GOVERNMENT AFFAIRS WEEKLY

AAFP Division of Government Relations — 2021 Massachusetts Avenue, NW — Washington, DC 20036

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IN THIS REPORT…

NEXT WEEK IN WASHINGTON…

* The House and Senate will be in recess until Monday, March 28.
* Wednesday, March 23 marks the One-Year Anniversary of the Affordable Care Act.

1. MEDPAC CALLS FOR INCREASE IN MEDICARE PAYMENTS TO PHYSICIANS

On March 15, the Medicare Payment Advisory Committee, an independent congressional agency to advise the U.S. Congress on issues affecting the Medicare program, released its 2011 Medicare Payment Policies report. The report includes a discussion of the Medicare physician payment system and includes the formal recommendation that "Congress should update payments for physician fee schedule services in 2012 by 1 percent." MedPAC also reported that, "a small share of the Medicare population continues to report problems finding a new primary care physician—an essential component to a well-functioning delivery system."

This report follows the recent letter the Centers for Medicare & Medicaid Services sent to MedPAC in which the agency forecasts that Medicare payments for Part B physician services will be reduced by approximately 29.5 percent on January 1, 2012 unless Congress intervenes.

On March 10, the AAFP along with 79 national medical associations and 51 local medical societies sent the entire Senate and House of Representatives a letter urging Congress to begin working in a bipartisan, bicameral manner to enact legislation this year that will eliminate Medicare's sustainable growth rate formula and lay the groundwork for adoption of broader physician payment and delivery reforms.

2. TEMPORARY FUNDING WILL TAKE THE GOVERNMENT THROUGH APRIL 8

Nearly six months into fiscal year 2011, the House and Senate continue to struggle to reach a deal to fund the government. On March 15, the House passed a sixth stop-gap continuing resolution to keep the government running through April 8 at a funding level slightly below that of fiscal 2010 (H.J.Res. 48) by a 271-158 vote with 54 Republicans and 104 Democrats opposing the bill. Although 186 Republicans voted for it, the CR would not have passed without the 85 Democrats who supported the bill. The Senate by a decisive 87 to 13 vote on Thursday cleared the bill for the President's signature.

Leaders of both parties and in both chambers continue to insist that they will avoid a shutdown and expect a final FY 2011 deal to be reached before Congress begins a two-week recess on April 18. However, some House Republicans continue to oppose any spending bill which does not include language that would block funding for health reform.

3. MEDPAC CHAIR TESTIFIES AT HOUSE WAYS & MEANS HEALTH SUBCOMMITTEE

The House Ways and Means Committee's Subcommittee on Health held a hearing Tuesday March 15 with Medicare Payment Advisory Commission (MedPAC) Chairman Glenn Hackbarth as the sole witness. Health Subcommittee Chairman Rep. Wally Herger (R-CA) described Medicare as a major driver of long-term debt and criticized health reform for reducing Medicare payments to some providers. Subcommittee Ranking Member Rep. Pete Stark (D-CA) said that many provisions of the ACA reflect MedPAC's recommendations to address unnecessary hospital readmissions, bundle payment, and promote value-based purchasing. MedPAC Chairman Hackbarth stressed that the SGR is continuing and growing problem and that he hopes to have recommendations on it by December. But he cautioned the committee a new payment system will not make the debt go away.

Rep. Tom Price, MD (R-GA) said that physician-owned hospitals and other facilities are "best-practices" that ought to be emulated; that multiple procedure payment reduction for imaging (more than one body part on same patient during the same visit) was not fair; and that no procedures are being valued higher now than they were 15 years ago. Rep. Price also asked about the valuation of E/M codes and implied that these have not kept pace with the cost of delivering the service. Chairman Hackbarth suggested that Medicare needs to change to paying not on the basis of the cost of delivery of a service and more on value to the patient.

Rep. Jim McDermott, MD (D-WA) pointed out that the AMA-RUC is influential but little known. Hackbarth agreed that CMS accepts the RUC recommendations over 90 percent of the time and that MedPAC recommended CMS take more active role in gathering data and valuing services. Both Rep. McDermott and Hackbarth said that the RUC was heavily weighted away from primary care. Chairman Hackbarth also said that CMS has to address overvalued services, because MedPAC believes there is enough money in system to care for beneficiaries but faces a distribution challenge, especially with respect to primary care.

4. SENATE FINANCE EXAMINES LESSONS LEARNED IN THE FIRST YEAR OF ACA

The Senate Finance Committee held a hearing Wednesday, March 16 to highlight the lessons learned in the first year of the *Patient Protection and Affordable Care Act* (PPACA). The discussion broke on predictable partisan lines as Democrats touted the benefits of the PPACA and Republicans continued to criticize the law. Chairman Max Baucus (D-MT) said that that the primary care bonus is already improving access to care for seniors. Ranking Member Orrin Hatch (R-UT) criticized heavy-handed government interference saying that his constituents find it too costly and object to the new entitlements paid for by new taxes. He lamented the cuts to Medicare Advantage and the double counting of financial savings.

HHS Secretary Sebelius outlined the positive provisions of the law including expanded coverage, insurance reforms, Part D improvements, new tools available to CMS and a projection of reduced rate of growth from 8 to 6 percent. She also stressed that while overpayments to Medicare Advantage have been reduced; the program is still robust, covering 24 percent of all beneficiaries. Doug Holtz-Eakin and Paul Van de Water, both formerly with the Congressional Budget Office (CBO), also testified. Dr. Holtz-Eakin ridiculed the ACA for dubious accounting and expressed frustration that it did not convert Medicaid to a block grant program. He believes that the ACA will not save money as determined by CBO. Dr. Van de Water said that more than 32 million Americans will be covered by the ACA and that it will reduce the rate of cost increases, especially in the second ten years. With respect to Medicaid expansion, he said that the federal government will pay approximately 92 percent of the costs through 2021 and that states will be liable only for a collective $60 billion, which is an amount that is exceeded by the cost of uncompensated care provided.

5. SENATE HELP COMMITTEE EXPLORES STATE INSURANCE EXCHANGES

On March 17, the Senate Committee on Health, Education, Labor and Pensions (HELP) held a hearing on health insurance exchanges and ongoing state implementation of the *Affordable Care Act*. Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight (CCIIO) under CMS, Steve Larson, JD, expects the agency to issue a rule this spring on health insurance exchanges, which is contingent on feedback from the Institute of Medicine and the Department of Labor. The panelists and several Senators urged HHS to publish the rule as quickly as possible. Mr. Larson reiterated how important state flexibility is in creating these exchanges. When asked about the Medical Loss Ratio waivers—requiring proof that the market would destabilize—Mr. Larson explained that four states have applied for such waivers but to date, HHS only reviewed and approved Maine's application.

Sandy Praegar, the Kansas Insurance Commissioner and former NAIC President, explained that Kansas is using the federal planning grant to analyze the state's insurance market and plans to soon apply for an establishment grant to get the program underway. Joshua Sharfstein, MD, pediatrician and Secretary of the Maryland Department of Health and Mental Hygiene, commented on the significant savings that the exchange will bring to Maryland by eliminating the need for and decreasing the size of many state programs, including the high-risk pool, senior prescription programs, and uncompensated care. Maryland legislators hope to pass one of a number of bills creating a state-based exchange to be coordinated with the state's existing PCMH program and HIT initiatives. Utah Speaker of the House David Clark (R) described how Utah was able to create an exchange with only $600,000 by learning from the Massachusetts model and is using a $1 million federal planning grant to expand the exchange.

6. FamMedPAC MAINTAINS HIGH VISIBILITY IN WASHINGTON

FamMedPAC participated in a number of fundraising events in Washington this week, continuing to focus on members of key Senate and House Committees as well as Congressional leadership. The main topic of discussion at these meetings was how to preserve the gains made by primary care in an era of budget cuts. Discussions also focused on the pending Medicare physician payment cuts and the need to address the SGR formula before the end of the year. GR staff met with these Congressional legislators this week:

- **Rep. Tom Price (R-GA)**, an orthopedist who sits on the House Ways and Means Health Subcommittee. He is also the Chair of the Republican Study Committee.
- **Sen. Tom Carper (D-DE)**, who sits on the Senate Finance Committee, Labor-HHS Subcommittee.
- **Rep. Lois Capps (D-CA)**, a former nurse who serves on the House Energy and Commerce Health Subcommittee.

- **Rep. Frank Pallone (D-NJ)**, the senior Democrat on the House Energy and Commerce Health Subcommittee.
- **Rep. Pete Sessions (R-TX)**, a member of the House Rules Committee and Chair of the National Republican Congressional Committee, the political campaign committee of the House Republicans.
- **Sen. Ben Cardin (D-MD)**, who serves on the Senate Finance Committee and on the Labor-HHS Subcommittee of the Senate Appropriations Committee.
- **Rep. Mike Simpson (R-ID)**, a dentist who serves on the House Appropriations Committee's Labor, Health and Human Services and Education Subcommittee.
- **Rep. Fred Upton (R-MI)**, the Chair of the House Energy and Commerce Committee.
- **Rep. Shelly Berkley (D-NV)**, a member of the House Ways and Means Committee. Rep. Berkley's husband and daughter are both physicians.

7. HHS REPORT ON ANNUAL WELLNESS VISIT
On March 16, the U.S. Department of Health & Human Services announced that over 150,000 Medicare beneficiaries in less than two months have received the new Medicare annual wellness visit benefit as supported by the AAFP and established in the *Affordable Care Act*. To prepare family physicians, the AAFP created a website containing FAQs on the Medicare Annual Wellness Visits as well as a 2011 Medicare Preventive Services Guide and Medicare Preventive Physical Exam encounter form.

8. DELAY URGED FOR UPCOMING HOME HEALTH DOCUMENTATION REQUIREMENT
On March 12, the AAFP and several other national healthcare and consumer organizations, including the AARP, the American College of Physicians, American Medical Association, and American Osteopathic Association, sent a letter to the Center for Medicare & Medicaid Services requesting the agency postpone enforcement until July 1 before the agency begins enforcement of a revised documentation requirement that physicians must see patients "face to face" and document that those patients need home health care. Such a face-to-face encounter would need to occur and be documented in the medical record within 90 days before the start of home health care or within 30 days after the start of care. Currently, the agency will enforce this on April 1. Further information on this requirement is on the AAFP' "Getting Paid" website.

9. AAFP RESPONDS TO MEDICAID HEALTHCARE ACQUIRED CONDITION REGULATION
The AAFP sent a letter to the Centers for Medicare & Medicaid Services on March 16 regarding a proposed rule that, beginning July 1, prohibits federal payments to state Medicaid programs for "healthcare acquired conditions". Though the AAFP supports efforts to eliminate both "never events" and healthcare acquired conditions, the letter pointed out that little evidence links payment denial with improved outcomes. The letter also recommended standard definitions for healthcare acquired conditions across all Medicaid programs, Medicare, and CHIP as well as urged the agency to immediately begin an aggressive education and outreach campaign for patients and physicians.

10. COMMENTS SENT TO JOINT COMMISSION ON PRIMARY CARE HOME
In a March 14 letter to the Joint Commission, the AAFP responded to their proposed new Primary Care Home standards. The AAFP commented by comparing their criteria with the recently published "Guidelines for Patient-Centered Medical Home (PCMH) Recognition and Accreditation Programs" developed by the AAFP, the American College of Physicians, American Academy of Pediatrics, and the American Osteopathic Association. In addition to commenting on specific pieces of their standards, the AAFP also expressed concern that the Joint Commission documents did not reference efforts by the four primary care organizations but also recognized that the Joint Commission documents largely comply with those guidelines and joint principles.

11. REGULATORY BRIEFS

- On March 14, the U.S. Preventive Services Task Force announced family physician Michael L. LeFevre, M.D., M.S.P.H., as a co-vice chair of the Task Force.
- On March 15, U.S. Department of Health & Human Services Secretary Kathleen Sebelius and Department of Justice Attorney General Eric Holder co-hosted the fifth regional health care fraud summit in Detroit, Michigan. They also published a fact sheet summarizing ways the *Affordable Care Ac*t is fighting healthcare fraud.
- On March 17, the Centers for Medicare & Medicaid Services released a final rule pertaining to civil money penalties for Medicare and Medicaid nursing homes. Required by Section 6111 of the *Affordable Care Act* and intended to improve the efficiency and effectiveness of nursing homes, the rule calls for the collection of civil money penalties when nursing homes do not meet Medicare and Medicaid program participation requirements.
- On March 22 from 12:00PM - 1:30PM ET, the Centers for Medicare & Medicaid Services will conduct a national conference call on the Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Programs designed for beginners. To participate dial 1-800-837-1935 and reference conference ID 51772165.
- On March 24 from 2:00PM to 4:00PM ET, the Centers for Medicare & Medicaid Services will hold a national conference call on transparency reports and reporting of physician ownership or investment interests. To participate dial 1-800-837-1935 and reference conference ID 51513526.

12. CO-OP ADVISORY BOARD ISSUES FINAL RECOMMENDATIONS

On March 14, the federal CO-OP Advisory Board formed by the *Affordable Care Act* to provide recommendations with regard to the award of grants and loans under the Consumer Operated and Oriented Plan Program (CO-OP) met to deliberate on and issue final recommendations. The Advisory Board endorsed four major principles: (1) consumer operation, control, and focus must be the salient feature of the CO-OP; (2) solvency and the financial stability of coverage must be vigilantly maintained and promoted; (3) CO-OPs should encourage greater care coordination, quality and efficiency to the extent feasible in local provider and plan markets, and (4) the program and first loans should be rolled out as expeditiously as possible (by the end of 2011) in order to provide CO-OPs the maximum opportunity to compete in Health Benefit Exchanges. Three family physicians served on the 15-member panel, David Buck, MD, David Carlyle, MD, and Michael Pramenko, MD—all of whom took part on the Infrastructure Subcommittee—recommending preference to those with strong local network and model of integrated care over those with statewide network and little emphasis on care coordination. The Subcommittee also urged CMS to provide flexible definitions for “medical home” and “accountable care organizations” in regulations to determine integrated care criteria.

13. ILLINOIS AFP LAUNCHES TWO-YEAR MEDICAL HOME PILOT PROJECT

The Illinois Academy of Family Physicians recently launched the Practice Improvement Network (PIN), a two-year commitment to make improvements to members in all practice settings. The PIN’s four components include (1) enhanced communications from the Illinois AFP to the statewide network; (2) ambassadors—physician leaders working in or towards a PCMH—providing a “show-how” approach to transitioning to a patient-centered medical home; (3) new CME opportunities, including regional meetings, self-study modules and webinars; and (4) a small practice pilot program providing matching funds, a shared personal coach and peer support to practices with up to eight primary care providers.

14. STATES CONTINUE TO IMPLEMENT HEALTH REFORM

- Governor Earl Ray Tomblin (D) currently is considering a measure (SB 408) to establish the West Virginia Health Benefit Exchange as a governmental body within the office of the Insurance Commissioner. If signed, the bill would also create a board of directors to oversee the exchange composed of 10 members, one of whom representing the interests of health care providers is selected by the majority vote of an advisory group which includes the **West Virginia Academy of Family Physicians**.
- Wyoming Governor Matthew Mead (R) recently signed a measure (HB 50) to form a study to determine whether the state should form a health insurance exchange or participate in a regional exchange. The measure also requires the study to evaluate options including the establishment of innovative service delivery system models such as accountable care organizations. The Governor also signed other legislation (SB 50) to study the options for reconfiguring of the Medicaid program and (SB 102) to study the cost of expanding the state's Medicaid program.
- North Carolina Governor Beverly Perdue (D) vetoed Republican-backed bill (HB 2) to challenge the Affordable Care Act by attempting to block the individual mandate provision. Although the Governor considered allowing the bill to become law without her signature, Attorney General Roy Cooper informed her that federal law trumps state legislation and suggested such language could harm state health programs. Although the General Assembly attempted to override the veto, legislators did not have the three-fifths needed.

15. AAFP PARTICIPATES IN CHILDHOOD OBESITY SUMMIT

GR staff, along with AAFP member, Dr. Yvette Rooks, attended a summit on childhood obesity this week sponsored by the Washington Post, Fuel up to Play 60, and the Gen Youth Foundation. Dr. Rooks and staff also attended a pre-conference dinner as a guest of the National Dairy Council and the American Dietetic Association. Both groups currently partner with AAFP on nutrition issues. The Summit consisted of three panel discussions, focusing on 1) the role of government, 2) health implications of childhood obesity, and 3) the role of schools and community. Panelists included Senators Tom Harkin (D-IA) and Mark Udall (D-CO), former Surgeon General of the United States, Dr. David Satcher, former Maryland Governor Robert Ehrlich (R), former Olympian and Chair of the President's Council on Fitness Dominique Dawes, and Baltimore Ravens running back Ray Rice.

You can see highlights from the Summit at the following link:
http://washingtonpostlive.com/conferences/obesity