

Health Policy REPORT

Tuesday, August 16, 2011

Leaders Name Budget Control Act Select Committee

Community Cancer Care Advocates Continue Grassroots Push Urging Opposition to Medicare Cancer Cuts

Following the passage of the [Budget Control Act \(BCA\)](#) in early August, Congressional leaders of both parties have named a group of seasoned veterans to sit on the 12-member bipartisan Joint Select Committee on Deficit Reduction (Select Committee).

As reported previously, the BCA calls for the creation of this committee and tasks it with developing a plan for an additional \$1.2 trillion in savings. The Select Committee is expected to consider tax and entitlement changes along with other cuts, **including potential cuts to Medicare payments for needed cancer care services and treatments.**

The Senate members of the Select Committee include Senators Patty Murray (D-WA), Jon Kyl (R-AZ), Max Baucus (D-MT), Rob Portman (R-OH), John Kerry (D-MA), and Patrick Toomey (R-PA). The House members are Jeb Hensarling (R-TX), Chris Van Hollen (D-MD), Dave Camp (R-MI), James Clyburn (D-SC), Fred Upton (R-MI), and Xavier Becerra (D-CA).

The Select Committee is required to submit a plan to the Congress prior to Thanksgiving, and the Congress must vote on the plan without amendments prior to Christmas. If the plan fails to produce \$1.2 trillion in savings, or if the Congress fails to pass the plan, the difference between the enacted plan and \$1.2 trillion will be cut through an across-the-board spending reduction to defense and domestic spending starting in 2013. **If triggered, this provision would allow for a maximum 2 percent cut in all Medicare spending on providers, Medicare Advantage plans and Part D drug plans with no eligibility, premium or out of pocket changes to Medicare beneficiaries.**

The BCA also requires that the House and Senate vote on a joint resolution proposing a balanced-budget amendment (BBA) to the Constitution. The BBA is considered unlikely to pass the Senate and be sent to the states, but if it were to pass, the President could then propose an additional \$1.5 trillion debt limit increase.

While the BCA does not include immediate cuts to oncology reimbursement, a significant threat remains as the Select Committee develops its plan and as members develop the offsets needed to fund another fix to the nearly 30 percent Medicare physician reimbursement cuts scheduled for January 1, 2012.

Please take this opportunity to contact your Members of Congress and ask them to oppose Medicare cancer care cuts.

To contact your Members of Congress (talking points provided), [click here](#).

Physician Groups Continue to Call for Long-Term SGR Fix

With the naming of the members of the Joint Select Committee on Deficit Reduction (Select Committee), physician groups are calling on its members to provide within its upcoming deficit reduction package a long-term solution for Medicare's sustainable growth rate (SGR) physician payment formula. Without Congressional action to prevent it, the SGR is scheduled to deliver a 29.4 percent payment cut to physicians on January 1, 2012.

On August 10, the American Osteopathic Association (AOA) sent a letter to Rep. Jeb Hensarling (R-TX) and Sen. Patty Murray (D-WA), co-chairs of the Select Committee, encouraging the panel to address the SGR in a "long-term manner," stating that the current formula harms innovation, impacts patient access to care and discourages doctors from participating in Medicare.

The American Medical Association (AMA) has also urged the Select Committee to repeal the SGR, noting that continued short-term fixes have increased the cost of a permanent solution (estimated to cost over \$300 billion over the next decade) and that the cost "will rise to \$500 billion in only a few years if Congress does not change course."

With the high price tag for a permanent fix and the Select Committee's task of identifying \$1.2 trillion in savings, it is considered highly unlikely that a long-term SGR fix will be included within the committee's package. *(Continued on page 2)*

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Physician Groups Continue to Call for Long-Term SGR Fix (*Cont'd*)

Although lawmakers – including the House Energy and Commerce Committee and House Ways and Means Committee – continue to search for solutions to replace the SGR, it is more probable that Congress will step in prior to January 1 with another short-term fix of a few years or a few months.

CMS Releases Results of Accountable Care Demonstration Project

This month, the Centers for Medicare and Medicaid Services (CMS) released the results of its Physician Group Practice (PGP) Demonstration, a five-year demonstration project that it says can serve as a foundation for Medicare accountable care organizations (ACOs).

Specifically, agency officials have said that the demo results indicate that pay-for-performance models can succeed in improving quality of care, coordinating services and reducing costs within Medicare.

The demonstration was designed to assess whether health systems could meet 32 performance measures and achieve cost savings, which would earn them incentive payments.

Ten large-size integrated health care systems participated in the project. These include Billings Clinic in Billings, Mont.; Everett Clinic in Everett, Wash.; Forsyth Medical Group in Winston-Salem, N.C.; Geisinger Health System in Danville, Pa.; Middlesex Health System in Middletown, Conn.; Park Nicollet Health Services in St. Louis Park, Minn.; St. John's Health System in Springfield, Mo.; Dartmouth-Hitchcock Clinic in Bedford, N.H.; the University of Michigan Faculty Group Practice in Ann Arbor, Mich.; and the Marshfield Clinic in Marshfield, Wis.

By the project's last year, seven of the 10 groups met all 32 of the performance measures, and the remaining three groups met 30 of 32. That was a marked improvement from the first year of the demonstration, when only two of the groups met all of the measures.

Although all project participants met all or nearly all of the benchmarks, CMS' results indicate that only four of the 10 participants will receive bonus payments in the final year of the demonstration. The four health care systems receiving bonus payments in the fifth year of the demo are as follows:

- Marshfield Clinic (group practice; PGP does not include hospital): \$15.8 million
- Park Nicollet Health Services (group practice; PGP includes hospital): \$5.67 million
- University of Michigan Faculty Group Practice (faculty practice; PGP includes hospital): \$5.3 million
- St. John's Health System (group practice; PGP includes hospital): Approximately \$2.6 million

Of the total savings generated in the project, 80 percent – amounting to \$110 million – went to performance payments, while Medicare kept the remaining 20 percent.

Many of the participating health systems have communicated concerns about CMS' proposed ACO structure, with nine of the participating health systems sending a letter to the agency in May noting they might not participate in the ACO program unless major changes are made to CMS' initial proposal.

According to the letter, the groups believe that "as currently proposed, ACOs have a greater potential for incurring losses ... than for generating savings."

[Click here](#) to read CMS' press release announcing the demo results.

Federal Appeals Court Rules Against Health Reform Individual Coverage Mandate

On August 12, a panel for the 11th U.S. Circuit Court of Appeals ruled that the Affordable Care Act's (ACA's) individual coverage mandate is unconstitutional, a move believed to bring the case against the law one step closer to being seen before the U.S. Supreme Court.

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Federal Appeals Court Rules Against Health Reform Individual Coverage Mandate (*Cont'd*)

The 2-1 decision was the second federal appeals court ruling on the mandate, with the 6th Circuit Court of Appeals ruling in favor of the ACA in June.

With the conflicting appellate court decisions, analysts note that this creates a more compelling reason for the Supreme Court to ultimately rule on the law. The Department of Justice is anticipated to appeal the 11th Circuit Court of Appeals decision.

Proposed Rules Released on Insurance Exchange Enrollment, Medicaid Eligibility, Premium Tax Credits

In August, the Department of Health and Human Services (HHS) and the Department of Treasury released three proposed rules regarding implementation of the new online health insurance exchanges to be created under the Affordable Care Act (ACA).

Beginning in 2014, the uninsured and small business employees will be able to purchase insurance through the state-based exchanges.

The proposed rules released by HHS outline how the exchanges will set eligibility for individuals seeking to buy insurance through the exchanges and how eligibility will be determined for low-income individuals applying for expanded Medicaid benefits under the law.

The Treasury proposed rule lays out the standards for premium tax credits to be made available to subsidize the purchase of insurance for taxpayers with incomes between 100 percent and 400 percent of the federal poverty level (FPL).

According to the Congressional Budget Office (CBO), the new tax credit will help about 20 million Americans purchase health insurance through the exchanges.

According to HHS, the new eligibility rules are intended to make obtaining health insurance through the exchanges easy and affordable, with the system directing individuals to the right program or plan for their situation.

Some of the rules' recommended online enrollment features include:

- A simplified system that determines enrollee income and eligibility in "near real-time;"
- Tools to determine eligibility for Medicaid and tax credits using a new calculation based on the individual's modified adjusted gross income; and
- A single online "data services hub" to verify consumer-provided information through federal data sources.

The new proposed rules are scheduled to be published in the Federal Register on August 17, and will be followed by a 75-day public comment period.