Supreme Court Rules in Favor of Obama Administration in King v. Burwell

On June 25, the U.S. Supreme Court ruled 6-3 to uphold the federal subsidies for people who buy insurance through state exchanges under the Affordable Care Act (ACA).

The plaintiffs in King v. Burwell had challenged whether the IRS had authority to issue a regulation that allowed subsidies for insurance purchased on the federal exchanges. Previously, the D.C. Circuit Appeals threw out the IRS rule and the Fourth Circuit Court of Appeals deferred to the agency’s interpretation of the ACA.

The ruling holds that the ACA authorized federal tax credits for eligible Americans in not only states with their own exchanges, but also the 34 states with federal marketplaces.

Chief Justice John Roberts wrote in the court’s opinion that “Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them. If at all possible, we must interpret the Act in a way that is consistent with the former, and avoids the latter.”

Justice Antonin Scalia called the ruling “interpretative jiggery-pokering” in the minority dissent and argued that it was not the Court’s job to make up for the sloppy drafting of the law by Congress.

To read the full ruling, click here.
The Centers for Medicare and Medicaid Services (CMS) released the Physician and Other Supplier Public Use File (Physician PUF) for 2013 this month, making available information for the 100 most common inpatient services, 30 common outpatient services, all physician and other supplier procedures and services, and all Part D prescriptions.

Specifically, the new dataset – which is part of CMS' third annual release – contains statistics for more than 950,000 distinct healthcare providers who received a total of $90 billion in Medicare payments while delivering care to approximately 34 million Americans in 2013. It also includes information regarding $72 billion for medical services and $17 billion for drugs administered.

The American Medical Association (AMA), voiced concerns about the data in a statement, expressly citing a lack of context and “actionable information on the quality of care that patients and physicians can use to make any meaningful conclusions.” In a follow-up statement, the group emphasized the following points about the Medicare Part B dataset:

- Medicare payments aren't the physician's personal income.
- The majority of physicians don't receive noteworthy Medicare payments.
- Attribution issues could distort the data. The data is tied to the National Provider Identifier (NPI), therefore some physicians who provide Medicare services may not be included at all because their claims were filed using a group NPI.
- Residents, physician assistants, nurse practitioners and others under a physician’s supervision can all file claims under a single physician’s NPI, which can make it appear that some physicians personally.
- Physicians can’t correct errors in the data.

In addition, a Wall Street Journal analysis of 2012 Medicare data showed that large shares of the reported money paid to doctors is dedicated to overhead expenses (see, for example, the case of cardiologists in the graphic below).

It should also be noted that Medicare pays differently when services are provided in a hospital setting versus a freestanding physician's office. When services are delivered in a hospital setting, Medicare makes two payments, one for the physician's professional fee and one for the hospital's technical services (the latter of which is not included in the Physician PUF). On the other hand, for services
delivered in a physician office setting, the Physician PUF represents the complete payment for the service (i.e. professional and technical fees).

For the full data set, click here.
For CMS’ official fact sheet on hospital charge data, click here.
For CMS’ official fact sheet on Medicare Part B physician data, click here.

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**MedPAC Issues Annual Report on Medicare and the Health Care Delivery System**

The Medicare Payment Advisory Commission (MedPAC) released its monthly report to the Congress on June 15, suggesting refinements to Medicare payment systems and issues affecting the Medicare program, including site neutral payment reforms.

MedPAC also repeated past claims that there are clear payment differentials depending on sites of service and echoed calls to explore the impact of equalizing payments across settings for similar short inpatient and outpatient stays. In its official letter to Congress, the Commission stated that, in the wake of physician payment overhaul, “[m]ore work remains to be done in other key areas, including site-neutral payment.”

Chapter 7 of the report explores equalizing payments across settings for similar short inpatient and outpatient stays as an option for reforming hospital short-stay policies. MedPAC remains supportive of the concept, but however does not recommend a specific payment approach.

MedPAC writes, “A site-neutral approach—one that pays comparable rates for similar inpatient and outpatient stays—is another option. The effect of a site-neutral approach may be different for medical and surgical hospital stays... Because surgery is a more clearly defined service, it might be possible to develop site-neutral payment for similar inpatient and outpatient surgeries without creating payment differentials based on length of stay. For example, criteria could be developed to identify surgical cases that occur in both the hospital outpatient and inpatient settings and that are also very common to the outpatient setting (e.g., more than half of cases are performed in the outpatient setting).”

For the full report, click here.
For an executive summary of the report, click here.
HHS to Test Payment Model Intended to Curb Cardiovascular Disease

The Department for Health and Human Services (HHS) introduced the Million Hearts Cardiovascular Disease Risk Reduction model on May 28, which aims to prevent heart attacks and strokes among Medicare beneficiaries.

According to an HHS fact sheet, the model will give providers an opportunity “to design sustainable models of care that help reduce 10-year atherosclerotic cardiovascular disease (ASCVD)” by assessing an individual patient’s risks for heart attack or stroke and working with them to reduce those risks. Participating providers will be compensated for reducing the absolute risk for heart disease or stroke among their high-risk patients.

The initiative’s payment and care delivery models will be tested from January 2016 to December 2020. In that time, HHS intends to enroll over 300,000 Medicare beneficiaries and 720 practices. A wide range of practices are invited to apply, including cardiovascular care providers. Interested applicants must submit a non-binding letter of intent (LOI) no later than September 4, 2015.

For background on the on the CVD Risk Reduction model, click here. For frequently asked questions, click here.

AMA Addresses Impact of SGR Reform, Alternative Payment Models

The American Medical Association (AMA) unveiled resource materials this month, which intend to explain the physician impact of SGR overhaul and recently introduced alternative payment models (APMs) outlined in the Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2).

The Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2) was signed into law this April, establishing payment stability for physicians through a 0.5% annual update. The legislation also requires a 5% annual bonus payment to physicians who are participating in alternative payment models, while also exempting such providers from participating in the new Merit-Based Incentive Payment System.

The resource, “Medicare Physician Payment Reform,” specifically addresses topics such as:

- Correspondence, testimony, and additional details regarding H.R. 2
- Medicare payment rate stabilization
State-specific impact of reform
Medicare sequester updates

The resource, “Medicare Alternative Payment Models,” specifically addresses topics such as:
- Efforts to support physician-designed alternative payment models
- Opportunities to improve care and reduce spending
- Barriers in current payment systems and potential changes
- Developing the business case for payment reform
- Designing alternative payment models

For AMA’s full analysis of Medicare physician payment reform, click here.
For the group’s full analysis of Medicare APMs, click here.

CMS Issues Final Rule for the Medicare Shared Savings Program

On June 3, 2015, the Centers for Medicare & Medicaid Services (CMS) released a final rule updating the Medicare Shared Savings Program. The agency states the final rule offers improvements, which they believe will “encourage the delivery of high-quality care for Medicare beneficiaries” and “build on Pioneer Accountable Care Organization (ACO) Model.”

Specifically, the final rule contained a number of updates from the proposed rule, including:
- Increasing the emphasis on primary care services in the beneficiary assignment methodology;
- Streamlining data sharing to provide improved access to data necessary for Accountable Care Organization (ACO) health care operations such as quality improvement and care coordination, while maintaining beneficiary protections;
- Adding a new performance-based risk option (Track 3) that includes prospective beneficiary assignment and a higher sharing rate;
- Providing ACOs choice of symmetric threshold for savings and losses under performance-based risk tracks;
- Addressing participation agreement renewals, including allowing eligible ACOs to continue participation under the one-sided model (Track 1) for a second agreement period;
- Establishing a waiver of the 3-day stay SNF rule for beneficiaries that are prospectively assigned to ACOs under Track 3;
Refining the methodology for resetting benchmarks to help ensure that the program remains attractive to ACOs and continues to provide strong incentives for ACOs to improve the efficiency and quality of patient care, and generate savings for the Medicare Trust Funds; and

- Refining eligibility and other requirements.

Four hundred ACOs – which serve more than 7 million beneficiaries – participate in the Medicare Shared Savings Program. In its first two years, participating ACOs have demonstrated improved performance in 30 of 33 quality measures established by CMS.

For background regarding the Medicare Shared Savings program, click here.

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**Senate Finance Leaders to Explore Improved Delivery of Chronic Care**

- Senate Finance Committee Chairman Orrin Hatch (R-Utah) and Ranking Member Ron Wyden (D-Ore.) announced the formation of a bipartisan working group to “explore solutions that will improve outcomes for Medicare patients requiring chronic care,” according to a May 22 letter to healthcare stakeholders.

The decision came on the heels of a May 15 Senate Finance hearing, entitled “A Pathway to Improving Care for Medicare Patients with Chronic Conditions.” As part of the group’s mission, lawmakers sought public comment from health stakeholders throughout the month of June in order to analyze and develop policy, which:

- Increases care coordination among individual providers across care settings who are treating patients living with chronic disease;

- Streamlines Medicare’s current payment systems to incentivize the appropriate level of care for patients living with chronic diseases; and

- Facilitates the delivery of high quality care, improves care transitions, produces stronger patient outcomes, increases program efficiency, and contributes to an overall effort that will reduce the growth of Medicare spending.

For the group’s official press release, click here.
Congress Removes Medicare Sequestration Cuts as Offset to Trade Bill

On May 22, the Senate passed H.R. 1314, the Trade Act of 2015. Among other things, this legislation contained a provision to require the President to order a sequestration for FY2024 that increases from 0.0% to 0.25% the reduction of Medicare payments for the second six months of the order. According to the CBO score for the provision, the additional sequestration amount would have cut $700 million from the Medicare program in 2024.

On June 11, however, the House passed H.R. 1295, the Trade Preferences Extension Act of 2015, to strike the Medicare sequestration provision contained in H.R. 1314 as follows:

SEC. 603. ELIMINATION OF MODIFICATION OF THE MEDICARE SEQUESTER FOR FISCAL YEAR 2024.

(a) IN GENERAL.—Subject to subsection (b), section 251A(6)(D)(ii) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 901a(6)(D)(ii)) is amended by striking “0.25 percent” and inserting “0.0 percent”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall not take effect unless the Trade Act of 2015 is enacted and if the Trade Act of 2015 is enacted after the date of the enactment of this Act, such amendment shall be executed as if this Act had been enacted after the date of the enactment of such other Act.

According to the CBO score for this provision, the striking of the Medicare sequestration provision would not cost money because H.R. 1314 has not been enacted.