Congress Passes $1.1 Trillion Spending Bill

In December, the U.S. Congress passed the “Consolidated and Further Continuing Appropriations Act, 2015.” The $1.1 trillion spending deal passed the Senate on December 13 by a vote of 56-40 and the House of Representatives on December 11 by a vote of 219-206. The bill was signed on December 16, 2014.

Among the healthcare related provisions in the bill, its report language expresses concern that CMS has not provided adequate opportunity for public comment on changes to surgical procedures described in the annual Medicare Physician Fee Schedule (MPFS) final rules. It also expresses concern that the appropriate methodology has not been tested to ensure that patient care and patient access are not impacted negatively, and that undue administrative burdens are not placed on providers. Further, the report language urges that additional consideration be given to these changes prior to implementation of the changes outlined in the MPFS.

For full text of the spending bill, click here.
To read the Labor, Health and Human Services Explanatory Statements, click here.

Congress Passes ABLE Act of 2014

On December 16, the U.S. Congress passed H.R. 5771 and the bill became law on December 19. The legislation included two divisions: (1) the Tax Increase Prevention act of 2014 and (2) the Achieving a Better Life Experience (ABLE) Act. The ABLE Act would allow states to establish a saving programs for the benefit of disabled people.

In order to offset the cost of the ABLE Act, the bill includes more than $1 billion in Medicare offsets,
including accelerated application of relative value targets for “misvalued” services in the Medicare physician fee schedule. According to the bill summary released by the House Committee on Ways and Means, Sec. 202 of the legislation would require the HHS Secretary to reduce payments to physicians. It reads:

This provision would now begin the policy requiring the Secretary to identify overpayments one year earlier and reduce the number of years it is in effect from four to three. The target would be 1 percent in 2016, 0.5 percent in 2017, and 0.5 percent in 2018. This policy would allow physician groups to have efforts to reduce overpaid services that are well underway, primarily through the Relative Value Scale Update Committee (RUC), counted against the target. Utilizing those efforts puts physicians in a position to avoid potential across-the-board cuts in 2016. CBO estimates that moving the effective dates and revising the first year target for this policy will reduce spending by $365 million.

Stakeholders, including the American Medical Association (AMA), have taken issue with budgetary offsets included in the legislation, citing potential physician service cuts. “[T]he provision effectively assures that physician services will be subject to across-the-board cuts for at least some portion of the 2016-2018 time period,” said AMA Director of Federation Relations Terri Marchiori in a statement. “Given Congress' failure to pass Medicare payment reform legislation that enjoys bipartisan, bicameral support, and the risk of multiple regulatory penalties for physicians under Health IT Meaningful Use, the Physician Quality Reporting System, and the Value-Based Modifier, the likelihood of additional payment cuts occurring as a result of this ABLE Act provision is especially egregious.”

To read the CBO score, including budgetary offsets, click here.

### MedPAC Examines Payment Adequacy

MedPAC commissioners met in December to review Medicare payment policies and to make recommendations to the Congress. The Commission asks whether payments to physicians and other health professionals are adequate and how they should be updated in 2016.

The group acknowledged a growing shift in care delivery from professional offices to hospitals. The trend leads to an increase in overall program spending, as well as beneficiary out-of-pocket costs, MedPAC stated.

Additionally, MedPAC pressed for an urgent repeal of the Medicare Sustainable Growth Rate (SGR). The Commission asserted that temporary “fixes” create uncertainty for beneficiaries and practitioners, whilst establishing administrative burdens to CMS and barriers to broad-based reform. The current slowdown in healthcare spending would make such a repeal more cost effective, they said.

To view the MedPAC presentation, click here.
CMS Proposes ACO Regulation Update

The Centers for Medicare and Medicaid Services (CMS) updated policies in the Medicare Shared Savings Program to help providers from Accountable Care Organizations (ACOs) in a recently issued proposed rule.

The guidance includes several changes to eligibility requirements, definitions of ACO participants, and the transition of “pioneer” ACOs. The proposed rule also offered experimental providers three extra years before they could be held accountable for poor performance.

Accountable Care Organizations are associations of doctors, hospitals and other providers that jointly care for Medicare patients with the goal of pocketing a portion of what they save the government. Those that spend above Medicare estimates, however, are set to be penalized. In the first year of the program, 118 ACOs saved Medicare $705 million, while another 102 ACOs spent more than the program’s benchmark.

CMS is now seeking comment on changes to the Shared Savings program, which includes the majority of ACOs. Specifically they hope to address providing additional flexibility for program renewal, performance-based incentives, and emphasize on primary care services. The agency is also looking to address alternative methodologies for establishing, updating, and resetting ACO financial benchmarks.

“This proposed rule is part of our continued commitment to rewarding value and care coordination – rather than volume and care duplication,” said CMS Administrator Marilyn Tavenner. “We look forward to partnering with providers and stakeholders to continuously refine and improve the Medicare Shared Savings program.”

To read the proposed rule, click here.

National Health Expenditures continued slow growth in 2013

National health spending in 2013 grew at its slowest pace in more than five decades, according the Office of the Actuary (OACT) at the Centers for Medicare and Medicaid Services (CMS).

On the whole, health spending grew 3.6 percent in 2013, following a 5-year pattern of low growth. The number represents a small drop from 4.1 percent growth in 2012. National health expenditures in the United States in 2013 reached $2.9 trillion, or $9,255 per person.

The report attributed the slowdown to a number of factors including slow growth in federal insurance programs, as well as in the private sector. Specifically the OACT cited “slower growth in private health insurance, Medicare, and investment in medical structures and equipment spending.” The agency also explained that faster growth in Medicaid, spurred by expansion efforts, partially offset the slowdown.

Medicare spending represented 20 percent of national health spending last year, growing 3.4 percent to $585.7 billion in. The slowdown was “primarily caused by a deceleration in Medicare enrollment
growth, as well as net impacts from the Affordable Care Act and sequestration,” CMS stated in a press release, “Per-enrollee Medicare spending grew at about the same rate as 2012, increasing just 0.2 percent in 2013,” they added.

To read the full Health Affairs report published December 3, click here.

The Physicians Foundation Releases 2015 Physician Watch List

The Physicians Foundation released a list of five aspects of care that will have major impact on practicing physicians and their patients over the next year.

The a nonprofit organization – which seeks to advance the work of practicing physicians and help facilitate the delivery of healthcare to patients – based the results of “The Physicians Watch List” on general industry knowledge, as well as its 2014 Biennial Physician Survey of 20,000 physicians and other Foundation research and white papers.

Specifically, “The Physicians Watch List” highlights:

• Increasing Consolidation Among Hospitals / Health Systems: The trend towards consolidation seems to be “adversely impacting competition in regions where consolidation is most pronounced, while increasing costs and reducing patient choice.” The move may also be “presenting a challenge to clinical autonomy.”

• External Pressures Strain the Physician / Patient Relationship: 80 percent of physicians describe doctor-patient relationships as the most satisfying factor of their vocation. However, “growing levels of non-clinical paperwork and rising administrative and regulatory pressures are leading to an erosion of quality face-time physicians are able to spend with their patients.” Additionally, “these pressures can also limit physicians’ choices in terms of practice type while increasing the amount of time and resources they must spend on negotiating with payers and vendors.”

• Administrative Problems Associated with the ICD-10: More than half of physicians have expressed concern with the complex nature of the new ICD-10. Preparation, implementation, and administration, will therefore require a vast amount of time and resources. Therefore, the organization asserts, “actionable steps must be implemented early in the year to ensure sufficient preparation, including auditing internal IT platforms and making key updates to computer systems.”

• Cost of Care Transparency: The discrepancy between services provided and their price “erodes the ability of physicians to make the best clinical decisions for patients, while further exacerbating patient concerns.” Therefore the organization urges policymakers to institute a system around cost-of-care transparency that provides clear information to both patients and physicians.

• Access to Physician Care: More patients than ever are now insured through the Affordable Care
Act. However, there is a striking trend among physicians, in which 44 percent are taking steps to reduce access to their service. The organization suggests an intensified focus on collecting data about physician shortages in order to better inform policymakers and the public. The use of new web-based tools will, therefore, better “ensure that patients have access to physician care as the healthcare system changes and expands.”

To read the Physician’s Foundation press release, click here.

Health Care Provider, athenahealth Announces Results of 9th Annual Epocrates Future Physicians of America Survey

Medical students shared their opinions about medical school training and industry challenges in an annual survey released by athenahealth this month.

The Epocrates Future Physicians of America survey, which featured a sample of more than 1,400 medical students, revealed a few key findings:

• **Students Seek the Security of Large Provider Employment**: In general, medical students were more likely to seek employment at a hospital or large group practice. In fact, the 73 percent of students reaffirmed this idea, while the percentage of those who aspire to private practice fell to 10 percent—a 50 percent drop since 2008. Students explained the disparity, citing a desire for work-life balance and the choice to avoid administrative tasks associated with private practice.

• **Enthusiasm for Care Coordination is High But Stymied by Poor Communication**: Students overwhelmingly believe that to deliver high quality care, it is important to collaborate with all those involved in the caregiving process – including registered nurses, physician assistants, specialists, and medical staff. Indeed, 96 percent of students believed in the importance of integrated care. However, 75 percent of students expressed concerns about inadequate cross-team communication.

To read a press release from athenahealth, click here.

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The CardioVascular Coalition (CVC), established in 2014, is a nonprofit organization representing freestanding cardiovascular centers. CVC members are comprised of national organizations representing providers (National Cardiovascular Partners and the Outpatient Endovascular and Interventional Society) and manufacturers (Cardiovascular Systems, Inc. and Covidien).

The mission of the CVC is to advance patient access to community-based cardiovascular and endovascular care. Recognizing that cardiovascular disease is a leading – and preventable – cause of death in the United States, the physicians, care providers, advocates, and manufacturers who comprise the Coalition are dedicated to community-based solutions designed to improve awareness and prevention of cardiovascular disease and peripheral artery disease, reduce geographic disparities in access to care, and secure patient access to high-quality, cost-effective, community-based interventional treatment across America.