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MedPAC Discusses Permanent SGR Fix

On September 15, MedPAC heard four draft recommendations to permanently move away from the current SGR system. In Chairman Glenn Hackbarth's opening statement he conveyed the Commission's growing sense of urgency to repeal the SGR due to the ever-growing cost of a fixing the SGR. Chairman Hackbarth asked staff to keep the following principals in mind when developing recommendations:

- Sever the formulaic link between physician fees and Medicare expenditures;
- Preserve access to care;
- Encourage participation by physician in new payment methods (i.e. ACOs, bundling);
- Accelerate revaluation of services within physician fee schedule; and
- Budget neutrality.

Using the above principals the staff presented the Commission with the following draft recommendations to permanently dissolve the SGR:

- Draft Recommendation 1: Congress should repeal the SGR system and replace it with a 10-year plan. The plan would freeze the current payment levels for primary care doctors and include an annual payment reduction of 5.9% for all non-primary care doctors for the first three years followed by a freeze.
- Draft Recommendation 2: Congress should direct the Secretary to regularly collect data, including service volume and work time, to establish more accurate work and practice expense values.
- Draft Recommendation 3: Congress should direct the Secretary to use data specified in recommendation 2 to identify overpriced fee schedule services and reduce their RVUs accordingly.
- Draft Recommendation 4: Under the 10-year update path in recommendation 1 the Secretary should increase the shared savings opportunity for physicians and health professionals who join or lead ACOs with a two-sided risk model.

The Congressional Budget Office estimates the cost to repeal the SGR and replace it with a 10-year freeze to be about $300 billion. The 3-year cut to specialists, in addition to the freeze, is

expected to reduce the cost of the repeal from $300 billion to approximately $200/$230 billion. On September 19, MedPAC released a list of proposals that could possibly offset the overhaul of the SGR.

The Commission is expected to vote on the recommendations at their next meeting on October 6-7, 2011.

President's Economic Growth Deficit Reduction Plan

On September 19, President Obama released his "Plan for Economic Growth and Deficit Reduction." Among the proposals included in the package are a $298 billion proposal to "prevent reduction in Medicare physician payments" and a $2.1 billion savings proposal to "End add-on payments for hospitals and physicians in frontier states." Also included are proposals to "Cut Waste, Fraud, and Improper Payments in Medicare," including the following:

- **Update Medicare payments to more appropriately account for utilization of advanced imaging.** Medicare spending for imaging services paid for under the physician fee schedule has grown dramatically in recent years due to an increase in the number and intensity of these services. MedPAC has stated that this volume growth may signal that these services are mispriced and has supported Medicare payment changes for expensive imaging equipment. Beginning in 2013, this proposal implements a payment adjustment for advanced imaging equipment to account for higher levels of utilization of certain types of equipment. This proposal will save approximately $400 million over 10 years.

- **Require prior authorization for advanced imaging.** The rapid growth in the number and intensity of imaging services in recent years raises concerns about whether these services are being used appropriately. This proposal would adopt prior authorization for the most expensive imaging services, beginning in 2013, to ensure that these services are used as intended and protect the Medicare program and its beneficiaries from unwarranted use. This is consistent with practices by private health insurance to manage spending growth and a GAO recommendation to consider prior authorization and other approaches to address rapid spending growth on these services. This proposal will save approximately $900 million over 10 years.

House Ways and Means Democrats Release Medicare Savings Options

On September 7, House Ways and Means Democratic staff circulated a list of potential healthcare savings options that might be considered as part of ongoing Joint Select Committee ("Supercommittee") deliberations. The list of options focused primarily on possible Medicare savings for a combined potential savings of more than $500 billion over 10 years. Savings options and descriptions included the following options:

- **Increase Utilization Rate of Advanced Imaging Equipment (-$0.4 billion, CBO):** This proposal increases the estimated amount of time advanced imaging equipment (such as CT and MRI) is in use. Under current law, reimbursement is based on an assumption that the imaging equipment is in use 75 percent of the time physician practices are open. The proposal would increase the estimated rate to 90 percent, phasing-in at 80 percent in 2012 and increasing to 90 percent in 2013 and thereafter. This policy was put forth by the Senate Finance Committee this past June as an offset for continuation of the Trade Adjustment Assistance (TAA) program, but later withdrawn.

  Discussion: MedPAC recommends an increased utilization rate to discourage providers from acquiring costly imaging equipment unless they have sufficient usage to justify the purchase. CMS also has data supporting the change to a 90 percent utilization rate. Radiologists (ACR) and broader groups such as Access to Medical Imaging Coalition (AMIC), which includes provider organizations and manufacturers, oppose this proposal.

- **Require Prior Authorization for Advanced Imaging Services (-$1.1 billion, CBO):** Under this proposal, physicians would be required to obtain approval from radiology benefit managers (RBMs) before ordering certain imaging services. RBMs would determine whether to grant coverage approval based on criteria formulated from recommended clinical guidelines. This proposal was included in Rep. Cantor's slides on debt ceiling/deficit reduction options.

  Discussion: Medicare has never used prior authorization with respect to physician services, so instituting this policy would be an unprecedented departure from current practice for physicians and beneficiaries alike. An argument for prior authorization is that there has been a steady and significant increase in imaging services and reduction in use of advanced imaging services that are of little or no clinical benefit would lower Medicare's expenditures and shield beneficiaries from unnecessary imaging services. MedPAC has recommended a limited prior authorization program for practitioners who order substantially more imaging services than their peers. However, evidence is unclear whether RBMs significantly reduce unnecessary utilization of imaging services. Private plans that employ RBMs have reported drops in use of imaging services immediately after implementing a prior authorization approach, but increases in use as physicians adapt to the new approval procedures. In many cases the growth of spending returned to its previous pace.

Joint Select Committee on Deficit Reduction Meetings

September 8 Meeting

On September 8, the JSC met for opening statements and to adopt proposed committee rules. The JSC-adopted rules require, among other things:

- An agenda to be delivered to JSC members not less than 48 hours in advance of any meeting.
- Legislative text to be available to JSC members not less than 24 hours in advance of any meeting.

- Public announcement of a hearing a week prior to the hearing, if practicable.
- Reports or bills may not be voted on unless a CBO score has been made available for 48 hours prior to the vote.
- Establishment of a publicly available website.
- Open hearings and meetings unless the JSC votes to meet in closed session. No votes on legislation may be taken in closed session.

Sept 13 Meeting

On September 13, the JSC met to consider "The History and Drivers of Our Nation's Debt and Its Threats." Member statement and the testimony of the Congressional Budget Office are available here. To underscore the gravity of the threat, CBO noted that current budget projections are not entirely reflective of current law. Stated CBO, "For example, if most of the provisions in the 2010 tax act were extended, if the AMT was indexed for inflation, and if Medicare's payment rates for physicians' services were held constant, then reducing debt held by the public in 2021 to the 61 percent of GDP projected under current law would require other changes in policy to reduce deficits over the next 10 years by a total of $6.2 trillion, rather than the $1.2 trillion in deficit reduction that this Committee would have to accomplish to avoid the automatic budget cuts required by the Budget Control Act."

In advance of the hearing, CBO also released a report entitled "Estimated Impact of Automatic Budget Enforcement Procedures Specified in the Budget Control Act." According to the report, assuming a full sequester under the Budget Control Act, Medicare would be cut by $11 billion in 2013 and $123 billion over 10 years.

IOM Releases 2nd Edition of Geographic Adjustments Report

The IOM has been tasked with making recommendations to improve the accuracy of the data sources and methods used in making geographic adjustments. On September 28, the IOM released the second edition of the Phase I report and included the recommendations made in the first edition (for more information, click here) plus the following four recommendations:

- GPCI cost share weights for adjusting fee-for-service payments to practitioners should continue to be national, including the three GPCIs (work, practice expense, and liability insurance) and the categories within the practice expense (office rent and personnel);
- Proxies should continue to be used to measure geographic variation in the physician work adjustment, but CMS should determine whether the seven proxies currently in use should be modified;
- CMS should consider an alternative method for setting the percentage of the work adjustment based on a systematic empirical process; and
- Nonclinical labor-related expenses currently included under Professional Expense (PE) office expenses should be geographically adjusted as part of the wage component of the PE.

The full report can be viewed by clicking here.

Health Care Consolidation Examined

The House Ways and Means Committee held a hearing on September 9 regarding health care industry consolidation. The hearing examined the effects of consolidation among hospitals, physicians, and insurance groups on healthcare consumers. Chairman Herger and several witnesses noted the balance policymakers must strike to ensure that efficient forms of integration are allowed to flourish even as consolidation "driven primarily by a desire to increase reimbursements" is mitigated. Paul Ginsberg, President of the Center for Studying Health System Change, noted while in the early 1990s health plans were able to pressure providers to accept lower payment rates, this balance of power shifted in the late 1990s (perhaps in part due to the economic boom). In the early 2000s, employers began to increase patient cost-sharing and hospitals "pursued aggressive specialty-service-line expansion for profitable services, such as cancer, cardiac, and orthopedic care." According to Ginsburg, "Despite the great recession of 2007-2009, employers remain reluctant to restrict provider choice and continue to increase patient cost sharing at the point of service and, most recently, by asking workers to pay a larger share of premiums." Ginsburg stated that a 2010 review indicated "insurers consistently cited higher payment rates to obtain hospital and large physician group participation in health plan networks as a major factor driving higher insurance premiums." Ginsburg noted that, for their part, hospitals acknowledged rising private insurance payment rates, but stated they were necessary to offset constrained Medicare and Medicaid rates.

2011 Medicare eRx and Incentive Program Final Rule

On September 6 CMS published the 2011 Medicare Electronic Prescribing (eRx) Incentive Program Final Rule. The final rule modifies the quality measures used for several reporting periods in calendar year (CY) 2011, provides additional hardship exemptions for eligible professionals (EPs) and group practices in CY 2011, and extends the deadline to file for submitting requests for exemptions from the 2012 eRx payment adjustment under the additional significant hardship exemption categories, as well as the two significant hardship codes established in the CY 2011 PFS final rule. The final rule extends the deadline to request a hardship exemption for the 2012 eRx payment adjustment to November 1, 2011.

The additional hardship exemptions include:

- EPs who register to participate in the Medicare or Medicaid EHR Incentive Program and adopt certified EHR technology;
- EPs who are unable to electronically prescribe due to local, state, or federal law or regulation;
- EPs who have limited prescribing activity; and
- EPs who have insufficient opportunities to report e-prescribing measures due to limitations of the measure. For example, physicians that often use CPT code 77427 can now request a hardship under the insufficient opportunity option.

Supreme Court Asked to Review ACA

On September 28, the Justice Department filed a writ of certiorari asking the U.S. Supreme Court to review the Constitutionality of the 2010 Affordable Care Act. The Administration is asking the Court to review the 11th Circuit Court ruling which ruled Congress exceeded its power in passing the law. The Administration's petition completes the conditions generally needed for a Supreme Court review: decision by a lower court that an act of Congress is unconstitutional, conflicting opinions at the Appeals level, and agreement by both parties that the Court needs to settle the dispute. If the Supreme Court agrees to hear the case in the term beginning October 3, 2011, a decision would be expected by the end of the Court session in June of 2012.

CMTP Releases CER Summit Final Report

On September 13, the Center for Medical Technology Policy issued its "2010 National Leadership Summit on CER Priorities, Methods, and Policy: Building a Strategic Framework for Comparative Effectiveness Research in Oncology" Final Report. The report highlights six key findings:

- CER studies in oncology are urgently needed.
- CER should fully engage patients and the general public.
- CER requires the development of new research methods.
    - Of note, the report states, "The traditional RCT can be an inefficient and costly way to address research questions, but other study designs require us to navigate complex tradeoffs between the level of certainty and the usefulness of the resulting evidence for real-world decision-making. Registry studies, pragmatic clinical trials and simpler variations of randomized trials offer alternatives that, when enhanced with innovative methodologies, can yield reasonably robust, clinically applicable results."
- Genomics and personalized medicine must be central to all CER studies in oncology.
- CER results must be translated into clinical practice.
    - According to the report, "the generation of reliable data requires the enrollment of patients from community settings who are representative of real-world clinical populations, as the vast majority of patients receive care there. Gathering data in community settings is challenging due to wide variations in practice patterns, limited systematic data collection, and a lack of financial incentives for community-based clinicians to participate in research."
    - The report further notes, "CER translation depends upon infrastructure development. Re-alignment of payment incentives would support the development of the information technology (IT) infrastructure. Similarly, the development of methodological and data standards would provide a coordinated framework for data acquisition. The IT infrastructure must accommodate patient-reported outcomes (PROs), as these data are

increasingly recognized as a central feature of CER. Feedback loops that connect researchers, guideline panels, and practitioners must be "hard-wired" through IT pathways to ensure that information flows bi-directionally to support formulation of clinically important research questions, hypothesis generation, study conduct, translation of results, and evaluation of impact. This is the starting point for the development of rapid learning systems in oncology."

- The CER enterprise must address cost and value.
  - Of interest to health policy observers, the report states, "While Congress limited consideration of cost and value in ARRA and PPACA, they will eventually demand attention."

Medicare Provider Payment Policies

The House Ways and Means Health Subcommittee held a hearing on Medicare provider payments, set to expire, on September 21. In opening remarks Chairman Wally Herger (R-CA) said that Medicare provider payments that are set to expire should be closely examined, and justified, before being reauthorized. He continued by saying that it would cost more than $2.5 billion to reauthorize "Medicare extenders" for a year.

Four out of the five witnesses (including the AMA and the AHA) stated their case for why extenders affecting their practice area should be extended. In his testimony, Dr. Wah, Chairman of the Board of Trustees of the AMA, advocated for an extension of the physician work GPCI in a way that did not require "budget neutrality." Dr. Wah also noted the ongoing work by the IOM on geographic adjustments and stated that "[a] supplemental report that discusses physician payment issues further will be issued, along with a report that is expected to be released in 2012." Dr. Wah stated that "once these reports are complete, they should be a starting point for Congress in examining geographic payment adjustments for physician work and practice expenses." Bruce Steinwald, President of Steinwald Consulting was the only witness to express skepticism in regard to reauthorizing the Medicare provider payments.

ACO Learning Session

In a continued effort to educate providers interested in becoming an ACO, the Center for Medicare & Medicaid Innovation is holding the third and final Accelerated Development Learning Session on November 17-18 in Baltimore, Maryland. Interested parties can find out additional information and register by clicking here.

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