President Barack Obama released his $4 trillion budget for fiscal year 2016 this month, including $434 billion in Medicare savings amongst a number of policy priorities. Related to healthcare, the budget included changes to the Medicare physician payment system (SGR) and payment parity reforms for services provided in both the hospital outpatient department and physician office setting.

Regarding these proposals, the Budget specifically states:

**Improve the Way Providers are Paid**

*Cost Estimate: $44 billion over 10 years*

The Budget adopts the following policies for reforming the way Medicare pays physicians, consistent with recent bipartisan, bicameral legislation:

- Terminates the Sustainable Growth Rate formula for updating physician payments;
- Provides a period of stability while promoting participation in alternative payment models that encourage high quality, efficient care; and
- Streamlines value-based incentives for those physicians remaining outside of alternative payment models.

**Encourage Efficient Care by Improving Incentives to Provide Care in the Most Appropriate Ambulatory Setting**

*Savings Estimate: $29.5 billion over 10 years*

The Budget proposes to improve incentives to provide ambulatory care in the most appropriate clinical setting. Evidence suggests that, in recent years, billing of many ambulatory services has been shifting from physicians’ offices to the usually higher-paid hospital outpatient department setting, increasing Medicare spending and beneficiary cost-sharing. This proposal helps mitigate the financial implications...
of this trend by lowering payment for services provided in off-campus hospital outpatient departments under the Outpatient Prospective Payment System to either the Medicare Physician Fee Schedule-based rate or the rate for surgical procedures covered under the Ambulatory Surgical Center payment system. These changes would be phased in over four years beginning in CY 2017, and Secretarial authority would be provided to adjust payments in the event beneficiary access problems arise.

Other Medicare providers are included below:

<table>
<thead>
<tr>
<th>Medicare Providers</th>
<th>10-year cost (or savings) in $ billions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclude radiation therapy, advanced imaging, pathology and therapy services</td>
<td>(6.0)</td>
</tr>
<tr>
<td>from the in-office ancillary services exception unless a practice is</td>
<td></td>
</tr>
<tr>
<td>clinically integrated and demonstrates cost containment</td>
<td></td>
</tr>
<tr>
<td>Repeal the SGR in a manner consistent with the recent bipartisan, bicameral</td>
<td>44</td>
</tr>
<tr>
<td>legislation</td>
<td></td>
</tr>
<tr>
<td>Incentivize care in the most appropriate ambulatory setting</td>
<td>(29.5)</td>
</tr>
<tr>
<td>Make permanent the Medicare primary care incentive payment; budget neutral</td>
<td>---</td>
</tr>
<tr>
<td>Value-based purchasing for ASCs, SNFs, home health, HOPDs,</td>
<td>---</td>
</tr>
<tr>
<td>and community mental health centers beginning 2017</td>
<td></td>
</tr>
<tr>
<td>Reduce bad debt payments</td>
<td>(31.1)</td>
</tr>
<tr>
<td>Align GME payments with patient care costs</td>
<td>(16.3)</td>
</tr>
<tr>
<td>Reduce payments for Part B drugs from 106% ASP to 103%</td>
<td>(7.4)</td>
</tr>
<tr>
<td>Reduce CAH payments from 101% of reasonable costs to 100%</td>
<td>(1.7)</td>
</tr>
<tr>
<td>Prohibit CAH designation for facilities less than 10 miles from</td>
<td>(0.8)</td>
</tr>
<tr>
<td>nearest hospital</td>
<td></td>
</tr>
<tr>
<td>Reduce fraud, waste and abuse</td>
<td>(1.8)</td>
</tr>
<tr>
<td>Adjust payment updates for certain post-acute care providers</td>
<td>(102.1)</td>
</tr>
<tr>
<td>Encourage appropriate use of inpatient rehabilitation hospitals</td>
<td>(2.2)</td>
</tr>
<tr>
<td>Implement bundled post-acute care payments</td>
<td>($9.3)</td>
</tr>
<tr>
<td>Extend accountability for hospital-acquired conditions</td>
<td>---</td>
</tr>
</tbody>
</table>

To read Health and Human Services’ FY2016 “Budget in Brief,” click [here](https://example.com).

For full summary tables of the budget proposal, click [here](https://example.com).

**GOP Leaders Introduce Affordable Care Act Replacement Plan**

Senator Richard Burr (R-N.C.), Senate Finance Chairman Orrin Hatch (R-Utah), and House Energy and Commerce Chairman Fred Upton (R-Mich.) unveiled a plan to repeal the Affordable Care Act this month.
The Patient Choice, Affordability, Responsibility, and Empowerment (CARE) Act would eliminate the mandates in the President’s signature health law while keeping tax credits in place to help low-income Americans purchase private health insurance.

According to a press statement, the CARE Act specifically aims to:

- Establish sustainable, patient-focused reforms;
- Modernize Medicaid to provide better coverage and care to patients;
- Reduce defensive medicine and rein in frivolous lawsuits;
- Increase health care price transparency to empower consumers and patients;
- Reduce distortions in the tax code that drive up health care costs; and
- Empower small Businesses and individuals with purchasing power.

To read a two-page summary, click here.

To see a comparison of Patient CARE with the Affordable Care Act, click here.

SGR Repeal to Cost Billions More, According to New Projections

The price of the bipartisan, bicameral proposal to replace the Medicare sustainable growth rate formula (SGR) formula has increased by $30.5 billion, according to updated Congressional Budget Office (CBO) projections.

The CBO originally estimated that total repeal of SGR – which calls for automatic reductions in reimbursement rates for doctors once spending reaches a certain rate – would cost $144 billion from 2015 to 2024. When factoring in an additional budget year, however, the organization now predicts the plan will cost $174.5 billion through 2025.

To read the full CBO score, click here.

CMS Announces Medicare Payment Cuts for Physicians Who Didn’t Adopt EHRs

The federal government will make Medicare payment cuts to 256,000 doctors who failed to participate in the Medicare Electronic Health Record Incentive program, according to new CMS data.
78,000 physicians – or 31% of all those levied with payment cuts – will see a pay reduction of at least $2,000. The remaining doctors will experience smaller reductions. The cuts for physicians who did not adopt EHRs began affecting Medicare claims on Jan. 5.

An electronic health record (EHR) allows healthcare providers to record patient information digitally, rather than using paper records. In order to incentivize doctors to utilize EHRs, CMS created the meaningful use penalty, which levies a one percent reduction in Medicare reimbursements each year that a provider doesn’t successfully participate in the EHR program.

CMS states that EHRs help providers “achieve benchmarks that can lead to improved patient care.” To access the CMS presentation, click here.

ICD-10 Implementation

Energy & Commerce Committee Discusses ICD-10 Implementation at Hearing

The House Energy & Commerce Committee examined the implementation of the ICD-10 coding system at a hearing this month. Lawmakers and stakeholders expressed differing opinions, with some arguing for uninhibited implementation and others calling for additional delays.

The International Classification of Diseases is a standardized coding system used by providers for identifying illnesses and treatments, as well as for reimbursement. The ICD-10 system – which is set to go into effect in October 2015 – would serve as an update to the current ICD-9 and will include an additional 55,000 entries. Implementation of the new code set has been delayed multiple times since its introduction in 2013, most recently by last year’s patch to the Medicare physician payment formula.

Many leading lawmakers, including E&C Chairman Rep. Joe Pitts (R-Pa.) and ranking member Rep. Gene Greene (D-Texas), did not favor additional postponements to ICD-10 implementation. “I support moving forward to ICD-10,” said Pitts. “No more delays.”

Earlier this month, Senate Finance Chair Orrin Hatch (R-UT) and ranking Democrat Ron Wyden (OR) also echoed Pitts’ sentiments. The two indicated that CMS would be ready to transition to the ICD-10 code set in October, stating that there is no reason for further delay.

CMS has introduced a number policies and procedures to smooth the healthcare industry’s transition to ICD-10. According to a report from the Government Accountability Office (GAO) released earlier this month, the majority of stakeholders now say the CMS efforts have been helpful.

“CMS has taken multiple steps to help prepare covered entities for the transition, including developing educational materials and conducting outreach, and the majority of the stakeholders we contacted reported that both of those activities have been helpful to preparing covered entities for the ICD-10 transition,” says the report.

The GAO said the CMS educational tools, which are all available on the agency’s website, include:
Information on why the ICD-10 transition is happening and how the ICD-10 codes differ from the existing ICD-9 codes;

Checklists and timelines intended to help stakeholders make the transition in a timely and efficient manner;

Videos and webinars; and

Links to outside organizations that include further ICD-10 educational tools.

A number of healthcare stakeholders also testified before the committee. Six of seven witnesses asserted that Congress should not delay the ICD-10 rollout, arguing that ICD-10 would improve patient care and research while helping to prevent billing fraud, including:

- **Edwin M. Burke**, MD, Beyer Medical Group
- **Rich Averill**, Director of Public Policy, 3M Health Information Systems
- **Sue Bowman**, Senior Director, Coding Policy and Compliance, American Health Information Management Association
- **Kristi A. Matus**, Chief Financial and Administrative Officer, Athena Health
- **Carmella Bocchino**, Executive Vice President of Clinical Affairs and Strategic Planning, America’s Health Insurance Plans
- **Dr. John Hughes**, Professor of Medicine, Yale University

To watch the hearing, or read full text of the witness testimonies, click [here](#).

For the full GAO report, click [here](#).

**ICD-10 System Completes First Week Testing**

The Centers for Medicare & Medicaid Services (CMS) completed the first week of end-to-end testing of new ICD-10 coding system this month, expressing generally positive results.

CMS announced that its systems are ready for ICD-10 implementation, based on test results. The agency also asserted that the health care community at large will be ready for implementation of the updated coding system on October 1.

“Overall, participants . . . were able to successfully submit ICD-10 claims and have them processed through our billing systems,” wrote CMS Administrator Marilyn Tavenner in a blog post. “To the extent that some claims were rejected, most didn’t meet the mark because of errors unrelated to ICD-9 or ICD-10.”

Approximately 660 providers and billing companies submitted nearly 15,000 test claims in the testing that took place from January 26 to February 3. The week of testing was first of three end-to-end testing weeks before ICD-10 implementation on October 1, 2015.
According to CMS, the tests will be useful in “identifying issues well before ICD-10 implementation,” while giving “CMS time to fix any issues and test them again to ensure that claims are processing as expected.”

In the blog post, Tavenner also explained that medical practices that bill Medicare may still choose take part in future testing opportunities.

For the CMS blog post, click here. For an ICD-10 fact sheet, click here.

The CardioVascular Coalition (CVC), established in 2014, is a nonprofit organization representing freestanding cardiovascular centers. CVC members are comprised of national organizations representing providers (National Cardiovascular Partners and the Outpatient Endovascular and Interventional Society) and manufacturers (Cardiovascular Systems, Inc. and Covidien).

The mission of the CVC is to advance patient access to community-based cardiovascular and endovascular care. Recognizing that cardiovascular disease is a leading – and preventable – cause of death in the United States, the physicians, care providers, advocates, and manufacturers who comprise the Coalition are dedicated to community-based solutions designed to improve awareness and prevention of cardiovascular disease and peripheral artery disease, reduce geographic disparities in access to care, and secure patient access to high-quality, cost-effective, community-based interventional treatment across America.