

# Health Policy REPORT

Wednesday, June 8, 2011

## Budget Negotiations Continue as Debt Limit Deadline Approaches

In an ongoing effort to reach a bi-partisan agreement on the debt ceiling prior to the August 2 deadline, President Obama met with both House Democrats and Republicans at the White House last week during the Senate recess to continue hashing out ways to resolve the debt limit debate. Following the Senate's May 25 vote against the House budget resolution which forced Republicans to go on record about whether they support the proposal's overhaul of both Medicare and Medicaid, lawmakers are now looking to President Obama for suggestions on how to reach an agreement.

In a closed-door meeting on June 1 between President Obama and most of the 240 House Republicans, GOP leaders challenged the President to present his own plan to cut the national deficit. The President responded that Vice President Joe Biden is continuing to host bipartisan talks with congressional leaders in order to reach a compromise on how to raise the debt limit and cut spending, although House Speaker John Boehner expressed concern over the slow pace of the Biden talks. Following the meeting, Boehner called for Obama to begin direct talks with members of Congress in order to come to an agreement before the end of June.

The following day, House Democrats also met with the President at the White House to continue debt discussions and press the President to stand firm on his word to preserve Medicare. While House Republicans have repeatedly maintained that they will not support any tax increases to achieve deficit reduction, tax reform was a major topic during the Democrats' discussions with the President, who made it clear that everything – including tax hikes and defense spending – would be on the table as discussions continue.

With the Senate back from recess, the Vice President and his bicameral group of congressional representatives will also be picking up debt limit discussions.

## CMS Receives Comments on the Proposed Rule for ACOs

As the June 6 comment deadline approached, the Centers for Medicare and Medicaid Services (CMS) continued to receive feedback from health care providers on the proposed rule for accountable care organizations (ACOs). In a May 24 letter to CMS, seventeen CEOs of health systems across the country told CMS Administrator Donald Berwick that they would be more likely to be able to participate in ACOs if the final rule allows for prospective attribution, narrows the quality measures, makes the shared savings percentages more favorable to providers, and eases antitrust limits.

In a May 26 letter to Federal Trade Commission Secretary Donald Clark, the American Medical Association (AMA) called for "significant modifications" to ACO requirements and antitrust clearance processes. According to the AMA, under the proposed rule, it would be difficult for doctors to work within an ACO without violating antitrust laws. The group says that 78 percent of office-based physicians work in practices of nine doctors or less and most are in groups of one to four doctors. The AMA is also calling on CMS to issue its upcoming regulation on ACOs as an interim rule, not a final one, so that CMS maintains the flexibility to modify and improve the regulation as the agency learns more about the model once implementation begins.

In addition, the [Patient Centered Primary Care Collaborative](#) has expressed numerous concerns about the ACO Proposed Rule. Specifically, the group is concerned that the proposed method of assigning Medicare beneficiaries into ACOs could lead to "gaming of the system" since providers can remove the attribution of patients by intentionally reducing billing by physicians. Under the proposed structure, patients would be assigned to ACOs only if they received multiple primary care services, based on allowed charges, from primary care physicians

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## CMS Receives Comments on the Proposed Rule for ACOs (Cont'd)

within the ACO.

As the comment period came to a close, CMS publicly acknowledged some of the [widespread criticism](#) they have received concerning the proposed rule over the last several months. On May 25, CMS Medicare chief Jonathan Blum indicated that the agency would be providing more time to phase in the two-sided risk ACO model. While major changes are expected to be implemented into the final rule, key Washington insiders are expecting CMS to reject GOP lawmakers' May 24 [letter calling on the](#) agency to scrap the entire proposed rule and start over.

## Whitfield Introduces CARE Act in Congress

On June 2, Congressmen Ed Whitfield (R-KY) and John Barrow (D-GA) introduced the Consistency, Accuracy, Responsibility and Excellence (CARE) in Medical Imaging and Radiation Therapy Act of 2011, which would set minimum certification and educational standards for non-physician technical personnel (radiation therapists, medical physicists, and medical dosimetrists) performing medical imaging and administering radiation therapy to patients. In the field of radiation oncology, the CARE Act would use a three-tiered approach to improve the quality and safety of radiation therapy delivery by requiring these non-physician personnel to graduate from a specialized education program, pass a national certification exam, and maintain competency by obtaining continuing education. This legislation is co-sponsored by a bipartisan group of 17 members of the House of Representatives.

“By setting minimum education and certification standards for the technical personnel involved in these procedures, Congress can address these concerns and assure patients that imaging and therapy personnel are qualified while also being responsible with taxpayer dollars spent on these procedures,” said Whitfield. “I look forward to

working with my colleagues to advance this legislation that would protect consumers by reducing errors leading to inaccurate diagnoses and treatments, and which in some instances have caused serious harm.”

On June 6, McKesson Specialty Care Solutions | US Oncology released a [joint statement](#) in support of the legislation in coordination with eight other organizations representing the radiation oncology community, including patients, physicians and manufacturer throughout the United States.

## Institute of Medicine Report Finds Inequities in Medicare Payments

On June 1, a [study](#) by the Institute of Medicine (IOM) found that Medicare is using inaccurate, unreliable geographic payment adjustments to pay doctors and hospitals and that the system should be replaced. The IOM recommends that Congress and the administration standardize the labor markets and wage and benefits indexes when determining adjustments for hospitals and physicians based on local costs.

“The Medicare program needs more precise and objective tools and methods to assure the nation that the billions being spent are appropriately and fairly disbursed,” said Duke University Professor Frank Sloan who chaired the IOM panel that prepared the report. “This report’s recommendations will increase the likelihood that the geographic adjustments reflect reasonably accurate measures of regional differences in expenses.”

Within its June 1 report, the IOM recommends that 1) Medicare should use metropolitan statistical areas (MSA) as the standard when determining adjustments for hospitals and physicians; 2) The wage index should be based on Bureau of Labor Statistics data; and 3) Data from all occupations within the health care industry should be factored into the adjustments.

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## **Institute of Medicine Report Finds Inequities in Medicare Payments**

According to Bruce Steinwald, an independent consultant and member of the panel, if all of the recommendations proposed by the IOM are adopted, they would represent the largest transformation in Medicare's geographic payment adjustments in two decades. Under the new health care law, the secretary of the Department of Health and Human Services must provide Congress with a plan to update the way Medicare adjusts payments to reflect regional differences in wages by the end of the year.