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- The SGR mechanism is permanently repealed, averting a 21 percent SGR-induced cut scheduled for April 1, 2015.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.

Physicians 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.

**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 operational 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.

**Supreme Court Considers Insurance Subsidies in King v. Burwell**

The Supreme Court heard oral arguments in King v. Burwell this month – a case that could disrupt federal subsidies for Americans purchasing health insurance on exchanges run by the federal government. Judges will consider the intention of vague wording in President Obama’s health law, most likely offering a decision in June.

The case centers on a single phrase in the Affordable Care Act that authorizes premium tax credits for middle-income people in states with exchanges “established by the state.” The plaintiffs argue that federal tax credits used to subsidize insurance premiums are, therefore, illegal in states that are not running their own health insurance exchanges. The Obama Administration has rebuked such claims, asserting that the law always intended to offer subsidies to all Americans.

Overall, the oral arguments offered few clues as to how the court will decide. For instance, Chief Justice Roberts – who many view as a potential swing vote in the case – did not ask any questions. However, Justices Kennedy, Ginsburg, and Alito raised three unexpected questions.
Justice Kennedy – another potential swing vote – raised the idea of “federal coercion,” suggesting that by removing subsidies, “[t]he States are being told either create your own exchange, or we’ll send your insurance market into a death spiral.”

Justice Alito raised the possibility that, in the event that the Supreme Court did rule against the health care law, it could maintain tax credits until the end of the year.

Justice Ginsburg challenged the plaintiffs’ argument of whether the people challenging the ACA were actually being harmed by the law.

Proponents of the ACA worry that eliminating federal subsidies will threaten the viability and affordability of health plans selected by 8.6 million people in 37 states. Indeed, the Department of Health and Human Services (HHS) now estimates that if the Supreme Court were to rule in favor of the plaintiff, individual premiums would increase by an average of 256 percent. The Secretary of Health and Human Services, Sylvia Burwell, publicly stated this month that the agency has no backup plan if the Supreme Court were to rule against the health law.

The King v. Burwell decision comes amidst the updated health care spending projection from the Congressional Budget Office, released just days following oral arguments. The non-partisan office now estimates that the ACA will cost taxpayers 11 percent less — totaling $142 billion — over the next decade. The cost of providing subsidies for people to buy insurance on the state and federal marketplaces — the centerpiece of the law and point of contention — will also be 20 percent lower than originally projected.

For a full transcript of the oral arguments, click here.

For the updated CBO report on baseline ACA spending, click here.

**CBO Estimates Cost 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.
More Doctor Groups Get Increases Than Cuts Under CMS’s Value-Based Modifier Program

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

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. The 691 groups that registered were then given the option to participate in the VM, which could lead to payment adjustments.

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.”

In 2016, physicians in smaller groups of 10 or more will also be subject to the VM based on their 2014 performance. Also beginning in 2016, “quality tiering” will automatically apply to all groups subject to the VM. In 2017, CMS will begin applying the value modifier to all physicians, including solo practitioners.

For the 2015 Value Modifier Results, click here.

Performance Improving for Many Quality Measures, According to CMS

The Centers for Medicare and Medicaid Services (CMS) announced performance improvements across several sets of quality measures, according to its Quality Measures Report released this month. CMS listed the report’s key findings in a blog post by Dr. Patrick Conway, deputy administrator for innovation and quality and chief medical officer at CMS. They included:

- Quality measurement results demonstrate significant improvement. 95 percent of 119 publicly reported performance rates across seven quality-reporting programs showed improvement during the study period (2006–2012).
Race and ethnicity disparities present in 2006 were less evident in 2012. Measure rates for Hispanics, Blacks and Asians showed the most improvement, and American Indian/Native Alaskans and Native Hawaiian/Pacific Islanders the least improvement.

Provider performance on CMS measures related to heart and surgical care saved lives and averted infections. From 2006 to 2012, 7,000 to 10,000 lives were saved through improved performance on inpatient hospital heart failure process measures, and 4,000 to 7,000 infections were averted through improved performance on inpatient hospital surgical process measures.

CMS quality measures impact patients beyond the Medicare population. Over 40 percent of the measures used in CMS quality reporting programs include individuals whose healthcare is supported by Medicaid, and over 30 percent include individuals whose healthcare is supported by other payer sources.

CMS quality measures support the aims of the National Quality Strategy (NQS) and CMS Quality Strategy. CMS quality measures reach a large majority of the top 20 high-impact Medicare conditions experienced by beneficiaries, with more measures directed at the six measure domains related to the NQS priorities, and better balance among those domains.

The Quality Measures Report was mandated by the Affordable Care Act and must be published and at least once every three years. The first report was released in 2012.

For the full CMS report, click here.

For more information on quality measures, click here.

HHS Announces New Accountable Care Organization Model

The Centers for Medicare and Medicaid Services (CMS) unveiled its updated Next Generation Accountable Care Organization (ACO) Model this month.

CMS states that the goal of the Next Generation model – which will replace the pioneer program currently in place – is part of the Obama administration’s plan to further bolster quality, rather than quantity, of care. It aims to set “predictable financial targets,” enable “greater levels of financial risk so that providers have more opportunities to coordinate beneficiaries’ care,” and maintain “the highest of quality standards consistent with other Medicare programs and models.”

Specifically, the core principals of the Next Generation model are:

- Protecting Medicare FFS beneficiaries’ freedom to seek the services and providers of their choice;
- Creating a financial model with long-term sustainability;
Utilizing a prospectively-set benchmark that: (1) rewards quality; (2) rewards both improvement and attainment of efficiency; and (3) ultimately transitions away from an ACO’s recent expenditures when setting and updating the benchmark;

- Engaging beneficiaries in their care through benefit enhancements that directly improve the patient experience and reward seeking care from ACOs;

- Mitigating fluctuations in aligned beneficiary populations and respecting beneficiary preferences through supplementing a prospective claims-based alignment process with a voluntary process;

- Smoothing ACO cash flow and improving investment capabilities through alternative payment mechanisms.

Accountable Care Organizations are associations of doctors, hospitals and other providers that jointly care for Medicare patients with the goal of pocketing a portion of what they save the government. Those that spend above Medicare estimates, however, are set to be penalized. In the first year of the “pioneer” program, 118 ACOs saved Medicare $705 million, while another 102 ACOs spent more than the program’s benchmark. ACOs were previously able to serve up to 5,000 patients, but will now be able to serve up to 10,000 in the Next Generation model.

For the official press release, click here.

For the CMS blog post, click here.

For the Next Generation ACO Model fact sheet, click here.

**MedPAC Delivers Annual Report to Congress**

The Medicare Payment Advisory Commission (MedPAC) analyzed payment adequacy in fee-for-service (FFS) Medicare in its annual report to Congress this month.

In the report, MedPAC offered a number of recommendations for annual rate adjustments under Medicare’s various FFS payment systems. Specifically, MedPAC urged congress to:

- Repeal the Medicare Sustainable Growth Rate (SGR) before the April 1 deadline;

- Increase shared savings opportunities for physicians and health professionals in Accountable Care Organizations (ACOs);

- Update inpatient and outpatient hospital payment rates 3.25 percent for 2016;

- Direct the regular collection of data—including service volume and work time—to establish more accurate work and practice expense values to.

- Identify overpriced fee-schedule services and reduce their relative value units (RVUs) accordingly.
Establish a prospective per beneficiary payment to replace the Primary Care Incentive Payment program (which provides a 10 percent bonus payment for certain primary care practitioner services) after it expires at the end of 2015.

The group also offered sector-specific updates. In terms of cardiovascular services, there was a 7.6 percent decrease in “units of service per beneficiary” and a 2.9 percent decrease in “volume per beneficiary” between 2012 and 2013. On the whole, cardiovascular services accounted for 1.7 percent of all allowed charges on the FFS model in 2013.

In addition to FFS updates, MedPAC reviewed the status of Medicare Advantage (MA) and the Part D prescription drug benefit. The group said that “MA enrollment increased by 9 percent to 16 million beneficiaries (or 30 percent of all Medicare beneficiaries)” in the past year. It also noted that while quality measures generally improved under the MA program, plans saw a decline in performance on mental health measures.

With regards to the part D drug program, MedPAC reported that “about 69 percent of Medicare beneficiaries (37 million beneficiaries) were enrolled in Part D plans” last year, while an “additional 5 percent received their drug coverage through employer-sponsored plans that receive Medicare’s retiree drug subsidy.” The report also focused heavily on part D’s ability to lower prescription drug costs, yet noted that “prices for single-source brand name drugs and specialty drugs are increasing rapidly, and are expected to drive an increasing share of spending.”

For the full report, click here.

For the official fact sheet, click here.

For MedPAC’s recommendations for physician services, 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.