Congress Passes Two-Year Budget Agreement

On October 30, the Bipartisan Budget Act of 2015 (H.R. 1314) passed the Congress and was sent to President Obama to be signed into law. The measure will reduce a scheduled Medicare Part B premium hike and extend the debt ceiling until March 15, 2017.

The bill will increase spending by $80 billion over two years – divided equally between defense and domestic programs - and will increase federal borrowing limit through March 15, 2017.

The Congressional Budget Office (CBO) estimated that the bill will result in a $57.6 billion net decrease in direct spending and revenue over the next decade. Direct spending under the health care title is estimated to reduce $6.2 billion and reduce revenues by $12.2 billion over the next decade as well.

The four provisions under the health title include:

1. Repealing the Affordable Care Act’s auto enrollment mandate for large employers;
2. Changes to Medicare premiums to prevent a large increase in January;
3. The application of inflation-based rebates to generic drugs; and

More specifically, one provision in the measure stipulates that new “provider-based off-campus hospital outpatient departments” are ineligible for reimbursements from CMS’ Outpatient Prospective Payment System (PPS), would remain eligible for reimbursements from either the Ambulatory Surgical Center (ASC PPS) or the Medicare Physician Fee Schedule.
CMS Asks for Feedback on Medicare Payment Systems

The Centers for Medicare & Medicaid Services (CMS) recently announced that those interested in commenting on the Medicare payment system replacing the sustainable growth rate formula (SGR) will have 45 days to submit their comments through the Federal Register, where their announcement was published.

Overall, CMS has requested that the public and stakeholders comment on two broad areas, including the Merit-based Incentive Payment System and Alternative Payment Models.

Another dozen topics were specifically highlighted for the public to respond, which includes the following:

- MIPS EP Identifier and Exclusions;
- Virtual Groups;
- Quality Performance Categories;
- Resource Use Performance Categories;
- Clinical Practice Improvement Activities Performance Category;
- Meaningful Use of Certified EHR Technology Performance Category;
- Other Measures;
- Development of Performance Standards;
- MIPS Composite Performance Score and Performance Threshold;
- Flexibility in Weighting Performance Categories;
- Public Reporting; and
- Feedback Reports

The written and electronic comments were originally due to CMS on November 2, 2015, but the Department of Health and Human Services has extended the deadline to November 17, 2015 at 5 p.m. All comments submitted will be made public.

To view CMS’ RFI, click here.

To view the RFI extension, click here.
MedPAC Meets to Discuss APMs and MIPS after SGR Repeal

On October 8, the Medicare Payment Advisory Commission (MedPAC) met to discuss alternative payment models (APMs) and the merit-based incentive payment system (MIPS), the statutory payment updates for clinicians after the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the sustainable growth rate formula.

Under the APM provision, clinicians will receive incentive payments, which are 5% per year from 2019 to 2024, if they participate in an APM. The same provision creates requirements for eligible APMs and the level of participation that allows clinicians to qualify for the incentive payment. Participating APM clinicians will be excluded from MIPS.

Some of the key implementation issues for CMS that were presented included what spending the APMs are responsible for, how clinicians and beneficiaries are attributed to APMs, what is quality comparable to MIPS, and how risk will be measured above a nominal amount.

Three different options were proposed as possible solutions, including:

1. APMs responsible for spending its clinicians bills;
2. APMs responsible for spending within a bundle; and
3. APMs responsible for spending all of beneficiary’s A and B spending.

Several key questions remained after the meeting, such as how CMS should define MIPS to minimize burden and emphasize outcomes, whether or not APMs should be required to lower costs and increase quality, how to balance scope of spending and variety of APMs, and if APMs should provide additional tools, including regulatory relief and shared savings with beneficiaries.

MedPAC also predicted what a hypothetical APM model would look like, based loosely on accountable care organizations (ACOs). This prediction suggested that APMs would be at risk for total spending with Medicare Part A and Part B, have sufficient numbers to detect changes in spending or quality, have the ability to share savings with beneficiaries, be given regulatory relief, and have a single entity to assume risk.

To read the meeting brief, click here.

For the PowerPoint presentation, click here.
GAO Appoints HHS Advisory Committee on Physician Payment Models

On October 9, the U.S. Government Accountability Office (GAO) announced first-time appointments to the Physician-Focused Payment Model Technical Advisory Committee. The Medicare Access and CHIP Reauthorization Act of 2015 established the 11-member committee to provide comments and recommendations to the Secretary of Health and Human Services on physician payment models established the 11-member committee.

The term lengths of committee members will be staggered, with the first set of appointments for terms between 1 and 3 years, although committee members may be appointed for subsequent 3-year terms.

“This committee will be a critical source of information and advice for the Secretary of Health and Human Services as the department considers new payment approaches for Medicare physician services,” explained Gene L. Dodaro, Comptroller General of the U.S. and head of the GAO. “We were extremely impressed by the caliber of the nominations received for the new committee, and it is with great pleasure that I announce today’s appointees.”

For the GAO press release, click here.

HHS Issues Ruling to Advance Electronic Health Records

The Centers for Medicare & Medicaid Services (CMS) recently released rules to “simplify requirements and add new flexibilities for providers to make electronic health information available when and where it matters most and for health care providers and consumers to be able to readily, safely, and securely exchange that information.”

The rule is designed to help the healthcare industry move away from a paper-based system by easing the reporting burden, supporting interoperability, and improving patient outcomes.

CMS has outlined several highlights of the 2015 Edition Health IT Certification Criteria (2015 Edition) final rule, including:

**Interoperability:** Improves interoperability by adopting new and updated vocabulary and content standards for the structured recording and exchange of health information, including a Common Clinical Data Set composed primarily of data expressed using adopted standards; and rigorously testing an identified content exchange standard (Consolidated Clinical Document Architecture (C-CDA));

**Accessibility and Exchange of Data:** Facilitates the accessibility and exchange of data by including enhanced data export, transitions of care, and application programming interface (API) capabilities in the 2015 Edition Base Electronic Health Record (EHR) definition;
Health IT Across the Care Continuum: Establishes a framework that makes the Office of the National Coordinator (ONC) for Health IT Certification Program open and accessible to more types of health IT, including health IT that supports a variety of care and practice settings, various HHS programs, and public and private interests;

EHR Incentive Program Requirements: Supports the Centers for Medicare & Medicaid Services' (CMS) Medicare and Medicaid EHR Incentive Programs (EHR Incentive Programs) through the adoption of a set of certification criteria that align with proposals for Stage 3;

Health Disparities: Addresses health disparities by providing certification to standards for more granular capture of race and ethnicity; for the collection of sexual orientation, gender identity, social, psychological, and behavioral data; for the exchange of sensitive health information (Data Segmentation for Privacy); and for the accessibility of health IT;

Privacy and Security: Ensures all health IT presented for certification possess the relevant privacy and security capabilities;

Patient Safety: Improves patient safety by applying enhanced user-centered design principles to health IT, enhancing patient matching, requiring relevant patient information to be exchanged (e.g., Unique Device Identifiers), improving the surveillance of certified health IT, and making more information about certified products publicly available and accessible;

Reliability and Transparency: Increases the reliability and transparency of certified health IT through surveillance and disclosure requirements; and

Flexibility and Innovation: Provides health IT developers with more flexibility, opportunities, and time for the innovative, usability-focused development and certification of health IT.

Along with this final rule, CMS has announced they will be collecting public feedback during a 60-day comment period about the EHR Incentive Programs.

For a fact sheet on the final rule, click here.
For a fact sheet one the EHR Incentive Programs, click here.

Study Finds Smoking Increases Costs and Hospitalizations for PAD Patients

A new study in the Journal of the American College of Cardiology reports that health care costs in one year were $18,000 higher in smokers with peripheral artery disease (PAD) than non-smokers with the condition.

Within one year, nearly 49 percent of the study’s tobacco users with PAD were hospitalized, whereas nonusers were hospitalized at a rate of 35 percent. The researchers found that smokers are more likely to be hospitalized for leg events, heart attack, and coronary heart disease related to PAD.

Led by the University of Minnesota Medical School, researchers analyzed claims data for 33,302 individuals with PAD from 2011 from the largest health plan in Minnesota.

For the full study, click here.
President Obama Signs Continuing Resolution

On September 30, President Obama signed a continuing resolution (CR) that prevented a government shutdown and provided funding through December 11. The measure provides funding at $1.107 trillion annually as required by the Budget Control Act for FY 2016. The bill passed the both chambers overwhelmingly, with the Senate voting 78-20 and the House voting 277-151.

For a summary of the CR, click here.

For the committee’s press release, click here.

For the full bill, click here.

New JAMA Study Finds that Rise in Medical Care Prices

A new study published in the journal JAMA Internal Medicine has found that as hospitals have acquired more doctor practices, prices for outpatient medical services have increased. The boost in outpatient costs was not due to physicians ordering or performing more services, but researchers found that it increased almost entirely by price increases. This increase likely reflects stronger negotiating clout held by hospitals as compared with most physician groups.

The study focused on a period from 2008 to 2012 and looked at 240 different cities. It also relied on Medicare data and a separate database that reflected claims for commercially insured patients. At the end of the four-year span, approximately 21.3% of the physicians in the communities on studied worked for a hospital-owned practice, up form 18%.

Dr. Paul Ginsburg noted that “The study had very important results” and that “we should be very concerned” as doctors are increasingly employed by hospitals. While hospitals are acquiring more physician groups, they are also merging themselves to form larger systems. Simultaneously, insurers are engaged in pending mergers that would shrink the industry’s top five to three.

The study concludes that changes in the structure of health care providers should be monitored, particularly as payment systems shift away from fee-for-service, and may require addition regulatory measures to control.

For the full study, click here.

Reconciliation Bill Passed by House

On October 23, the U.S. House of Representatives passed a reconciliation bill – the Restoring Americans’ Healthcare Freedom Act (H.R. 3762) -- by a vote of 240-189 that would repeal major pieces of the Affordable Care Act (ACA) and eliminates federal funding for Planned Parenthood for one year.
Specifically, the measure would repeal the ACA’s employer and individual mandates, as well as its medical device and Cadillac tax. The bill reflects combined recommendations of the House Committees on Energy and Commerce, Education and the Workforce, and Ways and Means.

As required by the Concurrent Resolution the Budget for FY 2016, the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) have estimated that the reconciliation bill would decrease deficits by approximately $130 billion between 2016-2015.

For the CBO score, [click here](#).

For the bill text, [click here](#).