 through March 2025) to -0.25 percent. CBO estimates that this change would reduce direct spending by $700 million in fiscal year 2025.

With respect to the dialysis provision, under current Medicare law, freestanding dialysis facilities—including facilities owned by hospitals—may treat patients with end-stage renal disease, but not people with acute kidney injury (AKI). Those freestanding facilities are paid an average of $240 per dialysis treatment. Medicare
beneficiaries with AKI may receive dialysis services from hospital outpatient departments (which are distinct from hospital-owned dialysis facilities). Those facilities are paid according to the hospital-outpatient prospective payment; the cost is about $600 per dialysis treatment. Under the bill, freestanding facilities would be allowed to treat beneficiaries with AKI and would be paid at the rate for freestanding facilities. CBO estimates that allowing those lower-priced dialysis services to be furnished to beneficiaries with AKI would save about $250 million over the 2015-2025 period.

A coalition of provider groups, including the American Hospital Association and the American Medical Association, sent a letter to members of Congress in opposition of the bill. "Hospitals, physicians, nursing homes, and home health and hospice providers have already absorbed hundreds of billions of dollars in cuts to the Medicare program in recent years," they wrote. "Additionally alarming is the use of Medicare cuts to pay for non-Medicare-related legislation, a precedent that we believe is unwise."

For the full bill, click here.

For a CBO score of the Medicare provisions, click here.

Congress Adopts FY 2016 Budget Resolution Conference Report

Congress has adopted the Conference Report to S. Con. Res. 11, the FY 2016 Budget Resolution. The Conference Report was adopted by the House of Representatives on April 30 by a vote of 226 – 197. The Conference Report was adopted by the Senate on May 5 by a vote of 51 – 48.

According to an announcement by Budget Committee Chairmen, Representative Tom Price (R-GA) and Senator Mike Enzi (R-WY), the FY 2016 Conference Agreement:

- Balances the budget within 10 years without raising taxes
- Ensures a strong national defense
- Repeals the Affordable Care Act to start over with patient-centered reforms
- Strengthens Medicare
- Protects Social Security
- Supports a healthier economy and stronger economic growth
- Improves efficiency, effectiveness & accountability of government

To download the FY 2016 Conference Agreement's legislative text, click here.

Budget Could Serve as Response to Supreme Court Ruling on Insurance Subsidies

Language in the GOP budget may suggest that House leadership will address any King v. Burwell ruling "legislatively – and do so through budget reconciliation," according to a recent blog post from conservative think tank, America Next.

Chris Jacobs, America Next's policy director, argues that the budget conference report would allow "the Budget Committee chairman to disregard the potential budgetary impacts of 'judicial actions' and 'adjudication'—such as a Supreme Court ruling in King v. Burwell—that take place after a budget is adopted." The Congressional Budget Office (CBO), he says, is directed to do the same.
POLICY UPDATE

This means that, if health subsidies were repealed, scorers could use the pre-King spending baseline. This would then allow the CBO and lawmakers to list subsequent health measures as spending cuts, rather than budgetary increases.

The Supreme Court is expected to offer its King v. Burwell decision this June.

To read the blog post, click here.

CMS Announces Pioneer ACO Model Savings

An independent evaluation report released by the Department of Health and Human Services (HHS) showed that an innovative payment model – Pioneer ACO Model – created as a pilot project by the Affordable Care Act (ACA) generated substantial savings to Medicare in just two years.

Additionally, the independent Office of the Actuary in the Centers for Medicare & Medicaid Services (CMS) certified that the Pioneer ACO Model is the first to meet the criteria for potential future expansion to a larger population of Medicare beneficiaries. The Actuary's certification indicates that expansion of Pioneer ACOs would reduce net Medicare spending as well as maintain or improve patient care without limiting coverage or benefits.

The independent evaluation report for CMS found that the Pioneer Accountable Care Organization (ACO) Model generated more than $384 million in savings to Medicare over its first two years, which equals an average of approximately $300 per participating beneficiary per year.

Previously, CMS reported that Pioneer ACOs generated Medicare savings of $279.7 million in 2012 and $104.5 million in 2013. Actuarial analyses show that ACOs in the Pioneer ACO Model and the Medicare Shared Savings Program have jointly generated more than $417 million in total program savings for Medicare.

To view the CMS Office of the Actuary Certification of Pioneer ACO Model savings report, click here.

To view the second Pioneer ACO Model evaluation report, click here.

New Report Details Current Cancer Care Landscape

The IMS Institute for Healthcare Informatics released a new report entitled "Developments in Cancer Treatments, Market Dynamics, Patient Access and Value: Global Oncology Trend Report 2015," which presents an updated perspective on the clinical landscape of cancer care, the dynamics of the market for oncology-related pharmaceuticals, and the current state of patient access to medicines and value considerations.

According to the new report, the landscape is shifting rapidly, bringing new complexity to oncologists, payers and governments who all look to provide appropriate care to patients while ensuring the sustainability of healthcare systems. Earlier diagnosis, longer treatment duration and increased effectiveness of drug therapies are contributing to rising levels of spending on medicines for cancer care.
Key report findings include:

- **Spending**: The report found that total global spending on oncology medicines – including therapeutic treatments and supportive care – reached the $100 billion threshold in 2014.
- **Survival rates**: Five-year survival rates have risen through continuous and small improvements in detection and treatment – including refinements with existing treatments and gains from new treatment options.

To download the report, click here.

**GAO Report: Better Data and Greater Transparency in Physician Payment Rates**

The U.S. Government Accountability Office (GAO) released a new report on May 21 that studies the Relative Value Scale Update Committee’s (RUC) process for developing relative value recommendations for the Centers for Medicare & Medicaid Services (CMS). This study was called for as part of the Protecting Access to Medicare Act of 2014. Specifically, the GAO sought to:

1. Evaluate the RUC’s process for recommending relative values for CMS to consider when setting Medicare payment rates; and
2. Evaluate CMS’s process for establishing relative values, including how it uses RUC recommendations.

To help improve CMS’s process for establishing relative values for Medicare physicians’ services, the GAO recommends:

- The Administrator of CMS should better document the process for establishing relative values for Medicare physicians' services, including the methods used to review RUC recommendations and the rationale for final relative value decisions.
- The Administrator of CMS should develop a process for informing the public of potentially misvalued services identified by the RUC, as CMS already does for potentially misvalued services identified by CMS or other stakeholders.
- The Administrator of CMS should incorporate data and expertise from physicians and other relevant stakeholders into the process as well as develop a timeline and plan for using the funds appropriated by the Protecting Access to Medicare Act of 2014.

To complete this study, GAO reviewed RUC and CMS documents and analyzed RUC and CMS data for payment years 2011 through 2015 and interviewed RUC staff and CMS officials.

To read the report highlights, click here.

To download the full GAO report, click here.

**USPSTF Guidelines Result in Lower Breast Cancer Screening Rates**


While mammography rates had been on the rise prior to the 2009 recommendations, researchers found that in the years following the revised guidance, screening rates for women ages 65 to 90 fell by 6 percent.
The researchers conclude, "The 2009 revision of USPSTF guidelines on breast cancer was associated with an immediate and significant decrease in screening mammography rates. The long-term impact of the guideline change differs by age and race and may not be fully quantifiable for years after its implementation."

In 2009, USPSTF changed its guidance, recommending that women aged 50 to 74 receive a mammogram every two years opposed to annually. Additionally, USPSTF recommended that women 75 and older skip the screening all together.

To download the full study, click here.

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