House Republicans Approve Debt-Limit Extension

On January 23, the House approved by a vote of 285 to 144 the "No Budget, No Pay Act," (H.R. 325). On January 31, the Senate approved the measure by a vote of 64 to 34. The President is expected to sign the legislation.

The measure would temporarily suspend the limitation on borrowing by the Treasury through May 18, 2013. On May 19, 2013, the current debt limit of $16.394 trillion would be raised by the amount of borrowing above that level during the period in which the limitation was suspended. The bill also stipulates that if a version of a budget resolution has not been passed by either chamber of the Congress by April 15, 2013, the salaries of Members of that chamber would be put in an escrow account. The escrow account for a given House would remain in place until a concurrent resolution on the budget was passed for fiscal year 2014 by that chamber, or until the last day of the 113th Congress, whichever was earlier.

Bill Changes the Order of Next Potential "Trigger" for Medicare Legislation

Policy watchers had considered the debt limit authority bill as a potential trigger for provisions also potentially requiring spending offsets, including Medicare offsets. While this issue has been temporarily postponed until May 18, 2013 (or later), other potential "triggers" are still on the immediate horizon.

- **Sequester.**
  - Pursuant to the American Taxpayer Relief Act (ATRA) of the sequester required under the Budget Control Act was delayed.
  - *Discretionary Spending.* The ATRA delayed the sequester applicable to discretionary spending (i.e. non-mandatory spending such as Medicare is not included in this category) until March 27, 2013.
  - *Medicare.* The sequester order is issued on March 1, 2013 and, pursuant to 2 USC 906, the 2% Medicare sequester will take effect for payments starting on April 1, 2013.

- **Continuing Resolution.**
  - Pursuant to the Continuing Appropriations Resolution for FY 2013, discretionary spending authority was extended through March 27, 2013.

Report on Radiation Oncologists' Experience with PQRS

A study published in the Journal of the American College of Radiology (JACR), "Medicare's Physician Quality Reporting System: Early National Radiologist Experience and Near-Future Performance Projections," evaluated the experience of radiation oncologists with the Physician Quality Reporting System (PQRS). The PQRS allows for incentive bonuses or penalties for physicians relating to specific documentation and reporting requirements. The current program methodology calls for bonuses of 0.5% through 2014. In 2015, bonuses will be replaced by penalties which are scheduled to rise to 2% of total individual physician Medicare payments in 2016.
Key points from the study include the following:

- Only a minority of radiologists successfully qualified for incentives under PQRS, but that number has increased each year.
- Those using registry (rather than claims-based) reporting systems were more likely to receive bonuses.
- Physician and practice improvements in documentation and reporting, respectively, will be necessary to avert widespread near-future physician penalties.
- The mean 2010 incentive bonus for radiation oncologists was $12,704.38.
- Between 2007 and 2010 radiation oncology eligibility increased 28.7% (from 3,457 to 4,448), participation increased 91.7% (from 519 to 995), and qualification increased 302.9% (from 139 to 560).
- Although only 23.7% of eligible radiologists qualified for PQRS incentives in 2010, radiologists overall fared more favorably than nonradiologists. The only nonradiology specialties that exceeded radiologists' qualification rates for eligible physicians in 2010 were emergency medicine (56.4%), pathology (43.4%), thoracic and cardiac surgery (31.4%), anesthesiology (30.6%), cardiology (28.6%), and ophthalmology (27.6%).
- Assuming steady-state conditions, on average, 13% of radiation oncologists would be eligible for annual bonuses of $2,010 for 2013 – 2014 and 87% of radiation oncologists would be subject to penalties of $6,029 and $8,039 in 2015 and 2016, respectively.

American Taxpayer Relief Act (ATRA) Registry Provision

The recently-enacted ATRA provides, for 2014 and subsequent years, Medicare will treat an eligible professional as satisfactorily submitting data on quality measures under the PQRS if the eligible professional is satisfactorily participating, as determined by the Secretary, in a qualified clinical data registry for the year. Under the provision the Secretary must establish requirements for an entity to be considered a qualified clinical data registry. In establishing such requirements, the Secretary must consider whether an entity: (1) has in place mechanisms for the transparency of data elements and specifications, risk models, and measures; (2) requires the submission of data from participants with respect to multiple payers; (3) provides timely performance reports to participants at the individual participant level; and (4) supports quality improvement initiatives for participants. The Secretary is required to consult with interested parties and to establish a process to determine whether an entity may be considered a qualified clinical data registry, including through a determination by the Secretary or by an independent organization designated by the Secretary with the authority to make such determination.

CMS Announces 106 New Accountable Care Organizations (ACOs) for the Medicare Savings Program

On January 10, the Centers for Medicare & Medicaid Services (CMS) announced the launch of 106 new Accountable Care Organizations (ACOs). This announcement brings the total number of ACOs created since the passage of the Affordable Care Act to 250 and the total number of patients served to 4 million. A list of the new ACOs is available here.

CMS Considers Allowing Specialists to Form ACOs

According to Inside Health Policy, CMS Principal Deputy Administrator Jonathan Blum recently indicated that CMS is considering allowing specialists to form accountable care organizations as demonstrations. According to the article, Blum said nephrologists and oncologists are among those who want to form ACOs.
**CMS Report on 2012 EHR Payments**

As of December 2012, CMS distributed $10.7 billion in electronic health record (EHR) incentive payments. $1.8 billion has been paid to Medicare physicians and other professionals. So far, $862 million has been paid to Medicare-eligible professionals for 2012. Program payments under Medicare were $981 million in 2011. Attestation for eligible professionals who participated in the 2012 Medicare Electronic Health Record (EHR) Incentive Program must be completed by February 28, 2013 with reporting completed by December 31, 2012.

**AMA Comments on Meaningful Use Stage 3 EHR Requirements**

On January 14, the American Medical Association provided comments on the Health IT Policy Committee’s proposal for Stage 3 of the Medicare/Medicaid meaningful use Electronic Health Record (EHR) Program. AMA concerns included the following:

- 100 Percent Pass Rate is Problematic.
  - Meaningful use requirements are problematic given the fact that failing to meet just one measure by one percent would make a physician ineligible for incentives and subject to penalties.

- One size Does Not Fit All.
  - Program requirements should be appropriately flexible and better structured to accommodate various practice patterns and specialties.

- Evaluation Process is Lacking.
  - The AMA believes it is a "serious mistake" to keep adding stages and requirements to the meaningful use program without evaluating Stage 1 of the program.

- Usability of certified EHRs Should Be Addressed.
  - According to the Healthcare Information and Management Systems Society (HIMSS) EHR Usability Task Force, "...usability is one of the major factors — possibly the most important factor — hindering widespread adoption of EMRs." Although ONC’s Regional Extension Centers (RECs) have been tasked with helping primary care physicians select an appropriate EHR product for their practices, the AMA believes information regarding an EHR's usability needs to be made available, so that physicians in any specialty can use this information to determine which EHR product(s) best meet their practice workflow and specialty needs.

- Health IT Infrastructure Barriers Should Be Resolved.
  - Improving the Health IT infrastructure to allow physicians to readily and securely exchange patient data with other health care providers should be made a top priority and take precedence over the development of future stages of the meaningful use program.

**CMS Office Of the Actuary Reports National Health Care Spending Stable**

On January 7, the CMS Office of the Actuary reported in Health Affairs that the health spending share of GDP stayed stable in 2011 at 17.9 percent. National health spending increased 3.9 percent, the same rate of growth experienced in 2009 and 2010. The recent recession was a contributing factor due to high unemployment, loss of private health insurance coverage, and a reduction in the resources available to pay for health care.

Despite the overall stability in health spending, the Office of the Actuary observed faster growth in spending among some payers and services in 2011. Medicare spending, for example, increased 6.2 percent in 2011 from 4.3 percent in 2010. Several factors contributed to the acceleration, including a onetime increase in spending for skilled nursing facilities, faster growth in spending for physician services, and an increase in Medicare Advantage spending growth.
MedPAC Assesses Payment Adequacy

On January 10, the Medicare Payment Advisory Commission (MedPAC) was briefed by MedPAC staff regarding payment adequacy for physicians and other professional services.

MedPAC made the following statements regarding repeal of the SGR:

- When the American Taxpayer Relief Act of 2012 was passed, Congress again deferred an SGR cut for one year at a substantial cost to the Medicare program, about $25 billion over 10 years.
- Moving forward, the Commission’s principles for the SGR are:
  - Preserve access,
  - Rebalance payments toward primary care,
  - Encourage movement toward new payment models and delivery systems,
  - Offset the cost of repeal.
- At this point in time, Medicare beneficiaries continue to have good access to physician services...but repeal of the SGR is urgent.

MedPAC staff also noted that MedPAC would not have a separate vote on an updated recommendation and is reiterating these principles moving forward.

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