MEDCAC Unveils Discussion Topics for July Meeting on PAD

The Medicare Evidence Development & Coverage Advisory Committee (MEDCAC) released three voting questions and two additional topics to be discussed at its July 22 meeting, which will specifically focus on lower extremity peripheral artery disease (PAD).

Specifically, the three discussion questions include:

- For adults with asymptomatic lower extremity PAD, how confident are you that there is sufficient evidence for an intervention that improves: a) Immediate/near-term health outcomes? b) Long-term health outcomes?

- For adults with lower extremity intermittent claudication (IC), how confident are you that there is sufficient evidence for an intervention that improves: a) Immediate/near-term health outcomes? b) Long-term health outcomes?

- For adults with lower extremity critical limb ischemia (CLI), how confident are you that there is sufficient evidence for an intervention that improves: a) Immediate/near-term health outcomes? b) Long-term health outcomes?

Additional discussion topics include:

- Important evidence gaps that have not been previously or sufficiently addressed.

- Lower extremity PAD treatment disparities and how they may affect the health outcomes of Medicare beneficiaries.

For more information on the meeting, click here.
Energy & Commerce Committee Passes 21st Century Cures Bill

The House Energy and Commerce Committee unanimously passed 21st Century Cures legislation on May 21 by a vote of 51-0. The bill aims “to bridge the gap between advances in science and medicine” and expedite the approval of breakthrough therapies.

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](#).

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.

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.

**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 free-standing 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.

**ACO Pioneer Model Saved Medicare Nearly $400 Million, HHS Considers Expansion**

The Pioneer Accountable Care Organization (ACO) pilot program established under the Affordable Care Act saved Medicare more than $384 million in 2012 and 2013, according to an independent evaluation report released by the Department of Health and Human Services (HHS). The Pioneer ACO model generated an average of approximately $300 in savings per participating beneficiary per year. Specifically, Pioneer ACOs generated Medicare savings of $279.7 million in 2012 and $104.5 million in 2013.

On the heels of the report, the Office of the Actuary in the Centers for Medicare & Medicaid Services (CMS) established the pioneer program as the very first patient care model to officially meet criteria for expansion to larger beneficiary populations, as growth would reduce future net Medicare spending. As a result, HHS will now “consider ways to scale the Pioneer ACO Model into other Medicare programs.”

ACO are associations of doctors, hospitals and other providers that agree to accept lump payments under Medicare instead of individual payments for each service they provide. Successful providers then pocket a portion of what they save the government, while those that spend above Medicare estimates are penalized. Thirty-two hospital systems signed up to become Pioneer ACOs in 2012, but 13 have dropped out since. The program currently serves approximately 600,000 people.
CMS announced an updated “Next Generation” ACO model in March, which the Obama Administration believes will help 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.”

For the official HHS press release, [click here](#).

To read the CMS Office of the Actuary Certification of Pioneer ACO Model savings, [click here](#).

To view the second Pioneer ACO Model evaluation report, [click here](#).

**GAO Report Addresses Impact of Transparency and Data on Physician Payment Rates**

The U.S. Government Accountability Office (GAO) analyzed the current process in place to regularly review Medicare physicians’ services’ work relative values (which reflect the time and intensity needed to perform a service) in a report entitled “Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy.”

In the report, GAO asserted that CMS’s “process for establishing relative values may not ensure accurate Medicare payment rates and lacks transparency.” Specifically, they wrote:

> “CMS’s process for establishing relative values embodies several elements that cast doubt on whether it provides assurance of accurate Medicare payment rates. While CMS stated that it complies with a statutory requirement governing how often physicians’ services are to be reviewed, CMS does not track when a service was last valued or have a documented standardized process for prioritizing its review of services. The agency also has limited documentation about its process, and does not have any documentation with specific information about the selected method used to review a specific RUC recommendation. Lack of transparency in its process and lack of data sources to validate RUC recommendations, combined with evidence that CMS relies heavily on the RUC for relative value recommendations despite weaknesses with the RUC’s data, may undermine payment rate accuracy.”

Ultimately, GAO made two general recommendations to Congress, which included:

- CMS should better document its process for establishing relative values and develop a process to inform the public of potentially misvalued services identified by the RUC.
- CMS should also develop a plan for using funds appropriated for the collection and use of information on physicians’ services in the determination of relative values.

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

For the one-page summary, [click here](#).
USPSTF Puts Forth Research Plan on Cardiovascular Disease Prevention

The independent U.S. Preventive Services Task Force (USPSTF) has unveiled its final research plan on behavioral counseling to promote a healthful diet and physical activity for cardiovascular disease prevention in adults without known cardiovascular disease risk factors. The analytic research framework – which was released after a month-long comment period – will now be used to guide a systematic review and, ultimately, form an official USPSTF “Recommendation Statement.”

Key questions to be systematically reviewed include:

- Do primary care behavioral counseling interventions to improve diet, increase physical activity, and/or reduce sedentary behavior improve health outcomes in adults?
- Do primary care behavioral counseling interventions to improve diet, increase physical activity, and/or reduce sedentary behavior improve intermediate outcomes associated with cardiovascular disease (CVD) in adults?
- Do primary care behavioral counseling interventions to improve diet, increase physical activity, and/or reduce sedentary behavior improve associated health behaviors in adults?
- What adverse events are associated with primary care behavioral counseling interventions to improve diet, increase physical activity, and/or reduce sedentary behavior in adults?

Contextual questions include:

- What is the relationship between behavioral outcomes (i.e., healthful diet, physical activity, and sedentary behavior) for which there is evidence that behavioral counseling interventions have an effect and health outcomes (i.e., cardiovascular morbidity and mortality, all-cause mortality, and health-related quality of life)?
- What is the relationship between intermediate outcomes (i.e., CVD risk factors) for which there is evidence that behavioral counseling interventions have an effect and health outcomes?

To view the full research plan, including the analytic framework and research approach, click here.