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MedPAC Recommends Aligning Payments Across Care Settings

On January 16, the Medicare Payment Advisory Commission (MedPAC) unanimously approved a series of recommendations for updating Medicare payment policies, including the alignment of Medicare payments for patient services provided in hospital outpatient departments (HOPD) and physician offices.

In their presentation, MedPAC commissioners recommend reducing payment incentives for shifting patients to higher-cost settings to receive care, which the Commission estimates costs the Medicare program and beneficiaries $2.1 billion more annually. MedPAC recommends removing pricing differentials between the settings and paying "hospital rates that are comparable to physician office rates for services that can be safely provided in physician offices." These services included in the recommendation include Level V drug administration, Level I radiation therapy, and intensity-modulated radiation therapy (IMRT) treatment delivery.

MedPAC supports payment reductions for services provided in the HOPD so that the total payment for HOPD services does not exceed total Medicare payments where the services are provided in the freestanding setting. The Commission offered specific criteria for narrowing payment differences for 66 Ambulatory Payment Classifications, known as APCs. APCs are Medicare's method of paying facilities for outpatient services. MedPAC's recommendation also adjusts hospital outpatient perspective payment (OPPS) rates for some APCs to more closely align OPPS and Medicare Physician Fee Schedule (PFS) payments.

MedPAC estimates that adjusting payment rates for these 66 APCs will reduce Medicare spending and beneficiary copayments by $1.1 billion annually.

The Commission further called for a repeal of the Medicare cuts imposed by sequestration. MedPAC Chairman Glenn Hackbarth stated that the Commission opposes the sequester cuts and strongly believes there are more targeted ways for reducing Medicare spending instead of arbitrary, across-the-board payment cuts. Many groups are calling on MedPAC to factor sequestration into their Medicare payment recommendations to provide Congress with a more accurate illustration of provider margins, which the Commission has not done to date.

Following the unanimous approval, the Commission's recommendations will be included in MEDPAC's report to Congress in March.

The US Oncology Network has called for payment neutrality across payment settings and supports these recommendations. A September 2013 report by the Moran Company found significantly higher costs to the Medicare program for patients receiving chemotherapy treatment in hospital outpatient departments versus physician offices.

In order to implement oncology payment neutrality more comprehensively across payment settings, Congress should include H.R. 2869, the *Medicare Patient Access to Treatment Act*, sponsored by Congressman Mike Rogers (R-MI) and Congresswoman Doris Matsui (D-CA) in any Medicare reforms scheduled this Congress.

Please contact your Member of Congress today and ask them to join Representatives Rogers and Matsui in supporting H.R. 2869.

To contact your Member of Congress, CLICK HERE
To view the Reps Rogers/Matsui letter of support, CLICK HERE
To view The US Oncology Network letter of support, CLICK HERE
To read MedPAC's brief of the meeting, CLICK HERE

CMS Announces Release of Physician Payment Data

The Centers for Medicare and Medicaid Services (CMS) announced last week it will consider individual requests for releasing physician information on Medicare payments.

CMS will accept individual requests for physician payment information and assess requests for releasing amounts paid to a physician by the federal government under Medicare. CMS will determine if the request meets the standards for releasing information under exemption 6 of the Freedom of Information Act. CMS has indicated it will review each request for data on a case-by-case basis to determine if disclosing the data protects the physician's privacy and ensures the privacy of Medicare beneficiaries.

In addition to releasing payment data for individual physicians participating in the Medicare program, CMS announced it will make public aggregate data sets on Medicare physician services.

CMS stated that the new policy is part of the agency's ongoing commitment to greater data transparency.

CMS Principle Deputy Administrator Jonathan Blum cited specific benefits of making physician payment data available to the public as offered in comments by organizations during the comment period, including:

- Providers to collaborate on improved care management and the delivery of healthcare at lower costs;

- Consumers to gain broader, more reliable measures of provider quality and performance which drives innovation and competition while informing consumer choice; and
- Journalists and others to identify waste, fraud, and abuse as well as unsafe practices.

The new physician-payment policy will become effective 60 days after the notice is posted in the Federal Register.

Congress Approves $1.1 Trillion Spending Bill

On January 18, President Barack Obama signed a $1.1 trillion spending bill to fund the federal government through September 2014. The budget measure passed the Senate by a vote of 72-to-26 and the House by a vote of 359-to-67.

The passage of the budget came with rare bipartisan support and represents the first time since 2012 Congress has passed a spending bill without temporary stopgap measures. By large, Congress delayed the most difficult spending decisions by extending past funding bills in an effort to avoid another government shutdown.

The spending bill offered little change to Medicare spending. The largest healthcare provision froze appropriations for President Obama's health care program at the reduced, post-sequester level and maintains current funding levels at the Centers for Medicare and Medicaid Services; however, the Administration retains the flexibility to find the financing it needs to implement the health exchanges. The bill also reduces funding for the Prevention and Public Health Fund by $1 billion and slashes $10 million for the Independent Payment Advisory Board (IPAB).

New Study: IMRT improved survival rates in head and neck cancer patients

New research conducted at the University of Texas MD Anderson Cancer Center in Houston demonstrates the benefits of intensity-modulated radiation therapy, or IMRT, to treat head and neck cancers.

The study indicates that patients with head and neck cancers treated with IMRT are significantly less likely to die from the tumors within 40 months than those

who receive conventional radiation treatments.

The study analyzed Medicare records and survival rates for 3,172 head-and-neck-cancer patients who received IMRT and conventional radiation treatments. By using a "cause-specific survival" measurement to determine a patient's chance of dying from head and neck cancer after 40 months, researchers found a 38.9 percent survival rate for patients treated with IMRT and an 18.9 percent survival rate for those receiving more conventional treatments.

In the final report, researchers were conservative in declaring the superiority of IMRT and instead stated, "the analysis and conclusions here should be considered hypothesis-generating."

"This analysis revealed that patients treated with IMRT have less cancer-related deaths than those treated with traditional techniques," said Beth M. Beadle, MD, PhD, of the department of radiation oncology at The University of Texas MD Anderson Cancer Center. "So, not only do they have fewer side effects, but they also have fewer life-threatening recurrences. An investment in IMRT may be cost-effective because it is better at both preventing side effects and cancer recurrence."

The American Cancer Society estimates that 54,000 patients in the U.S. were diagnosed with head and neck cancers in 2013 and that head and neck cancers resulted 12,000 deaths.

The study was published in the January edition of *Cancer*, a journal of the American Cancer Society.