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 Family Medicine Congressional Conference will convene on Monday, May 14.
* The Commission on Governmental Advocacy will meet on Wednesday, May 16.
* Senate HELP Committee holds a hearing on Health Care Delivery System Reform on May 16.

1. MEDICARE SGR REFORM GARNERS LEGISLATIVE ATTENTION

On May 9, Reps. Allyson Schwartz (D-PA) and Joe Heck (R-NV) introduced the *Medicare Physician Payment Innovation Act* (HR 5707), a bipartisan bill to eliminate the flawed Medicare sustainable growth rate (SGR) formula. The legislation would establish a six-year transition period. For the first year of that transition, all payment rates would be frozen at the current level. Then, for the next four years, physicians would get a 0.5-percent annual increase in the payment rate; however, primary care physicians who provide primary care services instead would receive a 2.5-percent annual increase in their payment rate. In the last year, the payment rate would be frozen at the previous year's level. During the transition period, CMS would establish at least four alternative payment models from which physicians could choose to operate after the transition period. The Schwartz-Heck bill uses the unspent Overseas Contingency Operations (OCO) fund to offset the cost of these Medicare payment reforms.

The Senate Finance Committee on May 10 held a roundtable "Health Care Payment – Moving Beyond the SGR" with an invited panel of former CMS administrators, Mark McClellan, Tom Scully, Bruce Vladeck, and Gail Wilensky. Both Vladeck and Wilensky urged experimentation with bundling of payments, but agreed that no quick fix it is wise given the complexity of the system and the challenges facing rural practices which will never have efficiencies created by volume. Scully apologized for his part in creating the SGR and said it was a big mistake to give the RUC to the AMA. Scully suggested that doctors receive a capitated rate so they are rewarded for practicing effectively and efficiently. McClellan cautioned against doing another patch; encouraged bundling and commended the Patient-Centered Medical Home (PCMH) model. Sen. Orrin Hatch (R-UT) asserted that the RBRVS will not work as long as the AMA controls the RUC and that physicians should be protected from medical liability suits for

adherence to evidence-based guidelines. Wilensky pointed out that CMS can reject RUC recommendations. Scully and Vladeck agreed that it would be better to have an outside entity value the codes and that more transparency is needed.

Chairman Baucus concluded the event by asking the panel members to submit short- and long-term ideas to the Senate Finance Committee on the SGR within a month. The current SGR patch expires on January 1.

2. CMS PROPOSES HIGHER MEDICAID PAYMENT FOR PRIMARY CARE

On May 9, CMS released the proposed regulation to implement Section 1202 of the *Affordable Care Act*. This section, titled "Medicaid payments to primary care physicians" calls for payments for certain primary care services furnished in 2013 and 2014 by physicians with primary specialty designations of family medicine, general internal medicine, or pediatric medicine to be paid at a rate equal to the Medicare conversion factor. For purposes of this section, the statute defined "primary care services" as Evaluation & Management codes and also services related to immunization administration for vaccines and toxoids (CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474).

In this proposed rule, CMS indicates that states will receive more than $11 billion in new federal funds to bolster access to primary care services in Medicaid programs. The federal government will pay the entire cost of the increase in payment for primary care with no matching payments required of states. The AAFP continues to analyze the proposal and will send formal regulatory comments to CMS by their mid-June due date.

3. HOUSE BUDGET BILL WILL SQUEEZE HEALTH CARE SPENDING

On May 10, the House passed the *Sequester Replacement Reconciliation Act* (HR 5652) to avert across-the-board cuts in defense spending by making greater cuts in domestic spending on a vote of 218 to 199. Sixteen Republicans joined the Democrats in opposing the bill.

The legislation would leave the scheduled nondefense cuts (including cuts to Medicare) intact. It also seeks to cut $238 billion from the deficit over ten years through a broad range of entitlement reforms including Medicaid cuts. In all, the cuts to health care are estimated to be $113 billion over ten years.

In FY 2013, the bill would cut $19 billion from the overall spending level agreed to in the *Budget Control Act* (BCA) enacted last summer which is likely to prevent any increase for Title VII primary care medicine training grants. The bill would strip entitlement spending such as the Prevention and Public Health Fund from the *Affordable Care Act*, impose more stringent eligibility reviews for Medicaid enrollees, and cap damages on medical malpractice awards to meet the savings targets in the House budget resolution.

The Senate is not expected to use the House budget as a framework for the FY 2013 appropriations bills, and the President has threatened to veto any spending bill that complies with the House reconciliation bill with lower levels of spending than mandated under the BCA.

4. HOUSE COMMITTEE UNANIMOUSLY APPROVES FDA REFORMS

The House Energy and Commerce Committee approved (46 to 0) legislation (HR 5651) to reauthorize the Food and Drug Administration's user fees program. It could be considered by the full House as early as next week and would provide a five-year extension to the collection of industry user fees that fund the FDA's review of prescription drugs and medical devices. It would also create new user-fee programs for biosimilars and generic drugs. The FDA currently receives more than $1 billion in fees from the drug and medical-device industries to help pay the

costs of evaluating new products, but the current authorization expires Sept. 30. The Senate is also expected to act soon on FDA user fee legislation.

5. CMS RELEASES 2011 PRIMARY CARE INCENTIVE PROGRAM DATA

In the May 9 press release regarding the Medicaid payment regulation for primary care physicians, HHS announced that in 2011 over 150,000 primary care providers nationwide received almost $560 million in higher Medicare payments due to the Primary Care Incentive Program (PCIP) called for in the *Affordable Care Act*.

In a letter sent to CMS on February 28, the AAFP urged the prompt release of data on the PCIP so that the AAFP and others can continue working with policymakers to address payments public and private payers make to primary care physicians.

Despite CMS not yet making the 2011 PCIP report publicly available, the AAFP and Robert Graham Center received an advance copy. In a May 7 response from CMS Acting Administrator Tavenner to the AAFP's February 28 letter, CMS specified that:

- 86 percent of PCIP payments were distributed to physicians in urban areas.
- 38.2 percent of payments were made to family physicians.
- 50.1 percent of payments were distributed to physicians in general internal medicine.
- And the remainder was made to nurse practitioners (7.0 percent), physician assistants (2.5 percent), geriatricians (1.7 percent), pediatricians (0.3 percent), and clinical nurse specialists (0.2 percent).

The AAFP will continue monitoring the PCIP program and will distribute PCIP data to members once available.

6. AAFP RESPONDS TO EHR INCENTIVE PROGRAM, STAGE 2 REGULATION

In a comment letter sent to CMS on May 7, the AAFP responded to the proposed Medicare and Medicaid Programs; Electronic Health Record Incentive Program, Stage 2 regulation. In the response, the AAFP applauded HHS for the efforts to drive interoperability, health information exchange, patient engagement, and quality measurement. The AAFP then noted some technical concerns regarding:

- Modification of Stage 1 Rules
- Penalties associated with action (or inaction) of others outside the practice
- Lack of interoperability by partners leading to excessive complexity in compliance with several proposed criteria
- Assurance of a simple, open, and standard transport mechanism for health information exchange is very important to permit eligible providers to meet the new Meaningful Use Stage 2 objectives.

7. AAFP OPPOSES FDA PROPOSAL ON PHARMACISTS DISPENSING DRUGS

In a comment letter sent to the FDA on April 30, the AAFP opposed a FDA proposal that would allow pharmacists to dispense certain medications without a physician's prescription. The FDA currently approves drugs either as prescription or nonprescription. In the proposal, the FDA sought input on a new and third paradigm that would allow the agency to approve and for pharmacists to dispense certain drugs, which would have otherwise required a prescription, for nonprescription use under conditions of "safe use," which would be determined specific to the drug product.

In the response, the AAFP recognized the important role of pharmacists, but then stated that it is the AAFP's policy to oppose regulations and legislation that would allow pharmacists to

dispense medication beyond the expiration of the original prescription for reasons other than emergency purposes. The AAFP then urged FDA to continue the existing two classes of drug products, prescription and nonprescription.

8. FamMedPAC CONTINUING TO RAISE VISIBILITY IN WASHINGTON

Since January 1, 2011, FamMedPAC, using the direct marketing program, chapter champions at meetings, and soliciting at national and regional meetings, has received a total of $656,571 from 2,114 AAFP members, with an average donation of $310.

The PAC had a booth at ALF-NCSC in Kansas City May 3 – 4, and received $18,617 in donations, just $178 less than in 2011. The PAC will have a booth at FMCC next week.

So far in the 2012 election cycle, the PAC made a total of $442,000 in campaign contributions to 95 campaigns and committees. Contributions have gone to both parties: $207,000 to Republicans and $235,000 to Democrats and one Independent.

Government Relations staff attended PAC events this week for the following legislators:

- **Rep. Bill Pascrell (D-NJ)**, a member of the Health Subcommittee of the House Ways and Means Committee
- **Rep. Paul Ryan (R-WI)**, the Chair of the House Budget Committee and a member of the House Ways and Means Committee
- **Rep. Bill Cassidy (R-LA)**, a physician and member of the Health Subcommittee of the House Energy and Commerce Committee
- **Rep. Shelley Berkley (D-NV)**, a member of the House Ways and Means Committee. Rep. Berkley is running for the Senate this year, who is married to a physician and who has a family physician daughter
- **Rep. Eric Cantor (R-VA)**, the Majority Leader in the House.
- **Rep. Dave Camp (R-MI)**, the Chair of the House Ways and Means Committee.

9. REGULATORY BRIEFS

- On April 25, the Patient-Centered Outcomes Research Institute Board voted to amend their draft research agenda in response to public comments. The changes clarify PCORI's focus on patient engagement and transparency, on patients with multiple chronic conditions, on patients with rare diseases, on improving health care systems, and on the importance of health literacy. A final National Priorities and Research Agenda is expected in late May.
- On April 26, HHS finalized the Community First Choice rule, which is a new Medicaid state plan option. The Community First Choice Option provides states choosing to participate a six percentage point increase in federal Medicaid matching funds for providing community-based attendant services and supports to beneficiaries who would otherwise be confined to a nursing home or other institution.
- On April 26, HHS announced the first 16 participants in the Independence At Home Demonstration. The demonstration encourages primary care practices to provide home-based care to chronically ill Medicare patients. The demonstration, scheduled to begin on June 1, 2012, and conclude May 31, 2015, will test whether delivering primary care services in the home can improve the quality of care and reduce costs for patients living with chronic illnesses. CMS indicated that 16 organizations were selected from a competitive pool of more than 130 applications.
- On April 30, CMS released updated statistics on use of Part D discounts and use of preventive services as authorized by the *Affordable Care Act*. In the first three months of 2012, more than 220,000 people saved an average of $837 on prescription drugs purchased

in the coverage gap, for a total savings of $184.5 million in the first three months. CMS also announced that 8.9 million beneficiaries with Medicare fee-for-service received at least one preventive service at no cost to the patient, including over 560,000 beneficiaries who have taken advantage of the new Annual Wellness Visit.

- On May 1, CMS released a final national coverage determination specifying that Medicare will cover Transcatheter Aortic Valve Replacement (TAVR) for Medicare Patients with Heart Valve Damage.
- CMS recently posted a revised educational document pertaining to the Health Professional Shortage Area (HPSA) Physician Bonus, HPSA Surgical Incentive Payment, and the Primary Care Incentive Payment Programs.
- On May 2, US Attorney General Holder and HHS Secretary Sebelius announced that a nationwide takedown by Medicare Fraud Strike Force operations resulted in charges against 107 individuals, including doctors, nurses and other licensed medical professionals, for their alleged participation in Medicare fraud schemes involving approximately $452 million in false billing. HHS also suspended or took other administrative action against 52 providers following a data-driven analysis and credible allegations of fraud.
- A May 3 blog post from CMS regarding implementation of the *Physician Payments Sunshine Act* stated that "in order to provide time for organizations to prepare for data submission and to sufficiently address the important input we received during the rulemaking process, CMS will not require data collection by applicable manufacturers and applicable group purchasing organizations before January 1, 2013." The agency is expected to release a final rule in 2012.
- On May 8, HHS announced the "first batch" of organizations receiving the Health Care Innovation awards totaling $122.6 million. These awards will support 26 innovative projects nationwide that are designed to save money and deliver high quality medical care.
- The Federal Motor Carrier Safety Administration recently released a final rule establishing a National Registry of Certified Medical Examiners. By May 2014, any physician who chooses to perform fitness examinations for interstate truck and bus drivers will need to undergo a training session and pass the federal certifying exam. Neither the training nor examination will be administered by the Federal government, but by accepted training organizations.
- On May 10, HHS released the final rule titled "Medicare and Medicaid Program; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction". The AAFP commented on the related proposed rule in a December 7, 2011 letter. The AAFP is thoroughly reviewing the final rule, but an initial assessment indicates that CMS accepted the AAFP recommendation to eliminate the re-enrollment bar in instances when physicians have not responded timely to requests for revalidation of enrollment or other requests for information initiated by CMS. Additionally CMS accepted the AAFP recommendation update e-prescribing technical requirements so that Medicare prescription drug plans and Medicare Advantage plans offering prescription drug plans meet the current HIPAA transaction standards. CMS states that this final rule will produce savings of $200 million in the first year by promoting efficiency and eliminating duplicative, overlapping, and outdated regulatory requirements for health care providers.
- On May 10, CMS updated an educational document regarding the home health face-to-face requirement. In it, CMS includes a FAQ that reiterates that CMS does not require a specific form to document the face-to-face encounter.