# GOVERNMENT AFFAIRS WEEKLY

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

March 16, 2012

**IN THIS REPORT…**



**NEXT WEEK IN WASHINGTON**…

* The House may begin debate later in the week on the *Medicare Decisions Accountability Act* (HR 452), which would repeal the Independent Payment Advisory Board (IPAB) and include medical liability reforms.
* The House Energy and Commerce Subcommittee on Oversight and Investigations will hold a hearing on Wednesday, March 21 on the CMS's Center for Consumer Information and Insurance Oversight and the ACA's second anniversary. Likely topics are the cost of the law and the impact on employer-sponsored health insurance.

## 1. PRIMARY CARE VALUATION TASK FORCE RECOMMENDATIONS SENT TO CMS

On March 12, AAFP sent a letter to Marilyn Tavenner, the Acting Administrator of the Centers for Medicare & Medicaid Services recommending the agency adopt a series of short term strategies for improving primary care payment as part of the proposed 2013 Medicare physician fee schedule. The AAFP's Task Force on Primary Care Valuation produced the recommendations, which call for new codes for primary care E/M services, payment for telephone and online E/M services and enhanced payment options for primary care physicians. If CMS adopts them, the recommendations would improve payment for primary care services by primary care physicians in the near term and support principles for longer term payment reform. For further information, see the related *AAFP News Now* article.

## 2. MEDICARE COMMISSION RELEASES REPORT, EXAMINES CARE COORDINATION

The Medicare Payment Advisory Commission (MedPAC) released its annual March report to Congress recommending payment equity between hospital outpatient visits and physician office visits. MedPAC also reiterated its recommendation that Congress repeal the sustainable growth rate (SGR) and replace it with a 10-year path of statutory fee-schedule updates with a freeze in current primary care payment levels and annual payment reductions of 5.9 percent for three years, followed by a freeze for other physician services.

MedPAC met on March 8 and 9 to deliberate on issues related to bundling of provider payments and to payment for care coordination. MedPAC staff outlined indicators of poor care coordination including beneficiaries repeatedly communicating key information about their medical history, polypharmacy, poor transitions between settings and providers, and unnecessary use of higher intensity services. Policies encouraging care coordination include

fee schedule changes, dedicated care manager payment, paying for outcomes and broader payment reform such as bundling, capitation and accountable care organizations. MedPAC staff identified examples of these policies before devoting a good deal of time discussing the results of Medicare demonstrations and challenges associated with applying care coordination models to Medicare's fee-for-service payments.

Possible steps the MedPAC may consider in future meetings include changing fee schedule codes, per member per month (PMPM) payment to a medical practice or to an external care manager; transitions payment or others that result from the experiences of the new Medicare Innovation Center.

**3. FAMILY MEDICINE RESPONDS TO COMPARATIVE RESEARCH AGENDA**

In a letter sent March 14 to Joe V. Selby, M.D., M.P.H, Executive Director of the Patient-Centered Outcomes Research Institute (PCORI), the AAFP and the Council of Academic Family Medicine (CAFM), which represents the membership of the Society of Teachers of Family Medicine, the Association of Departments of Family Medicine, the Association of Family Medicine Residency Directors, and the North American Primary Care Research Group, responded to PCORI's National Priorities and Research Agenda. The letter expressed support for PCORI's mission, which is to direct and fund research that provides patients and physicians with information for healthcare decisions. The letter recommended that PCORI initially focus its research on conditions that family physicians encounter every day in their practices in hopes of finding solid clinical evidence to assist the shared decision making process between patients and physicians.

**4. FINAL HEALTH INSURANCE EXCHANGE REGULATION RELEASED**

On March 12, the U.S. Department of Health & Human Services released a final rule regarding health insurance exchanges for individuals and small businesses under the *Affordable Care Act*. The rule will be effective in late May. AAFP submitted comments to HHS on the proposed rule in September. In a victory for patients, HHS agreed with AAFP's recommendations that patients be allowed to switch tiers of coverage during special enrollment periods, gaps in coverage be shortened, and consumers be represented on governing boards. Citing an interest in maximum state flexibility, HHS rejected or deferred to the states AAFP's recommendations regarding physician-insurer relations, such as standard contracts and prohibitions on local coding and billing rules. AAFP also recommended standardizing quality measures across plans participating in exchanges; however, HHS deferred action on that recommendation.

**5. REGULATORY BRIEFS**

- On March 1, CMS reopened the Quality Reporting Communication Support Page to allow individual eligible professionals and CMS-selected group practices the opportunity to request a significant hardship exemption for the 2013 Electronic Prescribing (eRx) payment adjustment. CMS will accept hardship exemption requests through June 30, 2012. CMS recommends their educational article for further details.
- On March 13, HHS announced that Blue Cross/Blue Shield Tennessee will pay $1.5M to settle potential violations of the Health Insurance Portability and Accountability Act's Privacy and Security Rules.
- On March 13, the CMS Innovation Center announced that 11 states and Washington, D.C. will participate in the Medicaid Emergency Psychiatric Demonstration which will provide up to $75 million in federal Medicaid matching funds over 3 years.
- On March 14, CMS announced 23 additional participants (joining seven others) in the Community-based Care Transitions Program (CCTP) which is designed to provide support for high-risk Medicare beneficiaries following a hospital discharge. Community organizations will help these patients stay in contact with their doctors, especially to

ensure they are taking medications. CMS indicates the CCTP will support more than 126 local hospitals and help more than 223,000 Medicare beneficiaries in 19 states across the country.

- On March 15, CMS's Office of E-Health Standards and Services (OESS) announcing a three month delay (through June 30, 2012) in enforcement action against any covered entity that is required to comply with the updated transactions standards adopted under the HIPAA: ASC X12 Version 5010 and NCPDP Versions D.0 and 3.0.
- On March 15, CMS announced the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents for Medicare and Medicaid beneficiaries. The initiative funds organizations that partner with nursing facilities to provide enhanced on-site services and supports to nursing facility residents. CMS commits up to $128 million to support a diverse portfolio of these evidence-based interventions.
- On March 20 from 1:30-3pm ET, CMS will host a call on the Physician Quality Reporting System & Electronic Prescribing Incentive Program. Registration is required.
- On March 29 from 1pm – 2pm ET, CMS will conduct a video streaming event launching a new initiative to improve behavioral health and reduce the use of antipsychotic medications in nursing homes residents. Registration is required.
- On April 10-11 in Washington, DC, HHS and the Association for Prevention Teaching and Research (APTR) are hosting the *2012 National Health Promotion Summit: Prevention. Promotion. Progress*.