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…

* On June 2, Subcommittees of the House Energy & Commerce and Small Business Committees have hearings on the regulatory burden of the Patient *Protection and Affordable Care Act* and HIT respectively.

* The Senate will be in pro forma session next week to prevent recess appointments.

1. AAFP COMMENTS ON TWO MEDICARE ACO REGULATIONS

In a May 20 letter, the AAFP submitted formal regulatory comments to the Centers for Medicare and Medicaid Services regarding the proposed Medicare Accountable Care Organization (ACO) regulation. While supportive of ACOs as a concept, the letter voiced concerns that the Medicare ACO program as currently proposed will fail to offer the potential benefits of better care for individuals, lower per capita costs for Medicare beneficiaries and improved coordination among physicians. To improve the final Medicare ACO regulation, the AAFP offered several recommendations including urging that CMS:

- Permit primary care physicians to participate in multiple Medicare ACOs
- Broaden its payment method beyond the current, traditional Medicare fee-for-service for ACO participants by employing a variety of payment approaches
- Offer greater flexibility so small- to medium-sized primary care practices will be able to participate more readily
- Specify that the Medicare ACO governance structure must utilize primary care physicians in the top leadership positions
- Outline quality reporting requirements for the full three-year program while significantly reducing the number of required quality measures.

In a May 25 letter, the AAFP responded to the Federal Trade Commission and US Department of Justice on the proposed antitrust enforcement policy regarding the Medicare ACO program. This second AAFP letter outlines antitrust barriers to physician collaboration and encourages FTC efforts that enable primary care physicians to contract with all insurers on level playing fields. The letter also expresses concern that the revised policy only applies to groups

integrating after March 23, 2010 and that the "rule of reason" analysis applies only to the three-year Medicare ACO program period instead of a longer timeframe.

2. HOUSE VOTES TO STRIP GME FUNDS FROM TEACHING HEALTH CENTERS

On Tuesday, May 24, the AAFP and the Council of Academic Family Medicine sent a letter to Congressional offices opposing the passage of HR 1216, a bill to convert $230 million of direct funding for graduate medical education in qualified teaching health centers (THC) into an authorization subject to the annual appropriations process. The House on Wednesday passed the bill, sponsored by Rep. Brett Guthrie (R-KY), on a vote of 234 to 185. HR 1216 is another in a series of Republican-sponsored bills to eliminate funding for the 2010 health care overhaul.

Two unsuccessful amendments were offered by legislators in support of AAFP interests. Rep. Paul Tonko (D-NY) proposed a study of the number of primary care physicians that would be trained as a result of the THC GME compared to the number of that would be trained should funding be eliminated or rescinded, but his amendment failed on a vote of 186 to 231. Rep. Dennis Cardoza (D-CA) offered an amendment to require the Government Accountability Office to study the number of physicians in areas with significant shortages and to examine the effects of expanding and establishing new medical graduate programs as directed by the health reform law on the number of physicians were the funding not rescinded by HR 1216. The Cardoza amendment failed 182 to 232.

The White House announced on Tuesday its opposition to HR 1216, but stopped short of issuing a veto threat. The Senate is not expected to consider the bill as a stand-alone measure, but it could become part of any larger bill.

3. HHS INCREASES NHSC AND TITLE VII PRIMARY CARE TRAINING FOR FY 2011

The *Fiscal Year 2011 Continuing Resolution* (HR 1473, PL 112-10) provided funding for the government to continue operations through the end of the current fiscal year (FY 2011). It required federal agencies to inform Congress of FY 2011 spending plans and HHS submitted the plan on May 13. While most HHS programs were forced to cut funding, the Administration increased the funds available for the education and training of family physicians.

According to the HHS plan, funding for the Title VII Section 747 primary care medicine training program is increased by 0.29 percent to $39 million for the rest of the fiscal year. Although most of the Title VII programs received a spending cut of 0.61 percent, Title VII overall is funded at $272.5 million, an increase of $18.4 million (7.3 percent) over comparable FY 2010 levels. The increase in Title VII overall comes from the boost for primary care, plus a hike for public health and preventive medicine of $20 million from the Prevention and Public Health Fund. The National Health Service Corps was increased from $141 million in FY 2010 to $315 million using trust fund monies made available for that purpose in the *Affordable Care Act*.

Agency for Healthcare Research and Quality (AHRQ) received $372 million, a $25 million reduction from FY 2010. AHRQ also received $8 million through a mandatory transfer from the Patient-Centered Outcomes Research Trust Fund and $12 million from the Prevention and Public Health Fund, bringing total funding to $392 million in FY 2011.

4. HOUSE SUBCOMMITTEE HEARS ABOUT INTERSTATE SALE OF HEALTH COVERAGE

On May 25, the House Energy and Commerce Subcommittee on Health held a hearing on allowing people to purchase insurance across state lines. The goal of this proposal is to lower the cost of care. Witnesses included representatives from CMS; the University of Minnesota, the American Legislative Exchange Council, the Manhattan Institute and the American Cancer Society. The witnesses emphasized the need for patients to be able to purchase plans that were best for them as individuals.

5. REGULATORY BRIEFS

- On May 13, 2011, the Centers for Medicare and Medicaid Services released the 2011 Medicare Trustees Report. The report projects that the Medicare Trust Fund will be exhausted in 2024, not 2029, as estimated last year. It also projects that the Social Security retirement program will be expended by 2036, one year earlier than the previous estimate.
- Also on May 13, the US Department of Health and Human Services released an online training video program titled Partnering to Heal. It contains separate and interactive training modules for established physicians, registered nurses, infection preventionists, patient family members and third-year medical students wishing to learn more about healthcare-associated infections.
- On May 16, the Centers for Disease Control and Prevention released an action plan titled Combating the Silent Epidemic of Viral Hepatitis. The plan focuses on educating health professionals and communities about prevention, care and treatment of the disease.
- On May 17, CMS made three announcements related to the Medicare ACO program. First, the agency launched the Pioneer ACO Model for organizations already coordinating care for a significant portion of patients using financial risk sharing contracts. CMS will conduct a conference call on the Pioneer ACO Model application process on June 7 at 12:00 PM ET. To participate, dial 1-866-501-5502 and reference conference ID 70961782. CMS also announced the Advanced Payment ACO Initiative, which will be available to those providers who currently lack the resources to form an ACO. This initiative offers certain Medicare ACOs access to a portion of their shared savings up front for infrastructure and staff investments. Finally, CMS announced an ACO educational opportunity. The first Accelerated Development Learning Session will be June 20-22 in Minneapolis, MN and the agency is expected to announce additional sessions.
- On May 19, the Medicare EHR Incentive Program issued the first round of payments totaling $75 million to providers who signed up in the first two weeks of the program (see item 7 below). Since January 2011, fifteen states have initiated their Medicaid EHR Incentive Programs and to date, over $83 million in incentive payments has been made to qualified Medicaid providers. Medicare EHR Incentive Program payments will continue to be made on the monthly basis.
- On May 26, CMS released the Changes to the Electronic Prescribing (eRx) Incentive proposed regulation. In it, the agency proposes steps effective in the 2011 reporting period that further align the eRx program with the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program. The agency also proposes new hardship waivers for physicians unable to participate in the eRx program.

6. FAMMEDPAC REPORTS STRONG INCEASES IN DONATIONS

FamMedPAC received over $60,000 in donations from almost 300 AAFP members in the month of May. Strong support from attendees at Annual Leadership Forum, the National Conference of Special Constituencies and the Family Medicine Congressional Conference, as well as the continued success of the PAC's direct marketing program, helped bring in almost $20,000 more than in May of 2010. The strong fundraising pace, if maintained, will help FamMedPAC achieve its goal of $1 million in donations this election cycle.

At Washington, DC fundraising events this week, the main topic of discussion was the Medicare physician fee schedule and the pressing need to prevent scheduled cuts in payments. The PAC supported events for the following Members of Congress this week:

- **Sen. Max Baucus (D-MT)**, Chair of the Senate Finance Committee. This was a physician-only event, sponsored by physician PACs.

- **Rep. Pete Stark (D-CA)**, Ranking Member on the House Ways and Means Health Subcommittee. This was an event solely for the physician PAC community.

7. VERMONT ENACTS HEALTH REFORM LEGISLATION

On May 26, Governor Peter Shumlin (D) signed state health reform legislation, HB 202. Endorsed by the **Vermont Academy of Family Physicians**, the bill creates a new health care board with the ability to control the rate of growth in both health insurance premiums and health care provider payments. In a press release on the ceremonial signing, the Governor spoke on the need to reduce cost growth without compromising health care quality by taking a new approach, saying "We can't simply cut provider fees." The new board, which will be appointed and in place by October, will work with health care providers to move away from fee-for-service medicine, put them on a sustainable budget, reward them for efficiency and for keeping people healthy, and reduce administrative burden and waste. In addition, Vermont will create a health insurance exchange to vastly simplify insurance purchasing for all Vermonters. Finally, the law requires detailed planning for a single payer health care system, which will maximize savings and take health insurance off the backs of employers by 2017.

8. OHIO AFP ROLLS OUT MEDICAL HOME PILOT PROJECT

The state of Ohio awarded a $300,000 grant to a patient-centered medical home educational task force that is responsible for establishing a PCMH pilot project. The state enacted a measure last year to create a PCMH pilot project for 44 primary care practices in the state. The legislation created a task force composed of primary care representatives to identify and work with practices willing to participate in the pilot project and become medical homes. The **Ohio Academy of Family Physicians** is acting as the fiscal agent for the project, employing its PCMH expertise to pull the project together. The chapter hired TransforMed, the AAFP's wholly owned practice redesign subsidiary, to evaluate practices for participation in the project and to make recommendations to the PCMH educational task force.

9. KANSAS AFP PRESIDENT FIRST TO RECEIVE MU BONUS

April 18 marked the opening day of the meaningful use attestation process and eligible professionals who have met all program requirements can expect to receive their 2011 incentive payments soon. **Kansas Academy of Family Physicians** President Jennifer Brull, MD was one of the first physicians to successfully attest to CMS' EHR meaningful use requirements and to meet all bonus eligibility rules for the program, receiving an $18,000 bonus check from CMS on May 25. Dr. Brull, who operates a solo practice with a patient panel of about 8,000 in rural northwest Kansas, went live with an EHR in 2008. "The best outcome was improving the quality of care provided to my patients." She called her meaningful use journey "challenging but not overwhelming," and encouraged her physician colleagues to lean on their local regional extension centers for assistance.

CMS reminds family physicians interested in incentive program payments that:

- bonus payments will not be made until the eligible professional meets the $24,000 threshold in allowed Medicare charges;
- payments will be made approximately four to eight weeks after program requirements are met;
- payments to Medicare providers will be made to the taxpayer identification number selected during registration for the incentive program; and
- CMS will deposit incentive payments in the first bank account on file, and the payment will appear on the bank statement as "EHR incentive payment."