House Energy & Commerce Committee Examines SGR Reform Options

On January 21 and 22, the House Energy and Commerce Committee held a two-day hearing to address the Medicare Sustainable Growth Rate (SGR) Formula, which is currently set to expire on March 31.

During the hearing, the Committee heard from witnesses representing senior advocates, provider groups and clinicians as well as a former Congressional Budget Office Director and U.S. Senator. Last year, lawmakers reached a bipartisan deal to fully replace the SGR formula, however the bill stalled because Congress could not come to an agreement on offsets. Several witnesses offered a variety of recommendations on how best to pay for repeal.

Hearing witnesses included:

- **Joseph I. Lieberman**, former United States Senator
  - Offset suggestions included:
    - Creating a single combined annual deductible for both Medicare Part A and B services;
    - Creating an annual “out-of-pocket maximum” under Medicare;
    - Reforming Medigap;
    - Increasing income-related premiums under Medicare;
    - Increasing the eligibility age; and
    - Raising the Medicare Part B premium.

- **Alice Rivlin**, Co-Chair, Bipartisan Policy Center; Delivery System Reform Initiative Director, Engelberg Center for Health Reform, The Brookings Institution

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- Increasing the eligibility age; and
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Offset suggestions included:
- Reforming Medicare supplemental insurance to eliminate first dollar coverage;
- Creating a single deductible and an out-of-pocket limit for hospital and ambulatory care (Parts A and B) and modifying Medicare copayments;
- Using competitive bidding to set payments and improve quality, starting with lab tests;
- Rewarding beneficiaries for using generic drugs;
- Raising the Medicare premium for higher income individuals;
- Paying for post-acute care in the setting most appropriate to the patient's needs (not necessarily where the acute care occurred);
- Encouraging the use of generic drugs;
- Modernizing the Medicare Parts A and B cost-sharing rules;
- Expanding the use of bundled payments;
- Restricting first dollar coverage in Medigap plans; and
- Combining the Part A and Part B deductibles.

Marilyn Moon, Institute Fellow, American Institutes for Research
- Offset suggestions included:
  - New sources of revenue for the Medicare; and
  - Closing tax loopholes or cutting other programs that are not performing as intended.

Richard Umbdenstock, President and Chief Executive Officer, American Hospital Association
- Offset suggestions included:
  - Modernize Medicare by Combining Parts A and B with a Unified Deductible and Coinsurance;
  - Modifications to First-dollar Medigap Coverage;
  - Increasing Income-related Premiums under Medicare; and
  - Reform the Medical Liability System.

Eric Schneidewind, President-Elect, AARP
- Offset suggestions included:
  - Accelerate and expanding competitive bidding for durable medical equipment;
  - Equalize Medicare payments for physician services between hospital outpatient and office settings;
  - Recoup overpayments to Medicare Advantage plans;
  - Provide rebates for drugs provided to Medicare Part D low-income support for beneficiaries who are dually eligible for Medicare and Medicaid;
Enable the Secretary of Health and Human Services to negotiate for lower prescription drug prices;
Reduce the exclusivity period for biologic drugs;
Prohibit pay-for-delay agreements between brand-name pharmaceutical maker and generic manufacturers; and
Stop Risk Evaluation and Mitigation Strategies (REMS) from being used to block generic drug and biosimilar product development.

Geraldine O’Shea, D.O., First Vice President AOA Board Of Trustees Medical Director Foothills Women’s Medical Center in California

Offset suggestions included:
Use of the Overseas Contingency Operations (OCO) funding that remains from the war efforts abroad.

To watch the full E&C hearing, click here.
To view the Committee’s press release, click here.

Center for Healthcare Quality & Payment Reform Offers Plan to Pay for SGR Repeal

The Center for Healthcare Quality & Payment Reform laid out a plan pay for repeal of the Medicare Standard Growth Rate (SGR).

The January report, entitled “How Should Congress Pay for the Cost of Repealing the Sustainable Growth Rate?” describes how:

Sufficient savings in Medicare spending to more than cover the costs of SGR repeal could be achieved by giving physicians the tools they need to keep patients healthy, avoid unnecessary tests and procedures, reduce avoidable hospitalizations, and prevent infections and complications.

The major barrier to redesigning care delivery to achieve savings is the current fee-for-service payment system, which penalizes physicians for reducing spending and fails to pay for many services that would be better for patients and reduce spending for Medicare.

Accountable Payment Models are needed in every specialty to give physicians the flexibility to redesign care along with accountability for the costs and quality of those aspects of care they can control or influence. Instead of waiting to “test” Accountable Payment Models in demonstration projects, CMS should make them immediately available on a voluntary basis to all physicians who wish to participate, and then the Accountable Payment Models can be evolved and improved over time.

Congress should create a faster pathway for reviewing and implementing the Accountable Payment Models that are already being developed by physician organizations and multi-stakeholder collaboratives across the country.

To read Center for Healthcare Quality & Payment Reform’s full plan, click here.
Hatch Prioritizes ACA Changes, Entitlement Reform and SGR in SFC Agenda

Senator Orin Hatch (R-Utah) presented the Senate Finance Committee’s agenda this month, pegging Affordable Care Act changes, Medicare physician payment reform, and Children’s Health Insurance Program (CHIP) extension as high priorities.

Hatch unveiled his 2015 plan in a speech at the U.S. Chamber of Congress. He asserted that the Senate Finance Committee would keep all procedural options open in order to pass “high-profile” bills on healthcare and tax reform through both chambers, including the budget reconciliation process.

While the Senator conceded that full repeal of the Affordable Care Act was unlikely, Hatch suggested that Republicans must consider an ACA alternative should access to insurance subsidies be limited following the Supreme Court case, King v. Burwell.

“It is important that Republicans begin to unite behind an alternative to Obamacare because as we all know, the Supreme Court is going to rule on the legitimacy of the Obamacare subsidies by the end of June,” Hatch said.

Hatch also called for the repeal and replacement of the Medicare Sustainable Growth Formula (SGR), referring to the current system as “broken.”

HHS Unveils Plan to Overhaul Medicare Payment Models

The Department of Health and Human Services (HHS) outlined a plan in January to overhaul the traditional fee-for-service payment model in place for standard Medicare beneficiaries.

The new plan primarily outlines goals to incentivize patient outcomes over volume of care – combatting long-standing criticism of the fee-for-service model. Specifically, the Obama Administration seeks to:

- **Increase the amount of payments tied to quality or value-based payment models.** According to its plan, HHS would tie 85% of reimbursements to patient outcomes by 2016. The number would then move to 90% by 2018.

- **Expand Medicare benefits linked to alternative payment models.** HHS would tie 30% of traditional Medicare payments models, such as accountable care organizations (ACOs) by next year. The number would then move to 50% by the end of 2018.

The plan would have vast implications, as nearly 70% of Medicare beneficiaries are currently enrolled in the traditional coverage program.

“We believe these goals can drive transformative change, help us manage and track progress and create accountability for measurable improvement,” HHS Secretary Sylvia Mathews Burwell said in a
statement announcing the targets.

HHS also announced the creation of the Health Care Payment Learning and Action Network, which will aim to expand value-based payment to additional sectors of the health insurance market, including employer-based coverage and state Medicaid programs.

House Energy & Commerce Committee Releases 21st Century Cures Discussion Document, Legislative Phase Underway

The House Energy and Commerce Committee released its first 21st Century Cures discussion document this month, highlighting specific proposals and setting the legislative phase in motion. Among a number of provisions, the discussion document specifically addresses:

- **Coverage with evidence development.** The provision would “address the long and sometimes costly process that new technology developers must go through to secure CMS coverage, while reducing seniors medical costs by allowing for Medicare beneficiaries to secure coverage from the program for products that are the subject of the clinical trial in which they participate.”

- **Provider consolidation.** The provision would “require CMS to analyze and seek public input on how proposed Medicare payment policies would affect the consolidation of providers and payers.”

- **Local and national coverage decision reforms.** The provision would alter the current Medicare local coverage determination (LCD) process, in order “to establish a timely process for development of local coverage determinations that provides for opportunities for 6 public comment and for disclosure of information to the public regarding such determinations.”

“These ideas represent an important milestone – a critical first step in a legislative process,” said committee Chairman Fred Upton (R-MI) in a statement. “However, this document is far from the final product. Some things may be dropped, some items may be added, but everything is on the table as we hope to trigger a thoughtful discussion toward a more polished product.”

For a section-by-section overview of the discussion document, [click here.](#)

For the legislative one-pager, [click here.](#)

Interventional cardiology recognized as separate specialty by CMS

The Centers for Medicaid and Medicare Services (CMS) now recognizes interventional cardiology as its own specialty.
The new designation allows interventional cardiologists to be compared against each other in performance metrics, rather than all cardiologists. It also will allow interventional cardiologists to be reimbursed for consulting with noninterventional cardiologists, which was not previously possible.

According to the Society for Angiography and Interventions (SCAI), “[t]he field of interventional cardiology was established nearly 40 years ago when innovative treatments, including coronary angioplasty, were first used to successfully treat heart disease patients. Since then, the field has broadened to include catheter-based treatments for a wide range of cardiovascular diseases, including peripheral artery disease, heart valve defects, stroke and congenital heart defects.”

In general, traditional cardiologists provide a range of different services and procedures in order to study, prevent, diagnose and treat heart problems including heart failure, cardiac arrest and coronary artery disease. They also largely perform less-invasive surgery.

“We pushed quite hard to get this [specialty designation] because [interventional cardiologists] make up a distinct group of individuals practicing cardiology, and should be recognized aside from general cardiologists and even our colleagues who are invasive but noninterventional cardiologists,” said Peter Duffy, MD, MMM, FSCAI, secretary and chair of the advocacy and government relations committee for SCAI, “More accurate physician profiles and fair comparison are critical to our success in the future.”

“[T]he concern is that if we are compared to general cardiologists, we are going to be seen in some cases as over-utilizers of procedures; our length of stay may be different; our mortality, even risk-adjusted, may be different,” Duffy explained. “We want to ... be able to compare ourselves to our colleagues who are doing pretty much the same work that we are doing. That hadn’t been possible in the past. With that comparison, we will be able to improve quality, find outliers ... and improve performance across the board.”

The decision went into effect on January 12, following approval from CMS last May. SCAI made the original request for re-designation. Interventional cardiologists must contact his or her local coverage determination contractor to officially change designation.

To read the full SCAI statement, click here.

MedPAC Meets to Discuss Medicare Payment

The Medicare Payment Advisory Commission (MedPAC) stressed the need for updated site-neutral payment policies, among several recommendations for the Medicare program at a meeting in January. Specifically, MedPAC stressed the need for equal site-neutral payment for inpatient rehab facilities (IRFs) and skilled nursing facilities (SNFs). The Commission also proposed a small hike in hospital reimbursement, as well as a freeze in rates paid to most caregivers in 2016.

“The Commission believes that Medicare should begin to move towards site-neutral payments where there is clear overlap in the services provided,” MedPAC wrote in a meeting brief. “In the longer run, Medicare is beginning efforts to develop a common payment system that will eliminate the current setting-based.”
In addition to addressing site-neutral payment in post-acute care settings, the Commission proposed a 3.5 percent increase in the rates paid for inpatient and outpatient hospital procedures in 2016. MedPAC also recommended freezing the rates paid not only to physicians, but also home health aides, skilled nursing facilities, ambulatory surgical centers, dialysis facilities, hospice, inpatient rehabilitation facilities and long-term care hospitals in the next year.

At the meeting MedPAC again called to replace Medicare Sustainable Growth Rate (SGR) payment formula.

For a full transcript of the MedPAC meeting, click here.

CMS Chief Tavenner to Step Down

- CMS Administrator Marilyn Tavenner will step down, leaving the Centers for Medicare & Medicaid Services at the end of February.

Tavenner led CMS for three years. In her role, Tavenner supervised the rollout of the Affordable Care Act’s federal insurance marketplace.

She was confirmed by the Senate 91-7 in mid-2013 but had been acting administrator since 2011. Her temporary replacement will be Andy Slavitt, formerly a UnitedHealth Group executive who is now CMS principal deputy administrator. It is unclear who will take on the permanent role of CMS Administrator, as appointing a replacement may prove politically problematic.

“It is with sadness and mixed emotions that I write to tell you that February will be my last month serving as the Administrator for CMS,” Tavenner wrote in a farewell letter to CMS. “I have great pride and joy knowing all that we have accomplished together since I came on board five years ago in February of 2010.”