Wednesday, June 29, 2016

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MedPAC Releases Report to the Congress

The Medicare Payment Advisory Commission recently released their Report to Congress examining Medicare Part B drug costs and physician payment reforms. **Read below.**

HHS' OIG Report Recommends Equalization of Payments Across Settings

The Department of Health and Human Services (DHHS) recently released their Office of Inspector General (OIG) report discussing the Centers for Medicare & Medicaid Services' oversight of provider-based billing. **Read below.**

Medicare Board of Trustees Release Annual Report

On June 22, the Boards of Trustees for Medicare issued their annual report, which includes information about the past and estimated future financial operations of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) Trust Funds. **Read below.**

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The US Oncology Network's Medical Director Dr. Debra Patt recently authored an opinion editorial published in *The Hill* which emphasizes the need to advance Medicare site neutral payment reforms and warns against back tracking on payment parity policies enacted in the Bipartisan Budget Act of 2015.

In the Bipartisan Budget Act of 2015, Congress included a site neutral payment provision that aligns payments for all newly acquired provider-based off campus HOPDs with payments to physician practices. A new hospital bill passed in the U.S. House of Representatives would provide exemptions from the site neutral payment policy to certain hospital outpatient departments, which would maintain higher costs for patients, Medicare, payers and employers.

Dr. Patt writes, "If we are truly interested in defending patients, as well as stabilizing the budget, it is critical that Congress not look back, and move forward with site neutral payment policies as they had originally intended. Site neutral payments are a policy that makes sense in any case, not only when the pressure is off."

To read Dr. Patt's column, CLICK HERE.

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In his opening statement, Chairman Orrin Hatch (R-UT) stressed, "this experiment is ill-conceived and likely to harm beneficiaries. It is an overreach on the part of CMS that, in my opinion, goes beyond the agency's statutory authority, extends nationwide, and requires all Medicare Part B providers to participate."

Dr. Patrick Conway, Acting Principal Deputy Administrator and Chief Medical Officer at CMS, was the sole witness. The read Dr. Conway's testimony, CLICK HERE.

To watch the hearing, CLICK HERE.

MedPAC Releases Report to the Congress

The Medicare Payment Advisory Commission (MedPAC) recently released their Report to Congress examining Medicare Part B drug costs and physician payment reforms. The report fulfills the Commission's legislative mandate to evaluate Medicare payment issues and provides suggestions to Congress to manage the growth of Medicare spending.

The report includes a chapter pertaining to Medicare's new framework for physician payment, which presents the Commission's principles concerning the implementation and structure of Alternative Payment Models (APMs) and key considerations for the design of the Merit-based Incentive Payment System (MIPS).

The Commission's basic principles for APMs include:

- Clinicians should receive an incentive payment only if the eligible alternative payment entity in which they participate is successful in controlling cost, improving quality, or both.
- The eligible alternative payment entity should be at financial risk for total Part A and Part B spending.
- The eligible alternative payment entity should be responsible for a beneficiary population sufficiently large to detect changes in spending and quality.
- The eligible alternative payment entity should have the ability to share savings with beneficiaries.
- CMS should give eligible alternative payment entities certain regulatory relief.
- Each eligible alternative payment entity should assume financial risk and enroll clinicians.

For MIPS, the Commission emphasizes its position that quality measures should emphasize population-based outcomes. The Commission concludes that clinician quality reporting under MIPS should reduce the number of inefficient quality measures and improve the overall value of the quality programs, which would make it easier for all clinicians to report under MIPS if they do not qualify for an APM.

The report also discusses Medicare Part B and oncology payment policy issues, including ways to modify how Medicare pays for general Part B drugs, and ways to improve the quality and efficiency of oncology care, recommending that a broader view be taken in examining cancer care by improving care coordination and management.

The Commission examines the add-on payment to Average Sales Price (ASP) and how Medicare covers and pays for Part B anticancer drugs and administration (infusion) services. The report also considers options for improving the efficiency of oncology services, including risk sharing agreements, oncology clinical pathways, oncology medical homes and episode-of-care approaches.

To read the entire report, CLICK HERE.

HHS' OIG Report Recommends Equalization of Payments Across Settings

The Department of Health and Human Services (HHS) recently released their Office of Inspector General (OIG) report discussing the Centers for Medicare & Medicaid Services' oversight of provider-based billing.

The report highlights the fact that services performed in provider-based settings are commonly over 50 percent higher than services provided in freestanding facilities, resulting in more revenue for provider-based facilities over freestanding ones.

The OIG found that half of the hospitals surveyed owned at least one provider-based facility, but CMS does not determine whether or not the facilities meet qualifications for receiving higher provider-based payment. Because the attestation process is voluntary, not all hospitals disclose the number of facilities they own or if they own any at all.

OIG reviewed 50 hospitals that had not voluntarily attested for all of their off-campus provider-based facilities and found that more than three-quarters of those hospitals owned off-campus facilities that did not meet at least one requirement. These facilities may in turn be billing Medicare incorrectly and may be receiving overpayments, and beneficiaries may be overpaying for services.

In their recommendations, OIG states, "we continue to support previous OIG and MedPAC recommendations to either eliminate the provider-based designation or equalize payment for the same physician services provided in different settings - actions that go beyond those required by the Bipartisan Budget Act of 2015."

If CMS decides not to implement the equalization of payments at these facilities or eliminate the provider-based designation all together, the OIG recommends:

1. Implementing systems to monitor billing by all provider-based facilities.
2. Requiring hospitals to submit attestations for all of their provider-based facilities.
3. Ensuring that all regional offices and MACs apply provider-based requirements appropriately when conducting attestation reviews.
4. Taking appropriate action against hospitals and their off-campus provider-based facilities that have been identified as not meeting requirements.

To read the entire report, CLICK HERE.

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On June 22, the Boards of Trustees for Medicare issued their annual report, which includes information about the past and estimated future financial operations of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) Trust Funds.

The report found that the estimated depletion year for the HI trust fund is 2028, two years earlier than determined in the last report. Financing for the fund is not sufficient over the next 10 years, and tax income is expected to be lower than estimated last year.

However, the SMI trust fund is adequately financed over the next 10 years because of the reset premium income and general revenue income for Part B and D, which cover expected costs and ensure a reserve for Part B contingencies. There is possibility for an increased Part B premium rate for some beneficiaries in 2017.

Other report findings include:

- Medicare's total costs will grow from roughly 3.6 percent of GDP in 2015 to 5.6 percent in 2040.
- Part B premiums could increase for an estimated 30 percent of Medicare beneficiaries next year.
- The growth rate will trigger Independent Payment Advisory Board (IPAB) in 2017.
- Part D drug costs per enrollee are expected to increase more than per enrollee costs for Parts A and B combined.

To address Medicare financial challenges, the Trustees recommend further reforms in the near future to increase the time available for affected individuals and organizations to adjust their expectations. They also recommend that Congress and the Executive Branch work closely together to address the depletion of the HI fund and projected growth of HI and SMI expenditures immediately.

To read the entire report, CLICK HERE.