Three-Month Doc Fix & Budget Deal Enacted

On December 26, 2013, President Obama signed H.J. Res. 59, legislation (1) to revise the limits on discretionary appropriations for fiscal years 2014 and 2015 (allowing for higher levels of funding in those years than is allowed under the caps and budget enforcement procedures in current law), (2) to establish a FY 2014 Congressional Budget Resolution, and (3) to provide for a temporary SGR "patch" and other "so-called" Medicare and Medicaid extenders, and (4) containing other provisions. In order to offset higher discretionary appropriations in 2014 and 2015, the legislation would extend direct spending sequestration cuts (including Medicare sequestration cuts) for an additional two years (i.e. for 2022 and 2023).

Pathway for SGR Reform Act

Division A of H.J. Res. 59 includes provisions relating to the near-term increase in discretionary spending limits and out-year extension of direct spending sequestration cuts. Division B of H.J. Res. 59 includes the Pathway for SGR Reform Act, which contains the following policies, among others:

- **Physician Payment Update**
  - This provision prevents a 20.1% cut in reimbursements for physicians treating Medicare patients on January 1, 2014 and replaces it with a 0.5% increase until April 1, 2014.
  - Under the update, the 2014 conversion factor is $35.8228.

- **Extension of the Medicare Work GPCI Floor**
  - This provision extends the Medicare GPCI floor until April 1, 2014.

- **Medicare Sequester Realignment**
  - This provision realigns the Medicare sequester in FY 2023 without increasing the overall annual impact of the sequester on Medicare providers. Specifically, the provision would allow for a 2.90% sequestration reduction in the first 6 months of FY 2023 and a 1.11% sequestration reduction for the second 6 months of FY 2023. This provision allows for additional savings within the 10-year budget scoring window in order to offset other provisions of the Pathway for SGR Reform Act.

A link to the CBO score for Division A of H.J. Res 59 is available here.

A link to the CBO score for Division B of H.J. Res 59 is available here.

A link to a section-by-section of Division A of H.J. Res. 59 is available here.

A link to a section-by-section of Division B of H.J. Res. 59 is available here.

CBO Lowers Estimated Cost for Permanent SGR Repeal

The Congressional Budget Office released an update to its previous estimate of the cost to repeal the sustainable growth rate (SGR) formula due to the release of the CY 2014 Physician Fee Schedule (PFS) Final Rule. Based on updated information provided in the rule, CBO now estimates that permanent repeal of
the SGR formula would cost $116.5 billion over 10 years under a 0% update scenario. Under a 0.5% update scenario, permanent repeal of the SGR formula would cost $136.1 billion over 10 years. With respect to one-year "patches," CBO estimates a 0% update for 2014 would cost $19.6 billion over 10 years, while a 0.5% update for 2015 would cost $18.7 billion over 10 years.

Senate Finance and Ways and Means Committees Mark Up Permanent SGR Replacement Bill

On December 19, Senator Baucus filed S. 1871, the "SGR Repeal and Medicare Beneficiary Access Act of 2013." This bill was reported by the Senate Finance Committee subsequent to a December mark-up. On December 12, the House Ways & Means Committee completed its mark-up of the Medicare Patient Access and Quality Improvement Act of 2013 (H.R. 2810). On November 20, the House Energy and Commerce Committee reported similar legislation under the same title.

S. 1871 contains the following specific provisions of note:

- **Physician Payment Update**
  - Zero percent update for 2014 through 2023.
  - In 2023 and subsequent years, professionals participating in APMs that meet certain criteria would receive annual updates of two percent, while all other professionals would receive annual updates of one percent.
    - Ways and Means legislation is similar except that it provides for 0.5 percent updates for 2014 through 2016.
    - Energy and Commerce legislation provides for 0.5 percent updates for 2014 through 2018. It also provides for a 0.5 percent update for each year beginning 2019 but this update would be adjusted depending upon the performance on certain quality measures.

- **Value-Based Purchasing**
  - Streamlines the Physician Quality Reporting System (PQRS), value-based modifier, and EHR Meaningful Use program into a single, budget-neutral, value-based, purchasing program starting in 2017.
  - PQRS and Meaningful Use penalties are sunset at the end of 2016.
  - The VBP program will assess the performance of eligible professionals in four categories: quality; resource use; EHR Meaningful Use; and clinical practice improvement activities.
  - Funding available for VBP incentive payments will be equal to 4 percent of the total estimated spending in 2017; six percent in 2018; eight percent in 2019; and ten percent in 2020. Starting 2021, the funding pool could increase but is capped permanently at no greater than 12 percent.
  - Professionals will receive a VBP payment reduction no greater than the size of the funding percentage amount for the year (e.g., four percent in 2017); the maximum payment increase will be no greater than funding percentage amount (e.g. four percent in 2017).
    - Ways and Means legislation is similar.
    - Energy and Commerce legislation implements a new Quality Update Incentive Program (QUIP) whereby the update for a physician could range from +1.5 percent to -0.5 percent (inclusive of the 0.5% standard update) beginning in 2019. It directs the Secretary to avoid redundant measures under the new QUIP and Meaningful Use program, and coordinates reporting periods under PQRS, the Meaningful Use program and the QUIP for 2019 and subsequent years.
Alternative Payment Models

- Professionals who receive a significant share of their revenues through an APM that involves risk of financial losses and a quality measurement component will receive a five percent bonus each year from 2017-2022.
- Professionals who meet these criteria will be excluded from the VBP assessment and most EHR meaningful use requirements.
  - Ways and Means legislation is similar.
  - Energy and Commerce legislation provides that physicians under an APM are paid in accordance with the model's payment arrangement, and the participating EP is deemed to satisfy PQRS reporting requirements.

Potentially Misvalued Codes

- The list of criteria the Secretary can use to identify potentially misvalued services is expanded to include codes: that account for a majority of spending under the physician fee schedule; with substantial changes in procedure time; for which there may be a change in the site of service or a significant difference in payment between sites of service; services that may have greater efficiencies when performed together; or with high practice expenses or high cost supplies.
- The legislation sets an annual target for identifying misvalued services of 0.5 percent of the estimated amount of fee schedule expenditures in 2015, 2016, 2017, and 2018. If the target is met, that amount is redistributed in a budget-neutral manner within the physician fee schedule. If the target is not met, fee schedule payments for the year are reduced by the difference between the target and the amount of misvalued services identified in a given year. If the target is exceeded, the amount in excess of the target is credited toward the following year's target.
- Beginning with the 2015 physician fee schedule, total downward relative value unit (RVU) adjustments for a service of 20 percent or more (as compared to the previous year) will be phased-in over a two-year period.
  - Ways and Means legislation is similar.
  - Energy and Commerce legislation mandates, for 2016, 2017, and 2018, annual reductions of not more than 1 percent of the projected amount of expenditures under the Medicare physician fee schedule from downward adjustments in relative values for misvalued services identified by the Secretary.

Appropriate Use Criteria

- The Secretary is required to establish a program that promotes the use of appropriate use criteria (AUC) for advanced diagnostic imaging. In consultation with stakeholders, and no later than November 15, 2015, the Secretary will specify one or more AUC(s) from among those developed or endorsed by national professional medical specialty societies or other entities, taking into account whether such criteria: have stakeholder consensus; are evidence-based; and are in the public domain.
- In consultation with stakeholders, and no later than April 1, 2016, the Secretary will identify and publish a list of qualified CDS mechanisms, at least one of which must be free of charge, that could be used by ordering professionals to consult with applicable appropriate use criteria.
- Beginning January 1, 2017, payment will only be made to the furnishing professional for an applicable advanced diagnostic imaging service if the claim for such service includes information: 1) showing that the ordering professional consulted with a qualified CDS mechanism, 2) as to whether the ordered service adheres to the applicable AUC(s), and 3) regarding the national provider identifier (NPI) of the ordering professional.
- Beginning January 1, 2020, outlier physicians shall be subject to prior authorization for applicable imaging services.
GAO is required to provide a report to Congress no later than 18 months after enactment of this legislation regarding other Part B services for which the use of clinical decision support mechanism would be appropriate, such as radiation therapy and clinical diagnostic laboratory services.

- Ways and Means legislation is similar.
- Energy and Commerce legislation has no similar provision.

**Medicare Work GPCI Floor**
- Permanently adjusts the physician work geographic adjustment floor from 1.0 to 0.99 over three years.
  - Ways and Means legislation has no similar provision.
  - Energy and Commerce legislation has no similar provision.

Details of the SGR Repeal and Medicare Beneficiary Access Act of 2013, including a section-by-section, committee amendments offered and accepted, and a CBO score are available [here](#).

A side-by-side is available [here](#).

**Letter to CMS Regarding Disparity in Medicare Oncology Rates**

A November 20 letter from Representative Mike Rogers (R-MI) to CMS Administrator Marilyn Tavenner expressed the need to reduce or eliminate Medicare payment differences that exist across ambulatory settings when the same or similar oncology services are provided to similar patients.

Citing MedPAC data, the letter states that payment rate differentials underlie the recent migration of a substantial number of outpatient services from the physician office to hospitals without any improvement in patient care.

MedPAC found that Medicare payments were about 70% more if a physician worked in hospital setting vs. a freestanding office. MedPAC analysis also found that "even though 87% of cancer care occurred successfully in community oncology practices as recently at 8 years ago, nearly a third of such care had shifted to a hospital setting."

Rogers expressed concern over the best way to address the added cost to Medicare of payment rate differences and urged CMS to provide further information on this issue.

**Health Affairs Article: Bundling as an Alternative to the SGR**

In a January 2014 *Health Affairs* article, author Gail Wilensky reviews several models, including bundling pilot projects still in the beginning stages of evaluation and implementation, to replace the sustainable growth rate (SGR) formula and slow spending growth for physician services.

The CMS Innovation Center’s Bundled Payment for Care Improvement Initiative funds four models of bundling. All have the hospital as the central point of the bundle, two of which include physician services, post-acute providers, related readmissions and any ancillary services provided during an episode of care. The organizations involved can request conditions they want to bundle and propose a price for care. Because hospitals are the focus of this bundle, Wilensky expresses concern that this will only magnify the shift in power to hospitals, which has been happening over the last 10 years as hospitals and physicians join larger hospital systems.
A Condition-Based Payment for Specialty Physicians, developed by the American Medical Association, is a bundling payment in which the bundle covers specialty physician costs for treating a given medical condition. In this instance, a provider would be chosen to negotiate an amount from Medicare that is less than what Medicare would typically pay for a given condition.

Wilensky states, "A system of bundled payments encourages the efficient provision of services because the amount paid for the bundle of services provided is fixed, irrespective of the costs incurred. A fee schedule that reimburses each physician on the basis of approximately 8,000 different codes makes it very difficult to hold physicians responsible or accountable for the health outcomes of their patients or the costs of treating them—both crucial for value.


A November 21 letter from Representative Renee Ellmers to Budget Conference Committee chairs Senator Patty Murray (D-WA) and Representative Paul Ryan (R-WI) urges a stop to the Medicare sequester payment cut to cancer drugs. The letter states, "The sequester cut to payment for cancer drugs is forcing clinics to send Medicare patients to hospitals for treatment, to close facilities, or to merge with hospitals. When cancer treatment facilities close, cancer patients have to travel longer distances to get treated and patient care suffers."

Rep. Ellmers is the author of the Cancer Protection Act of 2013 (HR1416), which currently has 109 cosponsors.


In a December 6 blog, The Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator of Health Information Technology (ONC) announced a new timeline to extend Stage 2 of the Electronic Health Records (EHR) Incentive Programs through 2016. The new timeline would allow Stage 3 to begin in 2017 for those providers that have been in Stage 2 for at least two years.

"This will allow CMS and ONC to focus efforts on the successful implementation of the enhanced patient engagement, interoperability and health information exchange requirements in Stage 2." It will also foster more analysis of data from Stage 2 progress and outcomes to determine possible Stage 3 requirements. Stage 2 is scheduled to begin in 2014.

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