Senate Finance Committee Begins Reviewing Submissions for Chronic Care Legislation Expected this Fall

On July 28, Senate Finance Committee Chairman Orrin Hatch (R-Utah) and Ranking Member Ron Wyden (D-Ore.) released 530 submissions from healthcare providers and beneficiary advocates responding to a initiative exploring cost effective solutions to improve health outcomes for Medicare patients living with one or more chronic conditions.

Senate Finance Committee (SFC) staff have been meeting with staff from the Centers for Medicare & Medicaid Services (CMS), congressional advisers, and researches since May to discuss delivery and payment policies to improve care delivery to seniors living with chronic illness. The committee is preparing to introduce chronic care legislation this upcoming fall, and began meeting with groups that submitted recommendations during the first week of August.

To view the committee’s press release about the submissions, click here.

New CBO Estimate: Medicare Spending to Increase

On August 25, the Congressional Budget Office (CBO) released a new report estimating that federal spending for all major health care programs will increase by $106 million in 2015 (13 percent).

CBO predicts Medicare spending will increase to $639 billion over the next decade, a $35 billion increase from previous
estimates. This would be the fastest spending growth since 2009. It further predicts that the repeal of the Medicare’s sustainable growth rate (SGR) will account for an increase in Medicare spending of $124 billion over the next decade.

The slight increase in spending means the government will spend $272 billion more on healthcare from 2016 to 2025.

For the full CBO report, click here.

CMS Reports Continued ACO Savings

The Centers for Medicaid & Medicare Services (CMS) issued 2014 quality and financial performance results on August 25 showing that Accountable Care Organizations (ACOs) continue to improve quality care for more beneficiaries. CMS estimates that ACOs have generated $411 million in financial savings. Ninety-seven ACOs qualified for the shared savings payments of more than $422 million by meeting quality standards and their savings threshold. The results also showed that ACOs with more experience in the program tend to perform better over time.

Additionally, Pioneer ACOs showed improvements in 28 of 33 quality measures and experienced improvements of 3.6 percent across all quality measures. Shared Savings Program ACOs reporting quality measures in 2013 and 2014 improved on 27 of 33 quality measures.

For a fact sheet on the findings, click here.

New Think Tank Report Reviews ACO Implementations, Recommends Improvements

The Bipartisan Policy Center (BPC) examined the implementation of Accountable Care Organizations (ACOs) in Medicare and offered near-term recommendations to improve the model in a July 30 report entitled, “Transitioning from Volume to Value: Accelerating the Shift to Alternative Payment Models.”

Overall, the group found that ACOs have experienced “modest success,” while encountering a number of significant challenges as “quality results were disappointing in many cases, and most ACOs generated modest or no savings.”

The authors of the study noted that ACOs would benefit from improvements such as:

- Giving providers clearer expectations;
- Engaging beneficiaries directly with the ACOs; and
- Establishing stronger incentives for both providers and beneficiaries to participate.
In addition, the report includes savings estimates to the Medicare program associated with several additional policy recommendations, including:

- Modernization of the basic Medicare benefit;
- Expansion of differential updates (higher updates for providers that participate in alternative payment models, lower updates for those that do not) to all Medicare providers; and
- Changes in Medicare reimbursement for Part B drugs to more accurately reflect acquisition costs and to remove unintended, counterproductive incentives in the current formula.

Together, the BPC estimates such reforms could reduce the federal budget deficit by $166 billion by 2025. By 2035, implementing these reforms could reduce the deficit by $537 billion, the report says.

For the full report, click here.

**New Survey Finds Mixed Views on Health Care Delivery Reforms**

The Commonwealth Fund and The Kaiser Family Foundation released a new survey of primary care providers, including physicians, nurse practitioners, and physician assistants, which asked participants about their experiences with and reactions to recent changes in healthcare delivery and payment.

The survey finds that although new primary care payment and delivery models have emerged to improve patient outcomes and lower health care costs, primary care providers view these new models more negative than positive. Though many providers are unsure about the impact of ACOs on quality of care, those who do have an opinion are likely to say ACOs have a negative impact.

Survey findings include:

- Health information technology received the most positive ratings, with half (50%) of physicians and nearly two-thirds (64%) of nurse practitioners and physician assistants saying it have made a positive impact.
- One-third (33%) of physicians and four of 10 (40%) nurse practitioners and physician assistants said they believe medical homes are having a positive impact on quality of care, while roughly one of 10 said the impact has been negative.
- Half of physicians (50%) and nearly four of 10 nurse practitioners and physician assistants (38%) feel that the increased use of quality metrics to assess provider performance is having a negative impact on quality of care.
- Nearly half (47%) of physicians and about a quarter (27%) of nurse practitioners and physician assistants said that recent trends in health care are causing them to consider retiring earlier than they originally planned.

To view the survey issue brief, click here.
Multiple PAD Treatment Devices Approved for Add-On Medicare Payments

The Centers for Medicare & Medicaid Services (CMS) will now take on a greater share of the cost of two PAD treatment devices – which are used to combat clogged arteries – as part of the agency’s new technology add-on payment (NTAP) program.

Specifically, CMS deemed drug-coated balloons from Bard Inc. and Medtronic Inc. innovative enough to merit increased federal support. Therefore, the agency will now offer an additional maximum NTAP payment of $1,035 for the use of each device. These changes are outlined in the FY 2016 hospital inpatient payment rule.

The NTAP program originally was designed to incentivize hospitals to utilize critical, yet expensive devices they may otherwise forgo due to cost. Once devices win approval, CMS calculates a specific reimbursement rate intended to make up about half of the loss a hospital might otherwise face in quickly adopting a new technology.

For the full FY 2016 Hospital Inpatient Payment Rule, 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 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.