

July 20, 2012

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### NEXT WEEK IN WASHINGTON...

- \* On Tuesday, July 24, the Health Subcommittee of the House Ways and Means Committee will hold a hearing titled, "Medicare Physician Payment Overhaul."
- \* The House Appropriations Committee is likely to debate and vote on the funding measure for the Departments of Labor, HHS, Education and Related Agencies for FY 2013.

## 1. HOUSE PANEL LOOKS AT PAYMENT REFORM, BUT SIMPLE EXTENSION LIKELY

The House Energy and Commerce Subcommittee on Health held a hearing on Wednesday, July 18, focusing attention on physician payment reform. The hearing started with the Subcommittee Chair, Rep. Joseph Pitts (R-PA) declaring that the "SGR is broken"...and every legislator who spoke echoed the statement. House lawmakers praised ideas to replace the current Medicare physician payment formula but acknowledged that anything more than an extension of rates is unlikely to happen this year. "This term, I've seen more work done on this problem than I have any other time that I have been in Congress, but we're still pretty far away from the goal that we all expect to achieve," said Rep. Michael C. Burgess, MD (R-TX).

There was division along party lines about whether to use the funds saved from winding down the wars in Afghanistan and Iraq, known as the Overseas Contingency Operations (OCO) funds. Rep. Phil Gingrey, MD (R-GA) called it "funny money" several times. Rep. Frank Pallone (D-NJ) said that he is not in favor of forcing other providers to pay for the extension of the SGR, pitting providers against each other. Rep. Burgess took the opportunity to announce that he is introducing a bill (HR 6142) to extend the SGR for a year; however, his bill does not specify how the extension will be paid for.

In his testimony to the subcommittee, Dr. David Bronson, president of the American College of Physicians (ACP), supported a patient-centered medical home model, in which each patient has a personal physician with a team of individuals who help provide care, with an emphasis on coordinating care and sharing information between practitioners. He also promoted the "medical home neighborhood" model. He testified that the neighborhood is essential to the success of the

medical home because it recognizes that specialties, sub-specialties, hospitals and other entities that provide treatment should receive incentives for engaging in patient-centered practices. He and other witnesses also discussed providing incentives for primary care physicians and rewarding practices that join accountable care organizations.

Mr. Scott Serota, President and CEO of Blue Cross and Blue Shield (BC/BS), said that changing payment incentives away from fee for service and toward innovative programs to award care quality is necessary for improved quality and efficiency. He promoted the BC/BS Medical Homes initiative as a way to reward quality. Dr. Bronson said that the PCMH model is the right approach and Dr. David Hoyt, Executive Director of the American College of Surgeons spoke on behalf of ACS's model, in which clinicians informally join a multi-specialty group and determine compensation based on quality rather than volume.

Dr. Kavita Patel, Managing Director for Clinical Transformation and Delivery, Engelberg Center for Health Care Reform at the Brookings Institution, cautioned that policymakers should be careful in pursuing reforms to keep the things that are being done correctly in health care delivery. Under questioning from Rep. Burgess about specific concerns about rural health care, Dr. Patel said that in some cases, perhaps in the rural areas with limited access, we need to preserve fee for service but do a better job of reaching out to other physicians to coordinate care and to innovate delivery. The panelists continued to make the point that they share an interest in linking reimbursement to quality.

## **2. HOUSE GOP PLANS TO SLASH HEALTH CARE SPENDING**

A House appropriations panel on Wednesday, July 18, backed a spending bill for labor, health and education programs that would rescind funding to implement the 2010 health care overhaul, despite vehement objections from Democrats over the GOP's proposed cuts. The Labor-HHS-Education Appropriations Subcommittee approved the draft fiscal 2013 measure mostly along party lines 8-6, with Rep. Jeff Flake (R-AZ) casting the sole Republican vote against it. The measure would provide \$68.3 billion for programs in the Department of Health and Human Services, \$1.3 billion less than fiscal 2012 and \$1.8 billion below the president's request.

Specifically, the measure would eliminate all funding for the Agency for Healthcare Research and Quality (AHRQ) and strip away funding for the implementation of the *Affordable Care Act* (ACA). AAFP Board Chair, Dr. Roland Goertz, wrote a [letter](#) to the Subcommittee Chairman, Rep. Denny Rehberg (R-MT), to express opposition to the elimination of funding for AHRQ, for the CMS Innovation Center and for the Preventive Health Care trust fund. Dr. Goertz also asked the subcommittee to make sure that the appropriations bill included at least \$71 million for the Primary Care Training and Enhancement (PCTE) program to support the education and training of family physicians.

## **3. HOUSE COMMITTEE EXAMINES DECLINE OF SMALL PHYSICIAN PRACTICES**

On Thursday, July 19, the House Small Business Subcommittee on Investigations, Oversight and Regulations held a hearing on the reasons for the decline in the number of small and solo physician practices. The subcommittee reviewed a recent analysis by Accenture that predicts that by 2013, less than one-third of physicians will be in private practices. Merritt Hawkins released a report at the hearing that claimed 75 percent of physicians would be employed by hospitals by 2014. The subcommittee highlighted several reasons for the trend toward consolidation and closure of private practices, including economic pressures, lifestyle preferences, better career development options and regulatory burdens.

## **4. CMS WILL HOLD BRIEFING ON PHYSICIAN VALUE-BASED PAYMENT MODIFIER**

The AAFP, along other physician groups, have considerable concerns about the proposed implementation of the new value-based modifier, which will be used to affect payments based

on claims data. On Wednesday, August 1 from 2:30-4 pm ET, CMS will hold a national call to discuss recently proposed regulations that implement the physician value modifier payment. The *Affordable Care Act* call for CMS to establish a value modifier that provides for different payments to a physician or group of physicians under the Medicare physician fee schedule. These different payments are based upon the quality of care furnished to Medicare beneficiaries compared to the cost of that care during a performance period. CMS proposes to apply the value modifier financially in 2015 to groups of physicians with 25 or more eligible professionals based off their 2013 performance.

[Registration](#) for this important call is required. The CMS presentation will describe the options for how to calculate the value modifier based on whether the groups participate in the Physician Quality Reporting System (PQRS). For groups of 25 or more that do not participate in the PQRS, CMS is proposing to set their value modifier at a 1.0 percent payment reduction. For groups that wish to have their payment adjusted according to their performance on the value modifier, the rule proposes a system in which groups with higher quality and lower costs would be paid more, and groups with lower quality and higher costs would be paid less.

Read more about the 2013 proposed Medicare physician fee schedule in the AAFP [summary](#).

## 5. FamMedPAC REPORT

FamMedPAC staff attended campaign updates from both the House and Senate Democratic Campaign Committees this week and met with the following candidates:

- **Sen. Lamar Alexander (R-TN)**, a member of the Health Subcommittee of the Senate Appropriations Committee and a member of the Health, Education, Labor and Pensions Committee. Sen. Alexander represents the home state of AAFP Board member Dr. Reid Blackwelder and FamMedPAC Board Chair Dr. Jim King.
- **Sen. John Barasso (R-WY)**, an orthopedic surgeon and Chair of the Senate Republican Policy Committee.

## 6. REGULATORY BRIEFS

- On July 18, CMS announced 15 additional accountable care organizations (ACOs) will participate in the [Advance Payment ACO model](#), which according to CMS, is designed “for small physician practices and rural providers who would benefit from additional start-up resources while participating as ACOs in the Medicare Shared Savings Program.” This announcement brings the number of ACOs participating in the Advance Payment ACO Model to 20.
- On July 19, CMS announced updates to the [Hospital Compare](#) and [Nursing Home Compare](#) websites. In addition to other information, these websites contain updated data on how well specific facilities perform on quality measures, such as the frequency of infections that develop in the hospital, how often patients have to be readmitted to the hospital, and the percentage of nursing home residents who report having moderate to severe pain.
- Also on July 19, HHS [announced](#) a new funding opportunity available to help states either test developed health care delivery transformation models or to assist them in designing system improvements that will work best in their state. This announcement will make funding available for up to five states to test developed state health care innovation models and for up to 25 states to help in the design of state-specific health care innovation models. CMS will host a related call on July 26, from 3 - 4pm ET, more details are [online](#).

## 7. HHS WILL HOLD FORUMS ON ACA IMPLEMENTATION IN DC, IL, CO AND GA

This week, Health and Human Services Secretary Kathleen Sebelius notified governors that HHS will conduct four regional forums in July and August to address questions and concerns from state officials and others about implementation of health care reforms. Acknowledging that the Supreme Court held that states may choose not to participate in the *Affordable Care Act* (ACA) provision to expand Medicaid, Secretary Sebelius noted that, “The Court’s decision did not affect other provisions of the law.” The Secretary reassured governors that HHS is committed to “providing states with as much flexibility as we can to achieve successful implementation of the many important opportunities provided by this legislation.” According to the announcement, forums are scheduled for:

- July 31 in Washington, DC
- August 2 in Chicago
- August 10 in Denver
- August 15 in Atlanta.

To register to attend, go to <https://www.quickbase.com/db/bg92mriu2>.

## 8. GOVERNORS COMMIT TO INSURANCE EXCHANGES

Proceeding the Supreme Court ruling, the governors of California, Colorado, Connecticut, Hawaii, Maryland, Massachusetts, Minnesota, New York, Oregon, Rhode Island, Vermont, and Washington have expressed firm commitment to HHS that they plan to establish and operate state-based insurance exchanges. The state exchange blueprints are due by November 16 and will go into effect in 2014. A “blueprint” application from the governor of each state must include an exchange model declaration letter and a description of the states’ readiness to implement and preform exchange undertakings and purposes.

## 9. NEW INDIANA HEALTH CARE LAWS AFFECT FAMILY PHYSICIANS AND PATIENTS

- [SEA 93 \(from 2011\)](#) – (Although parts of this law already went into effect in 2011, schools began implementing most of this law starting July 1.) If a student athlete has a suspected concussion, a licensed health care provider who is trained in the “evaluation and management of concussions” must give written clearance to the student before the school can allow the student to participate in athletics again. With no definition of “trained in evaluation and management of concussions” in the bill, individual schools are determining on their own what kinds of health care professionals they deem appropriate to sign off on the care of their students, and whether those health care professionals must complete additional training. The **Indiana Academy of Family Physicians** is discussing with the Indiana Department of Education and the Indiana State Health Department clarifications of the law and appropriate guidance to schools and physicians.
- [SEA 407](#) – The way family physicians write prescriptions may need to change. This new law allows a pharmacist to give a patient up to a 90-day supply of a prescription drug without approval from the prescribing physician, with several conditions. Under this new approach, the total amount of medication a patient receives over the course of a prescription will not change. What changes is the amount of medication a patient receives at one time. If a physician does NOT want a pharmacist altering the amount of medication dispensed at one time the physician must write on the prescription or must tell the pharmacist “the quantity of the prescription may not be changed.”
- [HEA 1149](#) – Workplaces in Indiana, with some exceptions, are now required to be smokefree. The following exceptions apply – cigar bars, casinos, and membership clubs (who must vote to allow smoking). All businesses are required to post at least 2 signs stating they are smokefree inside the building, and one sign at each public entrance to the building stating no smoking within 8 feet of the entrance.