Tuesday, December 22, 2015

In this Issue:

Congress Averts Cuts to Radiation Therapy

The Patient Access and Medicare Protection Act (S. 2425) – which includes key provisions impacting cancer care delivery to Medicare patients – passed the House and Senate on December 18. The bill is expected to be signed into law by President Obama. **Read below.**

Congress Passes Omnibus Spending Bill

On December 18, the U.S. Senate and House of Representatives cleared a $1.15 trillion omnibus appropriations bill and tax extenders package in advance of the holiday recess. **Read below.**

GAO Recommends Payment Reform to Curb Hospital-Physician Consolidation

A new Government Accountability Office (GAO) report examines trends in vertical consolidation between hospitals and physicians and the extent to which higher levels of vertical consolidation were associated with more evaluations and management (E/M) office visits being performed in hospital outpatient departments (HOPDs) between 2007 through 2013. **Read below.**

FULL ARTICLES

Congress Averts Cuts to Radiation Therapy

A bipartisan legislative package of Medicare reforms was passed in the House and Senate on December 18. Key provisions of the Patient Access and Medicare Protection Act (S. 2425) include:

- **Radiation Therapy Reimbursement Freeze**: A provision to freeze radiation oncology freestanding center payment rates for 2017 and 2018 at the levels set in the Medicare physician fee schedule for 2016.

- **Meaningful Use Hardship Exemptions**: A provision to make it easier for CMS to process meaningful use hardship exemptions for 2015.
- **Competitive Bidding Delay**: A provision to delay application of competitive bid pricing to complex rehab wheelchair accessories.

The bill also omitted provisions sought by hospitals to exempt some hospital outpatient departments (HOPD) from the site-neutral payment policy for all new or newly acquired provider based off-campus hospital outpatient departments included in the Bipartisan Budget Act of 2015. The policy prohibits any new off-site hospital location that is more than 250 yards from the main campus from billing under the Outpatient Prospective Payment System (OPPS) and would align their payments with other physician practices paid under either the Ambulatory Surgical Center (ASC PPS) or the Medicare Physician Fee Schedule (PFS).

To view S. 2425, CLICK HERE.

Congress Passes Omnibus Spending Bill

On December 18, the U.S. Senate and House of Representatives passed a $1.15 trillion omnibus appropriations bill (H.R. 2029) and tax extenders package, which was signed into law by President Obama.

The spending measure – the Consolidated Appropriations Act, 2016 – will fund the federal government through September 30, 2016.

Healthcare provisions in the bill include:

- Delays the “Cadillac tax” for two years to start in 2020;
- Delays the health insurance tax to 2017;
- Delays the 2.3 percent medical device excise tax to 2018;
- Cuts IPAB operational funding by $15B;
- Blocks breast cancer screening recommendations issued by the USPSTF for 2 years;
- Cuts AHRQ funding by $30M;
- Increases NIH funding by $2B;
- Reauthorizes and expands 9-1-1 emergency responder health care benefits; and
- Providers $20M for the National Diabetes Prevention Program.

According to the Congressional Budget Office, the $1.15 trillion fiscal 2016 omnibus package will increase the deficit by approximately $57.6 billion over the next decade.

To view the legislative text, CLICK HERE.

To view a section-by-section summary of the spending package, CLICK HERE.

GAO Recommends Payment Reform to Curb Hospital-Physician Consolidation

A new Government Accountability Office (GAO) report examines trends in vertical consolidation between hospitals and physicians and the extent to which higher levels of vertical consolidation were associated with more evaluations and management (E/M) office visits being performed in hospital outpatient departments (HOPDs) between 2007 through 2013.

GAO found that the number of vertically consolidated hospitals increased from about 1,400 to 1,700, while the number of vertically consolidated physicians doubled from about 96,000 to 182,000. The growth occurred across all regions and hospital sizes, but was found to be much more rapid in recent years. GAO found that in 2013, the total Medicare payment rate for a mid-level E/M office visit for an established patient was $51 higher when the service was performed in an HOPD instead of a freestanding physician's office.

The report also stated that the percentage of E/M office visits performed in HOPDs – instead of freestanding centers – was generally higher in counties with more vertical consolidations between 2007 and 2013. GAO noted that, "Such excess payments are inconsistent with Medicare's role as an efficient purchaser of health care services. However, the Centers for Medicare & Medicaid Services (CMS)—the agency that is responsible for the Medicare program—lacks the statutory authority to equalize total payment rates between HOPDs and physician offices and achieve Medicare savings."

In order to prevent the shift of services from lower paid settings to HOPDs from increasing costs for the Medicare program and beneficiaries, GAO recommends Congress direct the Secretary of the Department of Health and Human Services (HHS) to equalize payment rates between settings for E/M office visits and return the associated savings to the Medicare program.

For a one-page summary, CLICK HERE.

For the full report, CLICK HERE.