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President Signs Two-Month Zero Percent Medicare Update for Physicians

On December 23, President Obama signed into law H.R. 3765, the "Temporary Payroll Tax Cut Continuation Act of 2011." The legislation provides for a zero percent update for Medicare reimbursements to physicians for January and February 2012. The update costs $3.6 billion over 10 years. The legislation also provides funds for other so-called healthcare "extender" provisions, including a two-month extension of the work geographic adjustment floor.

House-Passed Legislation

On December 13, the House of Representatives passed a longer-term physician update as part of H.R. 3630, the Middle Class Tax Relief and Job Creation Act of 2011. However, the legislation never passed the Senate due, in part, to a veto threat issued by President Obama.

The legislation included a one percent (1%) update in Medicare reimbursement levels for physicians for 2012 and 2013. The payment update would have cost $38.9 billion over ten years. The legislation also would have extended for one year the Medicare geographic adjustment floor for work. Also of interest, the bill would have required a Department of Health and Human Services (HHS) study on bundled payments under Medicare for cancer services. The provision is excerpted below as follows:

- (1) STUDY BY SECRETARY ON OPTIONS FOR BUNDLED OR EPISODE-BASED PAYMENT.—
  - (A) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study that examines options for bundled or episode-based payments, to cover physicians' services currently paid under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4), for one or more prevalent chronic conditions (such as cancer, diabetes, and congestive heart failure) or episodes of care for one or more major procedures (such as medical device implantation). In conducting the study the Secretary shall consult with medical professional societies and other relevant stakeholders. The study shall include an examination of related private payer payment initiatives.

- (B) REPORT.—Not later than January 1, 2013, the Secretary shall submit to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance in the Senate a report on the study conducted under this paragraph. The Secretary shall include in the report recommendations on suitable alternative payment options for services paid under such fee schedule and on associated implementation requirements (such as timelines, operational issues, and interactions with other payment reform initiatives).

MedPAC Reiterates October SGR Repeal Recommendation

On December 15, the Medicare Payment Advisory Commission (MedPAC) held a meeting to discuss payment updates for various providers. The Commissioners unanimously supported the recommendation of re-submitting their October letter to Congress which called on Congress to replace the current physician payment formula with a 10-year fee schedule that would freeze primary care payment rates and cut rates for specialist providers by 5.9 percent for three years before freezing payments to specialists. Chairman Hackbarth also indicated, however, that MedPAC was established to advise only on Medicare policies and, as such, it was only offering a set of Medicare options to offset a fix to the Sustainable Growth Rate (SGR) formula. Otherwise, MedPAC would not necessarily recommend that the Congress offset the repeal of the SGR entirely through Medicare or impose fee-schedule reductions.

Hackbarth emphasized the importance of the October 14, 2011 letter noting the growing sense of urgency among the Commission for Congress to repeal the SGR. In noting the urgency, Hackbarth claimed it is getting to the point where "continuing the SGR could become a destabilizing force in the Medicare Program."

The Commissioner's draft recommendations are subject to change. MedPAC is scheduled to vote on final recommendations during their next meeting on January 12-13, 2012. The details of the updates will appear in MedPAC's March 2012 report to Congress.

NIH Drafts a Statement on Active Surveillance

On December 5–7, the National Institutes of Health (NIH) sponsored a "state-of-the-science" conference to examine the role of active surveillance (AS) in the management of men with localized prostate cancer. As part of the conference, the Agency for Healthcare Research and Quality (AHRQ) released a December 2011 technology assessment, entitled "An Evidence Review of Active Surveillance in Men with Localized Prostate Cancer."

At the conclusion of the conference the NIH released a draft statement concluding that AS is a practical option that should be offered to patients with low-risk prostate cancer. The draft statement also recommended that strong consideration be given to removing the word "cancer" from the prognosis of low-risk prostate cancer as it invokes anxiety among patients.

Supreme Court Sets Dates for Oral Arguments on Health Care Reform

On December 19, the U.S. Supreme Court issued its argument schedule for March 2012. The court scheduled oral arguments for March 26, 27, and 28 over the constitutionality of the Patient Protection and Affordable Care Act.

On March 26, the Court will spend one hour on whether a federal court may grant pre-enforcement review of a statute. In particular, the court will hear arguments on whether court action is premature because no individual has paid a fine for not purchasing insurance. Two hours of debate are scheduled for March 27 on the constitutionality of Congress mandating Americans to purchase health insurance (starting in 2014) or pay a penalty. March 28 will be split into two parts. 90 minutes will be allocated to the question of whether the rest of the law can survive if the insurance mandate is found unconstitutional. The court will also hear arguments on whether the law goes too far in coercing states to participate in the health care law by threatening to withhold federal money.

A ruling is expected by the end of June. The cases before the court are Dept. of Health and Human Services v. Florida (11-398); NFIB v. Sebelius (11-393); and Florida v. HHS (11-400).

CMS Announces Pioneer ACOs

Earlier this year CMS announced three new initiatives designed to help doctors, hospitals, and other Medicare providers become ACOs. One of the initiatives was the Pioneer ACO Model designed for relatively advanced organizations that are ready to participate in shared savings. CMS released a Request for Applications (RFA) in May 2011 and, on December 19, CMS announced the 32 organizations selected to participate in the Pioneer ACO Model beginning on January 1, 2012. The list is included below:

Organization	Service Area
1. Allina Hospitals & Clinics	Minnesota & Western Wisconsin
2. Atrius Health Services	Eastern and Central Massachusetts
3. Banner Health Network	Phoenix, Arizona Metropolitan Area (Maricopa and Pinal Counties)
4. Bellin-Thedacare Healthcare Partners	Northeast Wisconsin
5. Beth Israel Deaconess Physician	Eastern Massachusetts

Organization	
6. Bronx Accountable Healthcare Network (BAHN)	New York City (the Bronx) and lower Westchester County, NY
7. Brown & Toland Physicians	San Francisco Bay Area, CA
8. Dartmouth-Hitchcock ACO	New Hampshire and Eastern Vermont
9. Eastern Maine Healthcare System	Central, Eastern, and Northern Maine
10. Fairview Health Systems	Minneapolis, MN Metropolitan Area
11. Franciscan Health System	Indianapolis and Central Indiana
12. Genesys PHO	Southeastern Michigan
13. Healthcare Partners Medical Group	Los Angeles and Orange Counties, CA
14. Healthcare Partners of Nevada	Clark and Nye Counties, NV
15. Heritage California ACO	Southern, Central, and Costal California
16. JSA Medical Group, a division of HealthCare Partners	Orlando, Tampa Bay, and surrounding South Florida
17. Michigan Pioneer ACO	Southeastern Michigan
18. Monarch Healthcare	Orange County, CA
19. Mount Auburn Cambridge Independent Practice Association	Eastern Massachusetts
20. North Texas Specialty Physicians	Tarrant, Johnson and Parker counties North Texas
21. OSF Healthcare System	Central Illinois
22. Park Nicollet Health Services	Minneapolis, MN Metropolitan Area
23. Partners Healthcare	Eastern Massachusetts
24. Physician Health Partners	Denver, CO Metropolitan Area
25. Presbyterian Health Services – Central New Mexico Pioneer Accountable Care Organization	Central New Mexico
26. Primecare Medical Network	Southern California (San Bernardino and Riverside Counties)
27. Renaissance Medical Management Company	Southeastern Pennsylvania
28. Seton Health Alliance	Central Texas (11 county area including Austin)
29. Sharp Healthcare System	San Diego County
30. Steward Health Care System	Eastern Massachusetts
31. TriHealth, Inc.	Northwest Central Iowa
32. University of Michigan	Southeastern Michigan

Medicare Data Final Rule

On December 5, the Centers for Medicare and Medicaid Services (CMS) released a final rule to allow CMS to select "qualified entities" to produce public reports on physicians, hospitals and other health care providers. The objective of these reports is to combine private sector claims data with Medicare claims data in order to identify providers with the highest quality, cost-effective care. Employers and consumers will use the resulting reports to understand more about the relative performance of physicians and other providers in their area. Prior to the public release of the reports, providers and suppliers will have an opportunity to review the reports and provide necessary corrections.

Click here to view the fact sheet released by CMS.

Essential Health Benefits Update

On December 16, the Department of Health and Human Services (HHS) released a bulletin and related fact sheet outlining the approach that HHS intends to pursue in future rulemaking to define "essential health benefits." Pursuant to the Affordable Care Act, health insurance plans offered in the individual and small group markets must offer a comprehensive package of items and services, known as "essential health benefits."

Under the intended approach, states would have the flexibility to select an existing health plan to set the "benchmark" for the items and services included in the essential health benefits package. States would choose one of the following health insurance plans as a benchmark:

- One of the three largest small group plans in the state;
- One of the three largest state employee health plans;
- One of the three largest federal employee health plan options;
- The largest HMO plan offered in the state's commercial market.

The benefits and services included in the health insurance plan selected by the state would be the essential health benefits package. If a state does not select a benchmark health plan, the default benchmark plan for that state would be the largest plan by enrollment in the largest product in the state's small group market.

HHS is accepting comments on its intended approach through January 31, 2012. Comments may be made by emailing EssentialHealthBenefits@cms.hhs.gov.

CMS National Provider Call on the Medicare Physician Feedback and Value Modifier Program

On December 21, CMS held a national provider call on the Medicare Physician Feedback and Value Modifier Programs. The Physician Feedback Program uses annual Quality and Resource Use Reports (QRURs) to provide comparative performance information to physicians. Created in 2008 and refined by the Affordable Care Act, CMS is using the Physician Feedback program to help develop methodologies that could be used for the Value Modifier Program. Under the Value Modifier Program, CMS will pay physicians differently based on the quality of care delivered. CMS has stated it will propose a methodology for the Value Modifier Program in next year's Physician Fee Schedule rulemaking. The purpose of the December 21 call was to solicit stakeholder input on methodologies for payment standardization (e.g. how to account for geographic variation) and risk-adjustment (e.g. how to account for a patient's underlying health status) for the aforementioned programs.

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