HALL RENDER'S THIS WEEK IN WASHINGTON – APRIL 8, 2016

CMS BEGINS TESTING OF BUNDLED PAYMENT PROGRAM FOR JOINT REPLACEMENT

On April 1, CMS launched a bundled payment demonstration for inpatient knee and hip surgeries. The agency will pay nearly 800 hospitals across 67 metro areas bundled payments for joint replacement procedures, which is expected to save Medicare $343 million over the course of the five-year program. The agency's target cost per episode of care, which extends from admission to the hospital to 90 days after discharge, is roughly $25,565.

The demonstration program is part of a larger goal by HHS of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value-Based Purchasing Program and the Hospital Readmissions Reduction Program. CMS is not expected to announce another bundling initiative this year.

The program comes after CMS determined that hospitals in five metro markets were spending above the regional average on joint replacement. These five areas include: Miami-Fort Lauderdale-West Palm Beach, Florida; Beaumont-Port Arthur, Texas; Tampa-St. Petersburg-Clearwater, Florida; Tuscaloosa, Alabama; and New York-New Jersey. The average cost of hip and knee procedures in those metro areas was in the low-$30s, while the regional average costs being paid by Medicare were in the mid-$20s.

Hospitals participating in the program will receive target places for inpatient knee and hip surgery episodes at the beginning of each year. If spending on joint replacement procedures is less than CMS's target thresholds, hospitals may receive an additional payment from Medicare. Hospitals will be charged penalties and may be required to repay Medicare for part of the difference if they exceed the agency's target per-episode payment amount. Hospitals not meeting the threshold will not be penalized in year one but can receive a payment reward of up to five percent. Medicare will phase in penalties in year two. CMS will apply the gain and loss limits of five percent in year two, 10 percent in year three and 20 percent in years four and five.

SENATE HEALTH COMMITTEE APPROVES BIOMEDICAL BILLS

On April 6, the Senate HELP Committee advanced five bills in the final markup of its biomedical innovation reform. The markup was the third in a series of markups held by the Senate HELP Committee to pass companion legislation to the House's 21st Century Cures Act. The latest round of bills involved a limited population approval pathway for antibiotics, strengthening the workforce at the National Institutes of Health ("NIH") and support for the president's Precision Medicine Initiative.

Senate leaders will try and strike a deal on funding for the Food and Drug Administration and the NIH before the full Senate takes up the legislation on the floor. Senate Democrats have said they will not support a final bill without an agreement for new, mandatory funding for NIH. The House's 21st Century Cures bill, which is the companion to the Senate bill, provides $8.75 billion in mandatory funds for NIH over five years; however, the Senate version has struggled with Republicans less willing to agree to a major increase in mandatory funds after the NIH received a $2 billion increase in the 2015 spending deal.

CMS DELAYS ENFORCEMENT OF CERTAIN MEDICAID DRUG RULE PROVISIONS

Earlier this week, CMS delayed until July 1 enforcement of certain provisions of its final rule changing the Medicaid Drug Rebate Program and Medicaid reimbursement for covered outpatient drugs. The rule took effect April 1. The enforcement delay applies to provisions specific to identifying and calculating average manufacturer prices for "5i drugs" - inhalation, infusion, instilled, implanted or injectable drugs that are not generally dispensed through retail community pharmacies. CMS also plans to issue a Frequently Asked Questions document and operational guidance to address questions received since the final rule was published.

HEALTH-RELATED BILLS INTRODUCED THIS WEEK

Sen. Ron Johnson (R-WI) introduced a bill (S. 2758) that would amend Title XVIII of the Social Security Act to remove consideration of certain pain-related issues from calculations under the Medicare hospital value-based purchasing program. The Promoting Responsible Opioid Prescribing Act is intended to ensure that pain management questions on patient surveys would not factor into Medicare reimbursement calculations. The bill is the Senate companion to H.R. 4499, a measure introduced by Rep. Alex Mooney (R-WV).

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NEXT WEEK IN WASHINGTON

The House and Senate return next week. On April 14, the 302B allocation level will be disclosed for each of the Appropriations subcommittees. This will inform each subcommittee of their discretionary spending level for FY 2017. The Senate will begin floor debate of the various appropriation bills as early as next week.

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