White House Releases FY2017 Budget Proposal

President Barack Obama released his Fiscal Year 2017 Budget on February 9 with a $4.1 trillion proposal. Under the President’s budget proposal, an estimated $375 billion in savings would be achieved through reforms to Medicare, Medicaid and other programs over the next decade.

The President’s Budget Proposal includes the following healthcare provisions:

**Biomedical Research**

$33.1 billion has been proposed to support biomedical research at the National Institutes of Health (NIH), which would provide nearly 10,000 new NIH grants to better understand the causes and mechanisms of disease. This includes $300 million for the Precision Medical Initiative.

**In-Office Ancillary Exception**

Prohibit self-referrals for advanced imaging, radiation therapy, and anatomical pathology services from the in-office ancillary exception of the Stark law, except in those cases where a provider has met certain standards.

**Transparency in Drug Pricing**

The proposed budget calls for direct government “negotiation” in Medicare Part D and to mandate drug makers to publicly disclose their cost inputs with respect to production, research and development, and discounts for specific high-cost drugs to be identified by the Secretary of HHS.

**Primary Care Payments**

Also beginning in FY2017 is a proposal to allow the Secretary to introduce additional primary care payments into the Medicare Physician Fee Schedule (PFS). These
payments will be exempt from beneficiary cost sharing and incorporated into the PFS in a budget neutral manner with new per-beneficiary payments equaling the average per-beneficiary payment under the expired incentive program.

To view the Budget Proposal Summary Tables, click here.
To view an overview of the HHS budget, click here.

Ways & Means Committee Holds Budget Hearings

On February 10, HHS Secretary Sylvia Mathews Burwell testified before the House Ways & Means Committee to discuss the Department of Health and Human Services FY 2017 Budget Request. To view Secretary Burwell’s testimony, click here.

On February 11, Treasury Secretary Jacob J. Lew testified before the same House Committee to address the President’s Fiscal Year 2017 Budget Proposal. To view Secretary Lew’s testimony, click here.

Avalere Health: Outpatient Departments Receiving Three Times Amount of Medicare Reimbursements

A recent study by Avalere Health confirmed the conclusion of several previous studies that found Medicare payments to be higher in hospital outpatient departments (HOPDs) compared to the Physician Fee Schedule or ambulatory surgical center (ASC) setting.

The white paper assesses Medicare payment differentials for episodes of care across the HOPD and physician office setting for three services commonly provided in outpatient settings: cardiovascular imaging, colonoscopy, and evaluation and management (E&M) services. Avalere reviewed published literature from prior studies addressing this issue, and then performed an original analyses of episodes of care using Medicare claims data.

The white paper draws two conclusions:

1. Payments for services in the HOPD are higher for the primary service, and also for many related services during the episodes examined. Thus, the higher payments often associated with a HOPD procedure are not limited to the primary procedure, but can extend to related services performed adjacent to the primary procedure analyzed; and

2. Many HOPD-based procedures tend to be followed by a higher rate of additional procedures in the HOPD setting compared to office-based procedures.

For the full study, click here.
AMA Asks CMS to Cover Diabetes Prevention

On February 10, the American Medical Association (AMA) sent a letter to the Centers for Medicare & Medicaid Services urging the federal agency to ensure coverage of the Diabetes Prevention Program (DPP) and the associated physician services by plans offered in the Healthcare Marketplace and by the Medicaid program. The AMA also urged CMS to use the national coverage determination (NCD) process to extend coverage of this preventative service to Medicare beneficiaries in order to prevent cardiovascular disease and Type 2 diabetes mellitus.

The U.S. Preventative Services Task Force (USPSTF) recently gave risk assessment and intensive behavioral counseling interventions to prevent diabetes under Medicare, Medicaid, and the Healthcare Marketplace a grade of “B,” as required by the Affordable Care Act.

For the full letter, click here.

LAN Hosts Webinar on Patient Attribution and Financial Benchmarking with Payment Models

On February 9, the Health Care Payment Learning & Action Network (LAN) hosted a webinar titled, “Patient Attribution & Financial Benchmarking for Population-Based Payment Models.” The webinar was provided to help stakeholders understand the PBP Work Group recommendations on patient attribution and financial benchmarking, as well as identify barriers to payer and provider alignment on patient attribution and financial benchmarking methodologies.

LAN reported that they intend to use the alternative payment models (APM) framework as a gauge for measuring progress toward adoption of APMs. The resulting approach will be used to measure the nation’s progress toward the goals of 30 percent adoption by 2016 and 50 percent adoption by 2018.

Recommendations for patient attribution include:

1. Encouraging patient choice of a primary care provider;
2. Using a claims/encounter-based approach when patient attestation is not available;
3. Defining eligible providers at the beginning of the performance period;
4. Providing transparent information to patients about their attributions;
5. Prioritizing primary care providers in claims/encounter-based attribution;
6. Considering subspecialty providers if no primary care is evident;
7. Using a single approach for attribution for performance measurement and financial accountability;
8. Using the patient attribution guideline nationally for commercial products;
9. Alignment among commercial, Medicare, and Medicaid populations with adjustments; and
10. Providers receiving clear, actionable information about patients attributed to them

Recommendations for financial benchmarking include:

1. Encouraging participation in the early year’s of the model’s progressions, while driving convergence across providers at different starting points toward efficiency in the latter years; and
2. Striking a balance so providers serving disadvantaged populations are not unduly penalized, and disadvantaged populations do not receive substandard care.

For the full presentation, click here.

HHS Presents on Payment Model Proposals and Review Process

Recently the U.S. Department of Health and Human Services (HHS) presented on the payment model proposal submission and review process. The goals of the presentation were to raise some of the issues the Physician-Focused Payment Model Technical Advisory Committee (Committee) will need to consider in developing a process for proposal submission and review, providing the Committee with the opportunity to share initial thoughts, and also inviting the public to comment as well.

The Committee outlined the basic steps developed so far, which include:

1. Stakeholder submission;
2. Preparation for review;
3. Committee review and recommendations; and
4. Secretarial review

Specifically, the Committee sought public comments on what principles should guide the Committee’s development of a process for proposal submission and review and what elements of the process are most important.

For the full presentation, click here.

CMS Proposes Rule Measuring Performance of ACOs in the Medicare Shared Savings Program

On January 28, the Centers for Medicare & Medicaid Services (CMS) released a proposed rule that would update the methodology to measure the performance of Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program (MSSP).
The proposal would modify the process for resetting the benchmarks, which are used to determine ACO performance for ACOs renewing their participation agreements for a second or subsequent agreement period. The updated methodology would incorporate factors based on regional fee-for-service expenditures, into establishing and updating the ACO’s rebased historical benchmark, including an adjustment to the benchmark based on regional spending that is phased-in over several agreement periods.

Some of the key provisions include:

- Recognizing that health cost trends vary in communities across the country by using regional, rather than national, spending growth trends when establishing and updating an ACO’s rebased benchmark;
- Adjusting an ACO’s rebased benchmark when it enters a second or subsequent agreement period by a percentage (increased over time) of the difference between fee-for-service spending in the ACO’s regional service area and the ACO’s historical spending, which will provide a greater incentive for continued ACO participation and improvement; and
- Giving ACOs time to prepare for benchmarks that incorporate regional expenditures by using a phased-in approach to implementation.

The proposal hopes to build on the momentum of growth in the Shared Savings Program and charts a path for long-term sustainability by improving the long-term incentives for ACOs as they continue to provide care for beneficiaries.

For the press release, click here.

**House Committee Seeks Feedback on Site-Neutral Payment Policies**

- The House Energy and Commerce Committee recently requested comments from industry stakeholders regarding potential changes to Medicare’s site-neutral payment policy.

The site-neutral policy – contained in Section 603 of the Bipartisan Budget Act of 2015 – equalized Medicare reimbursements for hospital outpatient departments (HOPDs) and was meant to address the practice of hospitals acquiring physician offices and then billing patients under the outpatient prospective payment system, which has higher reimbursement rates than the Medicare physician fee schedule.

For the full request, click here.
CMS & AHIP Release Clinical Quality Measures

The Centers for Medicare & Medicaid Services (CMS) and America’s Health Insurance Plans (AHIP) recently announced seven sets of clinical quality measures to support multi-payer alignment on core measures primarily for physician quality programs.

The guiding principles in developing the core measure sets are that they be meaningful to patients, consumers, and physicians, while reducing variability in measure selection, collection burden, and cost. The goal is to establish broadly agreed upon core measure sets that could be harmonized across both commercial and government payers.

The core measures include:
- Accountable Care Organizations (ACOs), Patient Centered Medical Homes (PCMHs), and Primary Care;
- Cardiology;
- Gastroenterology;
- HIV and Hepatitis C;
- Medical Oncology;
- Obstetrics and Gynecology; and
- Orthopedics

For the press release, click here.

For the fact sheet, 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.