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Health Policy Briefing

December 9, 2013

Congress Rushes to Adjourn: At Stake—Budget Deal & Medicare MD Payment Reform

Budget Agreement on the Verge?

House Speaker John Boehner (R-OH) said he will keep his word to adjourn the House for the year after this week's legislative agenda is concluded. This gives little time for Budget conference leaders to use regular order to move a concurrent resolution (CR), H.Con.Res. 25, setting federal spending priorities for fiscal year (FY) 2014 and, possibly, for FY 2015. If not, House and Senate leaders may resort to an expedited procedure to pass a stand-alone bill to set overall spending priorities and give appropriators time to allocate agency spending to avoid breaching the January 15th date when the current CR runs out. Alternatively, the House may resort to passing another CR to extend the January 15th date. It has been reported that the **Senate and House Budget Committee chairs, Senator Patty Murray (D-WA) and Rep. Paul Ryan (R-WI)**, are nearing agreement to about a $1 trillion overall FY 2014 spending level which differs from the levels preferred by the two bodies ($967 billion in the House and $1.058 trillion in the Senate). Major spending issues left in the balance are the scheduled 2% cut in Medicare spending mandated under sequestration and the January 1st cut in Medicare physician payments (see more on this latter issue below). Potential allocations to Labor-Health and Human Services-Education agencies also differ in the House ($121.8 billion) and the Senate ($164.3 billion). Also, the extent to which negotiators will give agencies additional flexibility to reallocate spending reductions remains to be seen. Members are also lining up to voice their preferences on spending issues; for example, **Reps. Bill Cassidy (R-LA), John Barrow (D-GA)** and 81 other members sent a letter to House leaders expressing their opposition to any further cuts to the Medicare Advantage (MA) program. At a House Energy and Commerce Committee hearing, Chairman Fred Upton (R-MI) said that "While Medicare Advantage continues to grow, the cuts made in

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the health-care law threaten the future of the program and could put coverage at risk for thousands of beneficiaries in 2014 and many more in the future…."

PPACA Health Reform Update

HealthCare.gov Website Improves Performance; Questions Remain

The President doubled-down on his previous statements that the Obamacare website's problems will be fixed by stating that up to 800,000 individuals can now access the site and sign up for coverage. The U.S. Department of Health and Human Services (HHS) said it has fixed more than four hundred software glitches and substantially improved the speed of the site. The agency said that about 100,000 individuals were enrolled in coverage in November, a four-fold increase over October's level. However, it is reported that "enrollment" does not guarantee that insurers have received all the information necessary to actually include eligible individuals on their health insurance rolls. House Ways and Means Health Subcommittee Chairman Kevin Brady (R-TX) said at last week's hearing on Patient Protection and Affordable Care Act (PPACA) problems that "We are all hoping for the best, but the November 30th deadline to fix the website problems has passed, and no one knows if the system has the capacity to enroll, accurately determine subsidies and complete a new insurance policy for all the millions of Americans abandoned when their policies were canceled…." While consumers have until December 23 to signup on the website for coverage, panel members expressed concern that many will not be able to sign up in time or have all their information finalized by insurers to ensure they have actual coverage on January 1, 2014. Witnesses at the hearing also brought up other problems, such as the narrowing of provider networks among the plans offered on the exchanges and the lowering of provider reimbursements. If insurers do not gain the number of younger and older enrollees they assumed in setting their premium rates, they could experience unanticipated losses. HHS has also given notice that it may address the situation, including the revised policy of the President to allow cancelled policies to be extended in 2014, by providing insurers with financial assistance over the next three years. Some Democrats are also seeking evidence on the website's functioning. Reps. Daniel Lipinski (D-IL), Kyrsten Sinema (D-AZ) and eight other House Democrats have asked the Government Accountability Office (GAO) for a report on the extent of the functional and security operations of the HealthCare.gov website. Rep. Lipinski said "Despite assurances that healthcare.gov has been fixed after the disastrous rollout, significant concerns still remain….critical parts of the system still have not been built and insurers may not be receiving correct information about the individuals and families who have enrolled in their plans…." Rep. Lipinski is among the Democrats who may be open to delaying the open enrollment period. The Internal Revenue Service (IRS) Inspector General has also issued an audit warning that the IRS should be making substantial changes in the systems it uses to determine eligibility for and the amount of individual subsidies under the PPACA.

Small Businesses Say PPACA Employer Mandate Rules Too Complicated

At a House Small Business Committee hearing held last week, both Republicans and Democrats expressed some concern over how the PPACA's IRS "ownership" rules implementing the employer mandate are too complex and, perhaps, thrusting small businesses past the 50 full-time-employee mandate threshold. Witnesses said that the rules should be revised to reflect a "facts and circumstances" test. Because of the confusion, witnesses said that some health insurers are denying small businesses coverage in the small group market and treating them as large employers eligible only for large group coverage.

PPACA Health Reform Update cont.

Supreme Court Denies Review of Suit Contesting Employer Mandate

The U.S. Supreme Court refused to get into another debate over the constitutionality of the PPACA, this time the validity of the employer mandate and its penalty. The court denied review of a Fourth Circuit decision in a suit brought by Liberty University which held that the employer mandate is constitutional. The plaintiffs contend that the court should hold the employer mandate unconstitutional in the same manner that it held the individual mandate unconstitutional when considering the scope of the commerce clause. In that case, the court also said the individual mandate penalty is a "tax" and, therefore, the individual mandate and its penalty are constitutional.

Medicare/Medicaid/PHSA Corner

Movement on Medicare Physician Payment Reform

The Senate Finance Committee is scheduled this Thursday to mark up a revised version of the previously released draft of Medicare Part B physician payment reforms. The Senate Finance and House Ways and Means Committees' revisions are outlined in Appendix I below. With the House scheduled to adjourn for the year at the end of this week, the Chairman of the Ways and Means Committee said his committee still intends to hold a markup later this week. With enactment of the reforms this year, Congress will again have to act to avoid the Centers for Medicare and Medicaid Services' (CMS) scheduled reduction of physician payments beginning January 1st. In general, the revised draft would replace the sustainable growth rate (SGR) with a value-based pay for performance system (expanded to other non-physicians) with a chance for bonus payments to offset the freeze of physician payments for ten years. Some significant changes in the draft: the earlier proposed 10% penalty for failed reporting requirements was dropped; the bonus/penalty adjustments were narrowed in 2017-2020 with HHS given discretion to allow adjustments above 10-12% beginning in 2021; physicians would get credit for improving quality and use of resources from one year to the next; the inclusion of increased incentives for small practices to help them move to alternative payment models or the value-based purchasing program; introduction of a "partial qualifying Alternative Payment Model (APM) participant" category to allow providers to choose to participate in the value-based purchasing program and get a bonus;. Of note, the Congressional Budget Office (CBO) released an updated cost estimate for the House Energy and Commerce Committee SGR reform bill totaling $153.2 billion over ten years, a significant reduction. CBO indicated that freezing payments, rather than increasing them by 0.5% per year for 5 years, would reduce the cost to $116.5 billion.

Meaningful Use Program Delay

CMS announced that it will delay from 2016 to 2017 the start of the final stage (Stage 3) of the meaningful use (MU) program and extend the reporting timeline for Stage 2 of the program from 2016 to 2017. The agency said the extensions will not affect the Medicare payment penalties in 2016 which will apply to providers and hospitals not meeting the standards.

HRSA Awards Training Grants

The Health Resources and Services Administration (HRSA) announced that 270 grants totaling $55.5 million were awarded in FY 2013 for improving the training of health professionals, including $45.4 million to support nurse training and expansion.

FDA Issues

With the President's action to sign into law the Drug Quality and Security Act (DQSA), the FDA released implementation guidance, including: the creation of a new category of compounding facilities (i.e. outsourcing facilities); guidance on how such outsourcing facilities should implement drug reporting requirements; and guidance on the process for registering such facilities, including the payment of fees by September 30, 2014. The FDA plans to provide guidance on the Act's track-and-trace drug supply provisions in stages.

Upcoming Health-Related Hearings and Markups

House Energy and Commerce Health Subcommittee and Full Committee markup including the following health bills: Poison Center Network Act (HR 3527), Brain Injury Reauthorization Act (HR 1098), and Newborn Screening Saves Lives Reauthorization Act (HR 1281); 2:00 p.m., 2322 Rayburn Bldg.; December 10 [Health Subcommittee] and at 4:30 p.m., 2123 Rayburn Bldg.; December 10 and 12:30 p.m, 2123 Rayburn Bldg.; December 11 [Full Committee].

House Energy and Commerce Health Subcommittee: will hold a hearing to examine the Affordable Care Act, its implementation and the rollout of HealthCare.gov; Health and Human Services Secretary Kathleen Sebelius is scheduled to testify; 10:00 a.m., 2123 Rayburn Bldg.; December 11.

House Small Business Committee: will hold a hearing titled "The Small Business Health Options Program: Is It Working for Small Businesses?" 1:00 p.m., 2360 Rayburn; December 11.

Senate HELP Committee: will hold a hearing titled "Accreditation as Quality Assurance"; 10:00 a.m., 430 Dirksen Bldg.; December 12.

Senate Finance Committee: markup to consider legislation to repeal the sustainable growth rate system and to consider health care extenders; 10:00 a.m., 215 Dirksen Bldg.; December 12.

Appendix I

Modifications to the October 30th, Bipartisan, Bicameral Discussion Draft to Repeal the SGR and Reform Medicare Physician Payment

[Prepared by the staffs of the Senate Finance and House Ways and Means Committees]

Below is a description of changes to the October 30 discussion draft made in response to feedback from physician organizations and other stakeholders. These changes do not preclude additional future changes.

SGR Repeal and Annual Updates

• Two Medicare Payment Advisory Commission reports to Congress in 2016 and 2020 studying the relationship between professional spending and utilization of professional services paid under Medicare Part B, and total expenditures under Medicare Parts A, B, and D. o These reports will show how efforts by professionals to ensure appropriate utilization impact total program spending.

Single, Consolidated Incentive Program, the Value-Based Performance (VBP) Program

VBP Funding Pool Amount

• The funding pool change is shown in table below. This phase-in approach allows professionals time to adjust to the single, consolidated incentive program (while tying less payment to performance than under current law in the initial years of the program).

Proposal		Revised Proposal
2017	8%	4%
2018	9%	6%
2019	10%	8%
2020	Secretary has discretion to increase above 10%	10%
2021		Secretary has discretion to increase above 10% but not more than 12%

Maximum Upside Adjustment

• Establishes maximum upside incentive equal to the pool funding percentage (e.g., +4% in 2017). The downside risk for any individual professional, as stated in the initial proposal, continues to be no lower than the incentive pool funding percentage (e.g., -4% in 2017). Capping the upside incentive provides certainty over the range of payments professionals receive.

Reducing Lag Times

• Reduces lag times by requiring that the performance period be as close as possible to the payment year.

Performance Categories

• Professionals receive credit for improvement from one year to the next in the determination of their quality and resource use performance category score. The

Secretary may give credit for improvement in the other two performance categories. This responds to the concern that assessing performance only on achievement pits professionals against each other.

• Makes explicit that measures used in qualified clinical data registries can be used to assess quality performance even if they do not have consensus-based entity endorsement.

• Adds activities to the illustrative list in the clinical practice improvement category that would be attainable for surgeons and other specialists (e.g., using a clinical quality data registry, following surgical checklists, conducting a maintenance of certification practice assessment, use of shared-decision making mechanisms).

• Requires the Secretary to issue a request-for-information to solicit recommendations for selecting and specifying the criteria for clinical practice improvement activities.

• Requires the Secretary to take into consideration the circumstances of small practices and practices located in rural areas and HPSAs in establishing clinical practice improvement activities.

• As feasible and applicable, accounts for the cost of covered Part D drugs in the resource use performance category.

• Requires GAO to report to Congress on alignment of quality measures in Medicare fee-for-service, Medicare Advantage, and private sector and make recommendations on how to reduce professional administrative burden.

Professionals to Which VBP Program Applies

Include nurse practitioners, clinical nurse specialists, physician assistants, and certified registered nurse anesthetists in the VBP program starting in 2017 (rather than 2018).

Technical Assistance

• Increases the annual funding in 2014-2018 to $25 million, up from $10 million. Makes all small practices (10 or fewer eligible professionals) eligible for technical assistance to help succeed in the VBP or move to an APM. Priority for this funding will be given to small practices with low composite scores or practices in rural areas or HPSAs. Technical assistance could be provided through quality improvement organizations, regional extension centers, regional health collaboratives, and other appropriate entities.

Studies of VBP Impact

• Requires GAO to evaluate the VBP in 2018 and 2021, including an assessment of the provider types, practice sizes, practice geography, and patient mix that are receiving payment increases and reductions.

Encouraging Alternative Payment Model Participation

• Changes the six-year period that APM participation bonuses are available from 2016-2021 to 2017-2022 to give professionals more time to prepare.

• Creates a new "partial qualifying APM participant" category for professionals who come within a narrow margin of qualifying APM participation. Based on stakeholder concerns regarding the retrospective determination of APM participation, these partial qualifying APM participants will have the option of: 1) reporting VBP quality measures and receiving the corresponding incentive payment; or 2) not participating in the VBP program and receiving no payment adjustment. The partial qualifying APM participant revenue thresholds are: o 2017-2018: 20% of Medicare revenue

o 2019-2020: 40% of Medicare revenue or 40% of all-payer revenue and 20% of Medicare revenue

o 2021 and subsequent years: 50% of Medicare revenue or 50% of all-payer revenue and 20% of Medicare revenue

• Clarifies that Medicare Advantage (MA) contracts that involve risk for the professional are counted toward the all-payer threshold that triggers the 5% APM participation bonus payment.

• Encourages the testing of models relevant to specialist physicians.

Ensuring Accurate Valuation of the Physician Fee Schedule

• Reduces the target for finding misvalued services from 1% to 0.5% from 2015-2018 and count amounts found in excess of the target in one year toward the next year's target.

• Removes the 10% penalty for failure to provide requested information but retains incentive payments for participation in data collection.

• Removes the global surgical payments provision.

Measure Development

• Increases annual funding for professional quality measure development from $10 million to $15 million per year from 2014-2018.

Timely Feedback and More Efficient Two-Way Communication

• Expands the scope of information CMS would provide through the physician feedback program (likely a web-portal).

• Enables professionals to submit other information (e.g., quality measures) to CMS through the web-portal to reduce the administrative burden on professionals.

Promoting Evidence-Based Care through Appropriate Use Criteria

- Redefines applicable imaging services as an advance diagnostic imaging service under section 1834(e)(1)(B) of the Social Security Act, for which there are one or more applicable appropriate use criteria and one or more qualified clinical decision support mechanisms that are free of charge.
- The Secretary may require that clinical decision support mechanisms are capable of providing aggregate feedback to ordering professionals.
- Exceptions to the requirement to consult with appropriate use criteria will be made for imaging services ordered in an emergency situation, imaging services paid under Part A, imaging services ordered by a professional for patients attributed to an eligible APM, or for ordering professionals who face significant hardship (e.g., lack of Internet access).
- Requires the Secretary to obtain input from stakeholders through an Advanced Notice of Proposed Rulemaking before establishing an appropriate use program for other Part B services.
- Requires GAO to make recommendations to Congress on other services that could benefit from use of clinical decision support mechanisms.

Expansion of Availability of Claims Data

- Allows Qualified Entities (QE) to provide or sell analyses to medical societies and hospital associations in addition to employers, insurers, and providers.
- When directly identified in a non-public analysis, providers will have an opportunity to review and submit corrections before the QE sells the analysis to other entities.
- Allows QEs to give providers, medical societies, and hospital associations access to claims data through a qualified data enclave (e.g., web-based portal). QEs must de-identify data, except for services rendered by the provider accessing the data enclave.
- MA encounter data will not be made available.

Transparency of Physician Medicare Data

- The Physician Compare website will indicate, where appropriate, that publicized information may not be representative of the eligible professionals entire patient population, variety of services furnished, or the health conditions of the individuals treated.