

November 5, 2010

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COMING UP IN WASHINGTON...

* Congress is adjourned until November 15 when both Houses will reconvene to address several issues, including Medicare payment. The current SGR patch expires on November 30.

1. MEDICARE PAYMENT RULE INCLUDES AAFP-SOUGHT IMPROVEMENTS

The Centers for Medicare & Medicaid Services (CMS) issued the [2011 final physician fee schedule](#) on November 2, 2010. Included in it are several improvements as recommended by AAFP in a regulatory [comment letter](#) submitted on July 28, 2010. Of particular interest to family physicians are policies that:

- Significantly improve the eligibility rules for the Primary Care Incentive Program (PCIP) so that “over 80 percent of physicians who currently are enrolled in Medicare with a primary specialty designation of family medicine ... would qualify for the PCIP based on CY 2009 claims data,” according to the agency. Compared with CMS’ initial proposals, the final policy will allow considerably more family physicians to successfully qualify for the 10-percent bonus for primary care services as called for in the *Affordable Care Act (ACA)*. Based on suggestions from AAFP and other primary care physician groups, CMS will now exclude all non-physician fee schedule allowed charges (i.e., charges associated with labs, imaging, and durable medical equipment supplies) and hospital E&M codes when determining PCIP eligibility.
- Greatly expedite when newly enrolled Medicare primary care physicians become eligible for the PCIP.
- Reaffirm the agency’s 2010 decision to eliminate consultation codes (which allowed better payment for E & M codes).
- Clarify definitions, patient eligibility requirements, and payment levels for the new ACA-authorized Annual Wellness Visit and the Initial Preventive Physical Examination.
- Finalize CMS’ definition of preventive services.
- Reduce significantly the 2011 e-prescribing reporting burden, as AAFP had recommended: rather than requiring practices to report on 50 percent of all applicable services, CMS will award the entire year’s bonus after a practice reports e-prescribing just 25 times.
- Expand to 12 months (from the agency’s initial proposal of 6 months) the time physicians have to file a Part B claim under an exception to the ACA requirement that all Medicare claims must be submitted within 12 months.
- Expand the list of approved Medicare telehealth services, as AAFP had suggested.

Until it expires at the end of November 2010, the Medicare conversion factor is \$36.8729. CMS also included in the final rule information pertaining to the approaching reductions in Medicare physician payments. Unless Congress intervenes, the final 2011 conversion factor as published in the final regulation will be \$25.5217 on January 1, 2011.

2. MIDTERM ELECTIONS BRING GOP MAJORITY IN HOUSE AND MANY STATES

In midterm election results that President Obama termed a “shellacking,” Republicans regained a majority of the US House of Representatives by a margin not seen since the 1930s and came within a few seats of recapturing the US Senate.

The widely reported results show that Republicans won at least 60 seats in the House, with nine vote counts still outstanding, and picked up 7 seats in the Senate. Current counts indicate a margin of 239 Republicans to 186 Democrats in the House, and 52 Democrats to 48 Republicans in the Senate. Some analysts have speculated that voters may have sent a mixed message by leaving control of the two bodies in different hands, but the impact of the poor economy, President Obama’s policies, including health care reform, and the role of the Tea Party seemed have some bearing on the results.

Nevertheless, the newly-elected House members clearly are more conservative than the legislators they are replacing. Many ran on a commitment to bring down the federal deficit and decrease the role of government. This message was particularly persuasive in two types of districts: those that had been historically Republican but elected a Democrat to Congress in 2008, and those with conservative Democratic Representatives, the so-called “Blue Dogs.” Observers expect the new Republican members’ to pull the party more to the right, at the same time the remaining Democratic Representatives are pushing to the left. Regardless, the outstanding question is whether a more polarized House of Representatives will result in legislative standoffs, or some compromises.

The picture in the Senate is somewhat less defined. Tea-Party backed winner Senator-Elect Rand Paul won handily in Kentucky, while long-time incumbent and Democratic Majority Leader Harry Reid won an unexpectedly solid victory in Nevada. Other key races in the Senate included Republican winners with moderate to conservative backgrounds such as Marco Rubio in Florida, Mark Kirk in Illinois, Rob Portman in Ohio and Pat Toomey in Pennsylvania. In the only undecided Senate race, former Republican-turned Independent Senator Lisa Murkowski from Alaska may have sufficient write-in votes to defeat Republican candidate Joe Miller. If she is successful, she will caucus with the Republicans.

Democrats who came out on top in close races were Joe Manchin in West Virginia, Richard Blumenthal in Connecticut, Chris Coons in Delaware, Michael Bennet in Colorado, Patty Murray in Washington and Barbara Boxer in California. Despite these mixed election results, a number of factors will complicate action in the Senate. Majority Leader Reid has a narrower Democratic majority and Minority Leader Mitch McConnell’s has stated his top goal is to make President Obama a one-term President, making compromise difficult. In addition, Senator Reid will need to work with Democrats who ran away from President Obama in their campaigns and Senator McConnell will need to lead a fractious caucus that now includes several Tea Party winners. In particular, Kentucky colleague Rand Paul, who McConnell initially opposed, is now a fellow Senator and whose post-election statements have not been conciliatory.

Impact on Family Physicians

Congressional efforts to bring down the deficit and decrease government involvement in health care will generate countless attempts to repeal sections of the health care reform legislation and to strip funding for sections that are not repealed. The uncertain economy will generate additional pressure to reduce health care costs quickly. These issues will bring political pressure to bear on the White House and Congress to repeal portions of the health care reform

bill to offset necessary spending in other areas, like physician payment or operating funds to keep the government functioning. Specifically, we have long been concerned that Congress will ask physicians to support cuts in various health care programs to pay for an expensive fix for Medicare payments. Whether physicians supported health care reform, the legislation pitting repeal of some of its provisions against physician payment will be vetoed and put physicians in the middle of an extremely contentious partisan political battle.

More broadly, the entire health care law will be scrutinized and key members such as incoming Speaker John Boehner and likely incoming chairman of the House Energy and Commerce Committee Rep. Fred Upton (R-MI) have stated publicly that their goal is to repeal the *Affordable Care Act* (ACA). In a more probable scenario, the massive health care law will not be repealed in one swoop. It likely will be subject to investigative hearings featuring HHS Secretary Kathleen Sebelius and CMS Administrator Don Berwick, consistent efforts to weaken certain provisions and attempts to de-fund certain portions.

Due to these twin desires to decrease the deficit and cut back the health care law, the AAFP likely will be in a defensive position. We will need to defend Medicare payment increases in general and the primary care bonus as well as the Medicaid parity with Medicare for payment of primary care services in particular, as well as other provisions beneficial to family physicians and their patients. In addition, funding increases for Title VII will be extremely challenging. On a more positive note, Republicans likely will support changes to medical liability law.

In addition, many Congressional allies on family medicine issues lost their elections. Consequently, we will need to seek new champions, in particular, on the key health committees and in leadership. This will be especially important due to future Speaker Boehner's statement that he will restore the power of committee chairs.

3. LAME DUCK SESSION GETS UNDERWAY NOVEMBER 15

The 111th Congress reconvenes for a one-week lame duck session on November 15. There are several time-sensitive issues that will require attention. Legislation seen as "must pass" includes the measure to prevent the Medicare physician payment cuts as well as the fiscal year 2011 appropriations bills. The Congress will reconvene after Thanksgiving on November 29.

Most of the time during the week of November 15 will be devoted to leadership elections and determination of committee assignments. To stave off the December 1 Medicare payment cut of 23 percent cut, legislators are expected to pass a one-month patch. As a second step, the AAFP is urging that they extend Medicare physician payment updates for at least a year to prevent the estimated additional cut which would otherwise take effect on January 1.

Although the Senate Appropriations Committee reported the FY 2011 HHS spending bill on July 29, the full House Committee failed to consider it. There are a number of options available to the lame duck Congress:

- they could pass another short term stop-gap bill known as a continuing resolution (CR) through early next year leaving the FY 2011 bills to be finished by the 112th Congress;
- they could enact a year-long CR at FY2010 levels; or
- they could bundle together the FY 2011 spending measures into an omnibus spending package. The last alternative could mean an increase in Title VII primary care training grants and other AAFP priorities, but it is the least likely scenario.

4. MEDICAID PAYMENT COMMISSION

On October 28-29, the Medicaid and CHIP Payment and Access Commission (MACPAC) held its second meeting. MACPAC will report to Congress every March 15 and June 15 with recommendations on Medicaid and Children's Health Insurance Program (CHIP) policies concerning payment, eligibility, coverage, quality of care, access and coordination between

Medicare and Medicaid. Steve Waldren, director of AAFP's Center for HIT, is a commission member. Common themes of the meeting were:

- the complexity of accessing and comparing different states' Medicaid and CHIP programs in a timely way,
- emphasis on varying factors affecting access to care,
- concerns of sustaining provider levels and resources available after 2014, and
- a need for MACPAC to identify priorities and develop a long-term plan.

Michael Nardone, the Acting Secretary of the Pennsylvania Department of Public Welfare, reported on new efforts to improve access in the state through integration of real-time data, outreach to providers on access issues, and expansion of telemedicine options. Wisconsin Medicaid Director Jason Helgeson described his state's access initiatives that include expanding managed care, streamlining Medicaid eligibility, and avoiding across-the-board provider rate cuts through a state [Medicaid Rate Reform Project](#). Penny Thompson, the Deputy Director of the Center for Medicaid, CHIP and Survey & Certification at CMS emphasized simplifying data collection at the state level because currently it is far too burdensome. MACPAC's next meeting is December 9-10. The Commission's new [website](#) provides further details about MACPAC and scheduled meetings.

5. AAFP BOARD MEETS WITH DIRECTOR FOR NEW CMS INNOVATION CENTER

Drs. Heim, Goertz, Stream and Henley met on October 20 with Richard Gilfillan, MD, who is a family physician tapped by CMS Administrator Berwick to head up the new Innovation Center. AAFP leaders asked Dr. Gilfillan to discuss AAFP's views on how the new Center for Medicare & Medicaid Innovation (CMMI) will develop accountable care organizations and the patient-centered medical home demonstrations As outlined by the *Affordable Care Act* (ACA), the purpose of the CMMI is to "test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals." In selecting models, CMMI "shall give preference to models that also improve the coordination, quality, and efficiency of health care services furnished."

During the meeting, the PCMH's ability to prove cost savings on an actuarial basis was debated and Dr. Gilfillan suggested AAFP ought to involve an independent actuary for further analysis. Dr. Gilfillan agreed that PCMH's improve quality; however, he noted ACA's language which says the CMMI "shall focus on models expected to reduce program costs under the applicable title while preserving or enhancing the quality of care." Dr. Henley acknowledged and accepted Dr. Gilfillan's challenge and promised that AAFP would provide further information supporting the cost savings associated with PCMHs.

Regarding ACOs, Dr. Gilfillan commented against AAFP's first ACO principle by suggesting that patient-centeredness should be a higher priority compared with the need for AAFP to emphasize that ACOs be based on primary care leadership. The AAFP officers agreed with the need to be patient-centered, and then discussed how the principles were written to emphasize the preference for primary care over hospital and/or medical specialty based leadership.

6. REGULATORY REPORT

The Academy continues to submit formal regulatory comment letters to several federal agencies involved in implementing the *Affordable Care Act* (ACA) and other laws. Since the last report, AAFP:

- Urged the Food and Drug Administration (FDA) to implement and begin prompt enforcement of the ACA requirement that the agency develops federal nutrition labeling laws for restaurants with more than 20 locations and vending machine operators with more than 20 machines. In an October 8 [letter](#), AAFP expressed support for the new food menu labeling requirements as a way to help improve patients' knowledge of nutritional choices and help address the prevalence of obesity in the United States.

- Cautioned CMS against relying solely upon the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) in an October 8 [letter](#).
- Expressed in an October 11 [letter](#) to the Assistant Secretary for the Office of Healthcare Quality within the Department of Health & Human Services our existing policy that encourages healthcare workers to receive influenza vaccinations. These comments were sent in order to assist in the preparation of the “HHS Action Plan to Prevent Healthcare-Associated Infections.”
- Reiterated to CMS in an October 21 [letter](#) the Academy’s support regarding the elimination of consultation codes.
- Nominated two family physicians to serve on the National Committee on Vital and Health Statistics, which is advisory body to HHS in the areas of health data policy, data standards, health information privacy, population-based data and HIPAA Administrative Simplification. AAFP nominated Professor Michael S. Klinkman, M.D., MS from the University of Michigan Health System and Kevin A Peterson M.D., MPH, FRCS(Ed), from the University of Minnesota in an October 22 letter to the Deputy Assistant Secretary of the Office of Science and Data Policy in HHS.
- Expressed objection in an October 14 [letter](#) to the Acting Comptroller of the Government Accountability Office that no family physicians were included in the list of members of the Board of Governors of the Patient-Centered Outcomes Research Institute (PCORI)
- Nominated three family physicians, Alfred Berg, MD, MPH; Theodore G. Ganiats, MD; and Eric Wall, MD, MPH, to the Methodology Committee of the Patient-Centered Research Institute in an October 26 [letter](#) to the Acting Comptroller of the Government Accountability Office.
- Participated in a coalition letter to the Drug Enforcement Agency regarding the oral transmission of a Schedule II controlled substance.
- Supported the National Prevention and Health Promotion Strategy (NPS) through a coalition letter to the HHS Surgeon General.

In addition, CMS published on November 3, 2010 a final rule to update the Home Health Prospective Payment System (HH PPS) rate for 2011. AAFP, as part of a September 14 coalition [letter](#), recommended that the agency lengthen the timeframe for physician/patient face-to-face encounters. CMS agreed with this recommendation and made the specific timeframes included in the final home health rule 90 days for face-to-face encounters prior to the start of home care, and 30 days after the start of care.

7. FamMedPAC EXAMINES ELECTION RESULTS, PLANS FOR NEXT CONGRESS

With the election of 2010 over, for the most part, FamMedPAC is evaluating the results and formulating our strategy for the new Congress. FamMedPAC contributed \$675,500 to 146 candidates or committees in the last two years. Seventy-four percent of the candidates supported by the PAC were victorious on election night. Most of the candidates who lost to whom the PAC contributed were first- or second-term House Democrats who voted for health care reform. The PAC Board decided to target these vulnerable legislators after passage of the legislation.

The PAC contributed to several first-time candidates who won their races. In Kansas, the PAC supported Jerry Moran in his Senate campaign, and Kevin Yoder, who will represent the district that includes the AAFP headquarters. In Tennessee, the PAC supported Diane Black, a nurse, and Steve Fincher, who were both elected to succeed retiring legislators. In Delaware, John Carney received PAC support and will be the new Representative.

The PAC also contributed to several key Republican Representatives who will be leading the House in the 112th Congress, including presumptive House Speaker, Rep. John Boehner (R-OH), the expected Majority Whip, Rep. Eric Cantor (R-VA), and the new Chair of the Ways and

Means Committee, Dave Camp (R-MI). On the Democratic side, the PAC supported Senator Harry Reid (D-NV), Senator Patty Murray (D-WA), and Senator Michael Bennet (D-CO), all of whom won extremely close elections.

Fundraising efforts for the PAC are continuing through the remainder of this year. Thus far, the PAC has collected over \$680,000 in donations from 1,959 AAFP members for the 2009–2010 election cycle. The average contribution is \$347. In the same period in the 2007 – 2008 election cycle, the PAC received \$780,106 from 2,772 AAFP members, with an average contribution of \$281. The PAC currently has \$225,000 cash on hand, and is in an excellent financial position heading into the 2012 election cycle. The PAC Board will soon decide on a contribution strategy for the next cycle.