Omnibus Spending Bill Passed by Congress; Signed into Law

On December 18, Congress passed an FY2016 omnibus appropriations package that will fund federal agencies and programs through September 30, 2016.

The primary purpose of the measure is to fund $1.15 trillion in appropriations in FY 2016. The Congressional Budget Office has estimated that the omnibus package will increase the deficit by more than $58 billion over the next 10 years.

Among some of the health-related provisions include:

- $20 million was provided for the National Diabetes Prevention Program;
- Funding for NIH increased by $2 billion;
- Breast cancer screening recommendations issued by the USPTF were blocked for two years;
- IPAB operational funding was cut by $15 billion;
- AHRQ funding was cut by $30 million;
- Funds for 9-1-1 emergency responder health care benefits were reauthorized and expanded;
- Additional funds were provided for opioid prescription and drug overdose prevention;
- The annual ban on using CDC funding for gun violence epidemiological research was extended; and
- The ACA’s “Cadillac” medical device and health insurance taxes would be delayed until 2017.
Section 502 of the spending bill outlined Medicare payments for X-rays and other imaging services by:

**Part B Services**
- Reducing payments for the “technical” component of film X-rays on film starting in 2017, by 20 percent;
- Reducing payment for the “technical component” of “computed radiology” by 7 percent in 2018-2022 and by 10 percent starting in 2013;
- Allowing the Secretary to adopt new code modifiers to implement the preceding two reductions; and
- Sustainably reducing the current 25 percent discount that is applied to the “professional component” when there are multiple imaging services, to 5 percent in 2017.

**Hospital Outpatient Departments**
- Reducing payment for film X-rays by 20 percent in 2017;
- Phasing in reduction for “computed radiology” at the at the same levels as Part B services; and
- Allowing these two adjustments to be exempt from budget neutrality and to be implemented with the use of code modifiers.

Additionally, Section 503 limits the federal share of Medicaid payments for durable medical equipment to the same rate as Medicare, allowing states to also make further payments as well. Section 504 requires Medicare to pay for the home use of negative pressure wound therapy devices starting in 2017.

For the full legislative text, click here.

For the CBO Score, click here.

**U.S. Senate Passes Reconciliation Package**

- On December 3, the U.S. Senate passed a budget reconciliation package to reform the Affordable Care Act (ACA). The bill repeals the ACA’s premium subsidies, health insurance marketplaces, three risk mitigation programs, Medicaid expansion, and more.

The entire bill includes the following provisions:
- Defunds the Prevention and Public Health Fund;
- Gives the Community Health Center Program $235 million more for a total $3.8 billion; removes the HHS secretary’s authority to run a federal exchange as of Jan. 1, 2018;
- Makes the ACA’s section on territory health care ineffective; blocks the HHS secretary from collecting fees and making payments under the reinsurance, risk corridor and risk adjustment
programs;
- Addresses substance abuse-related public health crises and mental health needs; winds down
  the premium tax credits, cost-sharing subsidies and small business tax credits as of Dec. 31,
  2017;
- Ends the individual and employer mandate penalties retroactively effective as of Dec. 31, 2014;
  restricts federal funds to states that pay providers offering abortion services; rolls back Medicaid
  expansion;
- Repeals disproportionate share hospital payment reductions; ends the tax on over-the-counter
  medications for Archer MSAs, flexible spending arrangements and health reimbursement
  arrangements as of Dec. 31;
- Lowers the tax on health savings accounts to 10 percent, Archer MSAs to 15 percent and chronic
  care tax to 7.5 percent on Dec. 31;
- Blocks limits on contributions to flexible spending accounts; repeals the tax on prescription
  medicines, medical device excise tax and health insurance tax; restores deductions for
  Medicare Part D subsidy expenses;
- Repeals provisions related to Medicare tax increases, the tanning tax, net investment tax; and
- Includes provisions on extending Medicare solvency, remuneration and parts of economic
  substance doctrine.

The Congressional Budget Office (CBO) and Joint Committee on Taxation estimate that the
reconciliation package will reduce the federal deficit by $282 billion by FY 2025.

For the full bill, click here.

To view a section-by-section summary of the bill, click here.

To view the CBO score, click here.

**MedPAC Meets to Discuss Payment Adequacy
Recommendations**

- On December 10, the Medicare Payment Advisory Commission (MedPAC) met to review Medicare
  payment policies and recommendations to make for Congress, specifically examining whether
  payments to physicians, other health professions, and ambulatory surgical centers (ASCs) are adequate
  and how they should be updated in 2017.

The meeting included reports of decreases in volume of imaging and tests, which reflects a shift from
freestanding offices to hospitals, including a trend toward billing for some services in hospitals instead
of freestanding offices and increases in overall Medicare program spending and beneficiary cost
sharing. This trend includes hospital outpatient departments (HOPDs) providing echocardiography 7 percent more between 2013 and 2014, whereas freestanding offices witnessed a decrease during the same time period by 5.7 percent. Similarly, nuclear cardiology increase for HOPDs by 11 percent while freestanding offices declined 9.6 percent.

MedPAC’s future work includes addressing disparities in compensation, including revisiting the structure of the fee schedule and addressing Alternative Payment Models (APMs) and Merit-based Incentive Payment Systems (MIPS).

For the full presentation, click here.

GAO Report Recommends Congress Equalize Pay Rates

In December, the Government Accountability Office (GAO) released a report examining trends in vertical consolidation and its effects on Medicare. The report examines trends in vertical consolidation from 2007 to 2013 between hospitals and physicians and the extent to which higher levels of vertical consolidation with more evaluations and management (E/M) office visits being performed in hospital outpatient departments (HOPDs).

The GAO report finds that vertically consolidated hospitals grew from 1,400-1,700 and physicians increased from 96,000-182,000. The growth was indiscriminate, spanning across all counties and has rapidly accelerated in recent years. Further, GAO found that the Medicare payment rate for a mid-level E/M patient was almost $51 higher when treated in an HOPD.

The results also found that patients visiting HOPDs rather than physician offices was higher in counties with more vertical consolidations, noting that such payment policies are inconsistent with Medicare’s role. GAO notes that the Centers for Medicare & Medicaid Services (CMS) are unable to equalize the payment rates however.

Instead, the report recommends that Congress direct the Department of Health and Human Services to equalize payments across all settings to prevent the shift of services from lower paid settings to HOPDS from drastically increasing costs for Medicare and beneficiaries.

For the full report, click here.

Senate Finance Committee Releases Chronic Care Recommendations

The Senate Finance Committee’s Chronic Care Working Group released more than 20 proposals it is considering after convening 80 meetings on chronic care and receiving 530 comments from interested parties. The proposals are part of a long-term effort to improve care and reduce costs for
Medicare beneficiaries with chronic care.

In reviewing all submissions, the working group outlined three main bipartisan goals that each policy under consideration should strive to meet, including:

1. The proposed policy increases care coordination among individual providers across care settings who are treating individuals living with chronic diseases;
2. The proposed policy streamlines Medicare’s current payment systems to incentivize the appropriate level of care for beneficiaries living with chronic diseases; and
3. The proposed policy facilitates the delivery of high quality care, improves care transitions, produces stronger patient outcomes, increases program efficiency, and contributes to an overall effort that will reduce the growth in Medicare spending.

The report emphasizes that the committee is not endorsing any ideas outlined in the report and that any eventual initiatives will need to be budget neutral or save money, stating, “While we are committed to tackling this urgent matter head on, the Committee has repeatedly stated its intention to proceed thoughtfully.” Additionally, the Finance Committee is seeking additional comments on the proposals detailed in the report.

For the full report, click here.

---

Health Care Spending Increases in 2014

A report released on December 2 from the Centers for Medicare & Medicaid Services (CMS) found that health care spending increased 5.3 percent to $3 trillion in 2014.

Key report findings include:

- Consumer out-of-pocket spending grew by only 1.3 percent in 2014, as compared to 2.4 percent growth in 2013.
- On a per-enrollee basis, overall spending increased by 2.4 percent for Medicare beneficiaries.
- Medicare spending grew 5.5 percent to $618.7 billion.
- Health care spending grew 1.2 percentage points faster than the overall economy in 2014.
- 8.7 million individuals gain coverage in 2014.

To view the full report, click here.

For CMS’ press release, click here.

---

The CardioVascular Coalition (CVC), established in 2014, is a nonprofit organization representing freestanding cardiovascular centers. CVC members are comprised of national organizations representing providers and manufacturers.

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.