Sequester Ordered

Pursuant to the American Taxpayer Relief Act, the sequester order required under the Budget Control Act was delayed until March 1, 2013 and pursuant to 2 USC 906, the 2 percent Medicare sequester will take effect for payments starting on April 1, 2013.

On February 26, Senate Democrats announced a package — the American Family Economic Protection Act — to delay from March 1, 2013 to January 2, 2014 the sequestration order. The $110 billion package contained $55 billion in tax increases (primarily from generally requiring taxpayers with adjusted gross incomes greater than $1 million to pay at least a 30 percent tax on all of their adjusted gross income) and $55 billion in spending cuts (equally split between defense and agriculture) to pay for the delay.

On February 28, the American Family Economic Protection Act failed in the Senate by a vote of 51 to 49. Given the failure of this and related legislation, sequestration will proceed pursuant to the ATRA and the Budget Control Act.

Obama Delivers State of the Union Address

On February 12, President Obama delivered his 5th State of the Union Address.

The President signaled potential changes to Medicare this year by stating:

- "[T]hose of us who care deeply about programs like Medicare must embrace the need for modest reforms -- otherwise, our retirement programs will crowd out the investments we need for our children, and jeopardize the promise of a secure retirement for future generations."
- "On Medicare, I'm prepared to enact reforms that will achieve the same amount of health care savings by the beginning of the next decade as the reforms proposed by the bipartisan Simpson-Bowles commission."

House W&M, E&C GOP Introduce New Plan to Repeal SGR

On January 31, Republicans on the House Ways and Means Committee and the Energy and Commerce Committee introduced a multi-phase plan to repeal the Medicare Sustainable Growth Rate (SGR) formula. The framework calls for a three-phase approach, key elements of which are provided below:

- Phase 1: Repeal SGR and provide a period of predictable, statutorily-defined payment rates.
  - Duration of transition and size of payment rates TBD.
- Phase 2: Reform Medicare’s FFS payment system to better reflect the quality of care provided.
  - PFS payment updates based on performance on meaningful, physician-endorsed measures of quality and participation in clinical improvement activities.
  - This phase intends to "reduce the reporting burden on physician practices" and "override the current ineffective CMS quality measurement programs."
Physicians participating in "certain alternative reimbursement models" may opt out.

Phase 3: Further reform Medicare's FFS payment system to also account for the efficiency of care provided.

After several years of risk-adjusted quality-based payments, physicians who perform well on quality measurement will be afforded the opportunity to earn additional payments based on the efficiency of care.

A related joint E&C/W&M request for feedback questionnaire regarding quality measures, reporting burden and other issues is available [here](#).

Cost of Permanent SGR Repeal Significantly Reduced

According to the Congressional Budget Office's Budget and Economic Outlook 2013-2023 [released](#) on February 5, repealing the SGR and maintaining current Medicare PFS payment rates over the next ten years would cost $138 billion. According to CBO, "The estimated cost of holding payment rates constant is much lower relative to this baseline than was the case under previous CBO baselines, primarily because of lower spending for physicians' services in recent years." Lawmakers in the House of Representatives have noted that the lower cost of SGR repeal increases the prospects for fundamental reform and publically have targeted to move such a bill before the August recess.

Representatives Schwartz and Heck Reintroduce SGR Repeal Bill

On February 6, Reps. Allyson Schwartz (D-PA) and Joe Heck (R-NV) reintroduced legislation to repeal and replace the Medicare SGR formula. The reintroduced legislation, the Medicare Physician Payment Innovation Act of 2013, would permanently repeal the SGR formula; provide annual positive payment updates for all physicians for four years; aggressively test and evaluate new payment and delivery models; and stabilize payment rates for providers who move to alternative payment and delivery models.

Payment update provisions are similar to the legislation introduced in the last Congress (this newsletter reported on those updates [here](#)). In contrast to the legislation from the last Congress, the bill would not use savings from the so-called "overseas contingency operations" as an offset, apparently due to Republican opposition to that offset.

Medicare Request for Information on the Use of Clinical Quality Measures (CQMs) Reported under the Physician Quality Reporting System (PQRS), the Electronic Health Record (EHR) Incentive Program, and Other Reporting Programs

As this newsletter previously [reported](#), the recently-enacted American Taxpayer Relief Act (ATRA) provides, for 2014 and subsequent years, that 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. Pursuant to this provision, on February 4, 2013, CMS released a [Request for Information](#) (RFI) to solicit information from medical specialty societies, boards, and registries, other third party registry vendors, eligible professionals using registries to report quality measures, and any other party relating to:

- Ways in which an eligible professional (EP) might use the clinical quality measures (CQM) data reported to specialty boards, specialty societies, regional health care quality organizations or other non-federal reporting programs to also report under the Physician Quality Reporting System (PQRS), as well as the Electronic Health Record (EHR) Incentive Program.

- Ways by which the entities already collecting CQM data for other reporting programs might submit this data
on behalf of EPs and group practices for reporting under the PQRS and the EHR Incentive Program.

- Section 601(b) of the ATRA, which provides for treating an EP as satisfactorily reporting data on quality measures if the EP is satisfactorily participating in a qualified clinical data registry.

The information solicited in the RFI must be received by CMS no later than 5 p.m. ET, April 8, 2013.

Health Subcommittee on House Energy and Commerce Committee Hearing on Sustainable Growth Rate (SGR)

On February 14, the House Energy and Commerce Health Subcommittee held a hearing titled, "SGR: Data, Measures and Models; Building a Future Medicare Physician Payment System," that focused on repealing and replacing the current SGR formula with a new payment system. Key testimony was received from the following:

- **Glenn Hackbarth, Chairman, MedPAC**: "The SGR is fundamentally flawed and is creating instability in the Medicare program for providers and beneficiaries. The Commission recommends that the Congress repeal the SGR system for many reasons. First, the SGR system, which ties annual updates to cumulative expenditures, has failed to restrain volume growth and may have exacerbated it. Second, temporary, stop-gap fixes to override the SGR undermine the credibility of the Medicare program because they engender uncertainty and anger among physicians and other health professionals, which may in turn cause anxiety among beneficiaries. Third, the short-term overrides have led to an administrative burden for providers and CMS due to holding of claims, delays in submission of claims, and reprocessing of claims."

- **Harold D. Miller, Executive Director, Center for Healthcare Quality and Payment Reform**: "A major reason we’re still spending tens of billions of dollars on unnecessary and harmful care is because of the way we pay for healthcare today. The current fee-for-service system makes it difficult or impossible for physicians to help Medicare take advantage of these opportunities to improve care for patients and reduce healthcare spending."

- **Robert Berenson, M.D., Institute Fellow, the Urban Institute**: A few years ago, CMS reasonably reduced the overpayment for cardiac imaging tests performed in physician offices; yet, the correction initiated a hospital employment frenzy of cardiologists to take advantage of the higher outpatient payment rates. The result is that Medicare perversely wound up paying more for the same services to the same patients. Hospitals do have costs that independent practices do not face, but these costs should not be reflected in services that do not reflect hospitals’ unique obligations. The site-of-service differential for physician services should be significantly reduced or eliminated, while the costs that hospitals do bear for their unique obligations should be paid for but through other means, possibly through increases in inpatient, emergency department and other unique hospital services.

A background memorandum on this hearing can be found [here](#).

IOM Report ON Delivering Affordable Cancer Care in the 21st Century

On February 11, the Institute of Medicine (IOM) released a report from a workshop to examine the drivers of current and projected cancer care costs as well as potential ways to curb these costs while maintaining or improving the quality of care. The report highlighted possible solutions to improve the affordability and quality of cancer care, including:

- Improving the information patients have to make decisions about and manage their care.
  - Proposals included transparent quality metrics and incentivizing clinician communications with patients regarding prognosis and treatment options.
  - Encourage clinicians to deliver affordable, high-quality cancer care
• Proposals included adherence to guidelines and the incorporation of cost information with guidelines.
• Promote and facilitate best practices in cancer care
  • Proposals included 24-hour support to cancer patients; early integration of palliative care in cancer care delivery; improving the functionality and interoperability of electronic medical records; population-based performance measurements
• Enhance research that informs clinical practice
  • Proposals included collection of point-of-care data to inform comparative effectiveness; pragmatic trials with clinically relevant outcomes.
• Reward the provision of affordable, high-quality cancer care through delivery system and reimbursement changes
  • Proposals included capitation, episode-related payments, medical homes, accountable care organizations, and shared savings programs; coverage with evidence development programs to assess new innovations in cancer care.

Hatch Floats Medicare, Medicaid Reforms

On January 24, Ranking Senate Finance Committee Member Orrin Hatch (R-UT) outlined five proposed structural reforms to Medicare and Medicaid including:

• Adjust the Medicare eligibility age for seniors from 65 to 67 years of age
• Modernize the Medigap program
• Simplify Medicare beneficiary cost-sharing and establish a catastrophic limit
• Allow health plans to compete with traditional fee-for-service Medicare
• Limit the amount of federal dollars spent for each Medicaid beneficiary

Physician Payment 'Sunshine' Final Rule

On February 1, CMS published a final rule to make information publicly available about payments to physicians from certain manufacturers of drugs, devices, biologicals and medical supplies covered by Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

Under the rule, applicable manufacturers must report annually to the Department of Health and Human Services all payments or transfers of value from applicable manufacturers to physicians. In addition, applicable manufacturers must report ownership and investment interests held by physicians (or the immediate family members of physicians) in such entities. The law requires CMS to provide applicable manufacturers and physician owners and investors at least 45 days to review, dispute and correct their reported information before posting it on a publicly available website.

Data collection will begin on August 1, 2013. Applicable manufacturers will report the data for August through December of 2013 to CMS by March 31, 2014 and CMS will release the data publicly by September 30, 2014.

The final rule can be seen here. A fact sheet is available here.
CMS Announces Three-Year Bundling Initiative

On January 31, CMS announced that more than 500 organizations will start participating in a three-year bundled payment demonstration from the Bundled Payments for Care Improvement (BPCI) initiative. All four BPCI models are linked to an MS-DRG.

Under the BPCI initiative, participants can choose from 48 episodes of care. A list of the healthcare facilities and the episodes they will be testing can be found here. At this time, CMS officials are not making any savings projections related to this initiative.

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