President Obama Signs SGR Repeal Bill

The Senate passed the Medicare Access and CHIP Reauthorization Act (MACRA) on April 15 by a vote of 92-8, permanently repealing the Medicare sustainable growth rate (SGR) formula, which has been used to determine physician payment rates for more than a decade. President Obama signed the bill into law on April 16.

Legislators from both sides of the aisle introduced a total six amendments prior to voting on the legislation. However, none were able to achieve the necessary threshold to pass.

- **Repealing the individual mandate (R):** Offered by Sen. John Cornyn (R-TX), the amendment suggested paying for SGR repeal via the repeal of the Affordable Care Act’s individual mandate. The final count was 54 Yes and 45 No, failing to garner the 60 needed.

- **Stripping out the pay-go exemption that typically requires any spending increase be paid for by a tax increase or spending cuts elsewhere (R):** Offered by Sen. Mike Lee (R-UT), the amendment required that the SGR repeal measure be fully funded rather than subject to pay-as-you-go rules. The final count was 42 Yes and 58 No, failing to garner the majority needed.

- **Providing steady updates of payment rates under the Medicare physician fee schedule rather than incentive adjustments through “alternative payment models” (R):** Offered by Senator Tom Cotton (R-AR), the amendment would have made the 0.5% PFS pay hike permanent, indefinitely increasing physician payments. The final count was 11 Yes and 89 No, failing to garner the 60 needed.
- **Repealing the Medicare therapy caps (D):** Offered by Sen. Ben Cardin (D-MD), the amendment aimed to permanently fix physical therapy caps, which were only extended through 2017. The final count was 58 Yes and 42 No, failing to garner the 60 needed.

- **Extending CHIP for four years (D):** Offered by Sen. Michael Bennet (D-CO), the amendment aimed to extend CHIP an additional two years. The final count was 50 Yes and 50 No, failing to garner the 60 needed.

- **Eliminating abortion language and add two additional years to community health center funding (D):** Offered by Sen. Patty Murray (D-WA), the amendment aimed to alter language that the SGR bill's opponents believe will solidify abortion restrictions and limit low-income women’s access to abortion. The final count was 43 Yes and 57 No, failing to garner the 60 needed.

To download the bill, [click here](#).

**CMS Actuary Report on H.R. 2**

Despite passage, the resolution to repeal and replace the Medicare Sustainable Growth Rate (SGR) may not serve as a permanent solution for future physician payments, according to an April 9 report from the Centers for Medicare & Medicaid Services’ (CMS) Office of the Actuary.

“Absent a change in the method or level of update by subsequent legislation, we expect access to Medicare-participating physicians to become a significant issue in the long term under H.R. 2,” wrote the Actuary.

The American Medical Association, however, dismissed the report in a statement. Instead, AMA President Robert Wah concluded that H.R. 2 is “far better than current law and will ensure the sustainability of the Medicare program.”

**MEDCAC to Host Meeting on Peripheral Artery Disease**

- The Medicare Evidence Development & Coverage Advisory Committee (MEDCAC) announced this month that it would host a public meeting on Wednesday, July 22, which will specifically focus on lower extremity peripheral artery disease (PAD).

  At the meeting, the Committee will hear oral presentations from the public for approximately 45 minutes followed by open deliberation. MEDCAC will also allow a 15-minute unscheduled open public session for any attendee to address issues specific to the topics under consideration. At the conclusion of the day, Committee members will vote and make final recommendation(s) to CMS.

  For more information on the event and submission details, [click here](#).
CHQPR Report Outlines Effective Formation of Alternative Payment Models

The Center for Healthcare Quality & Payment Reform (CHQPR) examined the construction of alternative payment models that benefit patients, payers, and providers in a new report entitled The Building Blocks of Successful Payment Reform: Designing Payment Systems That Support Higher-Value Health Care.

Ultimately, CHQPR asserts that payment reforms must be formulated to achieve four separate goals, including:

- **Sufficient flexibility in care delivery** so that healthcare providers can deliver high quality, affordable services that are matched to the unique needs of individual patients;
- **Appropriate accountability for spending** to assure purchasers that healthcare will be more affordable than under the current payment system;
- **Appropriate accountability for quality** to assure both patients and purchasers that the quality of care will be maintained or improved; and
- **Adequacy of payment** to cover the costs of delivering high-quality, efficient care to the types of patients that providers see.

The report also addresses a number of key healthcare topics such as bundling, incentives, and issues with fee-for-service reimbursement models. Ultimately, though, the authors conclude that payment reform must take place on a case-by-case basis.

“The key is to ensure that if different payment systems are used to support a particular aspect of health care in a particular community, each payment system provides the necessary flexibility, accountability, and adequacy to enable providers to successfully provide high–quality care at an affordable cost,” they write.

For the full report, [click here](#).
For an executive summary of the report, [click here](#).

CMS Proposes Shortened Meaningful Use Reporting Period for EHRs

The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule on April 10 that would primarily simplify and streamline reporting requirements for the Electronic Health Record (EHR) program for meaningful use through 2017.
CMS claims the updated regulations will “allow providers to focus on objectives that support the advanced use of EHR technology, health information exchange, and quality improvement.” Specifically, the proposals in the rule include:

- Reducing the overall number of objectives to focus on advanced use of EHRs;
- Removing measures that have become redundant, duplicative or have reached wide-spread adoption;
- Realigning the reporting period beginning in 2015, so hospitals would participate on the calendar year instead of the fiscal year; and
- Allowing a 90-day reporting period in 2015 to accommodate the implementation of these proposed changes in 2015.

“Meaningful use” reporting was established in 2009 in hopes that the electronic exchange of health information would improve the overall quality of health care. According to the U.S. Department of Health and Human Services, “meaningful use” means providers need to show they’re using certified EHR technology in ways that can be measured significantly in quality and in quantity.

Established in multiple phases since its inception, Medicare will now require that all Medicare eligible professionals and hospitals meet meaningful use criteria or they may be subject to a financial penalty after 2015.

For a CMS fact sheet of the proposed rule, click here.

For the full Electronic Health Record Incentive Program proposed rule, click here.

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**CMS Hosts Forum to discuss Next Generation ACO Model**

In follow-up to the March 10, 2015 announcement of the Next Generation Accountable Care Organization (ACO) Model of payment and care delivery, the Center for Medicare and Medicaid Innovation (CMS Innovation Center) hosted the fourth in a series of open door forums on Tuesday, April 7, 2015. The open door forum focused on benefit enhancements and beneficiary care coordination reward.

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.”
The presentation's agenda specifically included:

- Preliminary Beneficiary Engagement Timeline
- Beneficiary Engagement Topics
  - Next Generation ACO Entities (Providers/Suppliers, Preferred Providers, Affiliates)
  - Coordinated Care Reward
  - Benefit Enhancements (Telehealth, Post-Discharge Home Visits, 3-Day SNF Rule Waiver, Implementation Plans)
  - Voluntary Alignment

To view the full CMS slide deck, click here.

**Pioneer Program Yields “Promising” Results in Year One, Needs Updates, Report Says**

A recent Harvard University report, which was published in the New England Journal of Medicine on April 15, found that ACOs under the Pioneer model – which preceded the Next Generation Model – cut overall spending on Medicare patients by 1.2 percent in the program’s first year.

The 32 Pioneer programs saved a total of $118 million, according to the report. As a result, the participants claimed a total of $76 million in bonuses. A total of nine organizations did not earn bonuses and consequently dropped out of the Pioneer program. Four additional organizations, however, decided to enroll.

The study’s authors called the findings “promising”, but suggested that CMS may need to need to make additional changes in order to ensure that doctors and hospitals remain in the program.

Specifically, the researchers recommended that CMS provide further incentives to providers by offering a greater share of the bonuses. They also advised the government to alter the way they judge ACOs, suggesting that federal agencies assess ACOs based on how much they can save compared with medical spending growth in their local area. The measure, they said, would prove to be an easier standard than measuring them against their own prior results of cost cutting.

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The CardioVascular Coalition (CVC), established in 2014, is a nonprofit organization representing freestanding cardiovascular centers. CVC members are comprised of national organizations representing providers and manufacturers.

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.