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…

* Tuesday, April 5 – national CMS physician conference call, further details in Regulatory Briefs
* Friday, April 8 – current FY2011 stopgap spending law expires.

1. PROPOSED ACCOUNTABLE CARE ORGANIZATION REGULATION RELEASED

On March 31, the Centers for Medicare & Medicaid Services released the highly anticipated *Medicare Shared Savings Program; Accountable Care Organization* (ACO) proposed rule (CMS-1345-P). It is accessible on the Office of the Federal Register's electronic inspection website until April 7 when it will then be permanently published in the Federal Register.

An ACO refers to a group of physicians, hospitals and other suppliers of services that will work together to provide coordinated care to Medicare beneficiaries. After publication of the final ACO rule, interested entitles must then apply to CMS to become an ACO. If accepted, the ACO must participate in the program for three years. Providers participating in the ACO continue to receive payments under original Medicare fee-for-service rules. The ACO's performance and ability to earn a portion of any shared savings will be measured annually against CMS's established benchmarks. ACOs have the option of choosing between a "one sided risk model" (sharing of savings for the first two years and sharing of savings and losses in the third year) or a "two-sided risk model" (sharing of savings and losses for all three years). If they are unable to provide efficient, cost effective care according to their specific performance benchmarks, ACOs may have to return funds to Medicare.

In the proposal, CMS estimates that 5 million Medicare beneficiaries will receive care from ACOs in 2012. As required by the *Affordable Care Act*, ACOs must include enough primary care professionals to treat at least 5,000 Medicare beneficiaries. In this regulation, CMS proposes to

define primary care as physicians who have a primary specialty designation as" internal medicine, general practice, family practice, or geriatric medicine" and who are providing the appropriate primary care services to beneficiaries are counted toward the statutory requirement. CMS proposes to define "primary care services" on the basis of the select set of HCPCS codes identified in the Primary Care Incentive Program. However CMS also expresses concern that this proposal:

> *could reduce the number of beneficiaries assigned to an ACO, by excluding primary care services delivered by specialists, especially in some areas that may have shortages of primary care physicians but a relatively greater number of specialists. Consequently, this option could make it difficult for ACOs to form in some geographic regions with such primary care shortages.*

The proposed regulation also specifies that 75 percent of the ACO's leadership and governance structure must be participants representing clinical (without regard to medical specialty) and administrative functions. ACOs must employ a physician-directed quality assurance and process-improvement committee in order to guarantee physician participation in the leadership of the ACO. CMS proposes to make payments directly to the ACO's tax identification number, for the ACO to then distribute to participating providers according to the ACO's legal structure. CMS proposes that the ACO reports on 65 quality measures including measures on patient experience, care coordination, patient safety, preventive health, and at-risk patient populations.

In the proposed regulation and in the related CMS materials, the agency specifies that Medicare beneficiary participation is completely voluntary and that there is no beneficiary enrollment or assignment. Medicare beneficiaries may receive care inside and outside of the ACO at no penalty to the patient. However, the ACO is required to notify the patient that they are participating as an ACO. In the spirit of improving the coordination of care, CMS propose to offer ACOs access to Medicare claims data for patients they are treating; however, the ACO must first obtain permission from the Medicare beneficiary to access the claims data.

CMS released several educational materials pertaining to the proposed ACO regulation:

- What providers need to know: Accountable Care Organizations
- Medicare shared savings program: a new proposal to foster better, patient-centered care
- Federal agencies address legal issues regarding participating Accountable Care Organizations
- Improving quality of care for Medicare patients: Accountable Care Organizations
- Summary of proposed rule provisions for Accountable Care Organizations under the Medicare shared savings program

The AAFP will analyze the regulation, offer further information and resources to members, and provide extensive comments to the agency before the public comment closes on June 6.

2. LEGISLATION WOULD REQUIRE BETTER DATA IN PHYSICIAN PAYMENT CODES

On March 31, Rep. Jim McDermott (D-WA) introduced the *Medicare Physician Payment Assessment and Transparency Act of 2011* (HR 1256), with the support of the AAFP and the Society of General Internal Medicine. This legislation is intended to enhance the analytic information available to CMS as it evaluates the recommendations of the Relative Value Scale Update Committee (RUC) of the AMA. The ultimate objective is to recognize the value of primary care by providing CMS the authority to use additional reliable data for setting values for medical services.

3. HOUSE BEGINS EFFORT TO DE-FUND HEALTH REFORM LAW

On March 31, the House Energy and Commerce Subcommittee on Health approved five bills that would repeal mandatory funding for several provisions of the 2010 health overhaul law. Three of the measures (HR 1213, HR 1214, HR 1217) would repeal the state-based insurance exchanges, school-based health center construction and the Prevention and Public Health Fund. They all were approved by votes of 14-11. The third bill (HR 1216) would make funding for state teen sex education programs subject to annual appropriations. This bill also received approval by a vote of 14-11. The final bill (HR 1215) would affect certain graduate medical education programs by making their funding discretionary. HR 1215 was approved, 15-11.

4. AAFP URGES BUDGET COMMITTEES TO PROTECT KEY PUBLIC HEALTH FUNDS

AAFP Board Chair Lori Heim, MD wrote on March 29 to members of the House and Senate Budget Committees calling on them to include adequate resources for discretionary health spending in the fiscal year 2012 budget resolution. The letter also urged the Budget Committee members to preserve a number of important provisions from the *Affordable Care Act* (ACA) including:

- the Medicare primary care incentive payment;
- Medicaid parity with Medicare payment for primary care services, as well as
- mandatory funds for
    - the Center for Medicare and Medicaid Innovation,
    - the Teaching Health Centers,
    - the National Health Services Corps (NHSC),
    - Patient-Centered Outcomes Research; and
    - the Prevention and Public Health Fund.

The letter also called on Congress to enact a multi-year Medicare schedule which narrows the payment differential between primary care and other physicians. A draft of the House FY 2012 budget resolution is expected to be released early next week.

5. BRIEFING PROMOTES TITLE VII AWARENESS ON CAPITOL HILL

Family physician John Franko, MD, Professor and Chair of the Family Medicine Department at Quillen College of Medicine at East Tennessee State University addressed a Congressional staff briefing hosted by the Health Professions and Nursing Education Coalition (HPNEC) on March 23. The briefing highlighted the need for continued federal support for HRSA's Title VII and Title VIII programs to strengthen workforce development activities across the country. The briefing also marked the launch of HPNEC's Title VII and Title VIII Video Profiles YouTube page, which features a collection of 1-2 minute videos from institutions and organizations across the country showing the programs in action.

6. HOME HEALTH APRIL 1 DEADLINE STANDS DESPITE COALITION EFFORT

On March 31, CMS responded to the letter that the AAFP and several other national healthcare and consumer organizations sent earlier this month 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. In their response, the agency indicated they will enforce this deadline on April 1 and that they will monitor for problems and unintended consequences. Further information on this requirement is on the AAFP' "Getting Paid" website.

7. AAFP COMMENTS ON NEW BENEFICIARY NOTIFICATION REQUIREMENT

In a March 30 letter to CMS, the AAFP commented on a new requirement that certain Medicare providers give beneficiaries with information about their right to file a written complaint with the state Quality Improvement Organizations and right to access state survey agencies.

Though the new requirement does not apply to physician offices, it does apply to ambulatory surgical centers, hospices, hospitals, long term care facilities, home health agencies, comprehensive outpatient rehabilitation facilities, critical access hospitals, and rehabilitation agencies, portable x-ray services, rural health clinics and federally qualified health centers.

The AAFP urges CMS to prove an example of an acceptable notification form in the final rule in order to simplify the process for sites creating their own forms and urges further clarification regarding providing the form to beneficiary representatives.

8. FamMedPAC CLOSES OUT BUSY FIRST QUARTER

During the first quarter of 2011, the PAC contributed $132,000 to 37 candidates and committees. During the same period, the PAC received $124,877 in donations.

The Government Relations staff met with the following legislators this week at their PAC receptions:

- **Rep. Ed Whitfield (R-KY)**, a member of the House Energy and Commerce Health Subcommittee.
- **Rep. Dave Camp (R-MI)**, the Chair of the House Ways and Means Committee.

9. REGULATORY BRIEFS

- On March 17, CMS announced updates to the Physician Compare website. This website is updated monthly and contains searchable information on physicians by specialty, location(s), education, hospital affiliation, gender, languages spoken, and whether or not the healthcare professional accepts the Medicare-approved amount as payment in full on all claims.
- On March 21, the CMS.s Center for Medicare and Medicaid Innovation announced the redesigned website Innovations.cms.gov that offers information about their mission to help transform the American health care system by delivering better healthcare for Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries, and to reduce costs through improvement.
- On March 21, HHS released the National Strategy for Quality Improvement in Health Care which is intended to guide local, state and national efforts to improve quality of care.
- On March 22, HHS issued a press release stating that nearly 4 million Medicare beneficiaries reached the Part D coverage gap in 2010 and received the one-time $250 rebate check as specified in the *Affordable Care Act*.
- On March 25, the Office of the National Coordinator for Health Information Technology released for public comments the Federal Health IT Strategic Plan: 2011-2015. The public has the opportunity to comment until April 22, 2011.
- On March 30, HHS announced a new immunization website at www.vaccines.gov. According to the press release, the site includes information about vaccine recommendations, the diseases that vaccines prevent, important information for getting vaccinated, and tips on travel health. It also links consumers with resources in their states to learn about vaccine requirements for school or child care entry and local community information.

- On April 5 from 2pm – 3pm ET, CMS will conduct the next Physician Open Door Forum conference call. To participate dial 1-800-837-1935 and reference conference #44695577.

10. FEDERAL TRADE COMMISSION ENTERING STATE SCOPE DEBATES
AAFP is alerting chapters (by attached memo from Greg Martin, Manager of State Government Relations), that Federal Trade Commission (FTC) staff are inserting the agency into the state issue of expanding nurse practitioners' and physician assistants' scope of practice. Recently, three FTC staff sent a letter to the **Alabama** State Board of Medical Examiners and a letter to **Florida** State Representative Daphne Campbell, RN (D) in support of the elimination of physician supervision requirements for nurse practitioners, CRNA's and physician assistants. The Florida letter indicates that the FTC is examining legislation and regulation in several other states, and will comment accordingly.

The FTC examines economic activities with two criteria in mind: improved competition (to lower prices for consumers) and consumer safety. The FTC does not deem the argument of education and training as germane to its responsibilities or expertise. AAFP will raise the issue with the Scope of Practice Partnership and work with the SOPP to ensure prudent and timely action.

11. CALIFORNIA GOVERNOR SIGNS BUDGET CUTTING MEDICAID PROVIDER RATES
On March 24, California Governor Jerry Brown (D) signed 13 bills—including Health Services bill AB 97—intended to chip away $11.2 billion from the state's $26.6 billion budget deficit. Although savings will result from increased revenue and shifting funds, the legislation will reduce state expenditures by $8.2 billion. Funding for health and human services was reduced by $6 billion, $1.7 billion of which will come from MediCal, the state's Medicaid program. Medicaid providers face a 10 percent rate reduction effective in June, and with a remaining $12.6 billion shortage, additional and more drastic cuts are expected.

Gov. Brown, who proposes a special election to ask voters to maintain a set of temporary sales, income and vehicle license taxes for five years to help close the gap, is seeking the two-thirds vote needed from the legislature to hold a statewide vote. In a press release, the **California Academy of Family Physicians** urged lawmakers to hold the special election. "Health care for millions of Californians is at stake," said California AFP President Jack Chou, MD.

12. SUCCESSFUL END OF STATE LEGISLATIVE SESSION FOR UTAH AFP
Because the Utah Legislature recently adjourned, Governor Gary Herbert (R) acted on a number of bills, several of which the **Utah Academy of Family Physicians** supported, including:

- HB 13 allows minors, who are pregnant or who are parents, to consent to immunizations.
- SB 180 requires the Department of Health to develop a proposal to modify the Medicaid program in a way that maximizes replacement of the fee-for-service delivery model with one or more risk-based delivery models.

Failed legislation opposed by the Utah AFP includes:

- HB 258 would have exempt operators of motor vehicles on roads with speed limits of 45 miles per hour or less from the requirement to use child restraint devices to restrain a person who is five years of age or older but younger than eight, if the child is secured in the vehicle's safety belt. The Utah AFP worked with other groups, including pediatricians and the Primary Medical Center, in opposition ensuring the measure failed to pass committee.

- HB 289 would have authorized psychologists in collaborative care models to prescribe psychotropic medications.

Other recently enacted Utah bills include:

- SB 61 requires all individuals licensed to prescribe controlled substances, as of July 1, 2012, to complete at least four continuing education hours.
- SB 129 provides issuance of a temporary license for foreign-educated physicians invited to serve as faculty at a Utah medical school, requiring application of a permanent license within five years.
- SB 134 requires an advertisement for health care services that includes a provider's name to identify the license type under which the provider is practicing.

13. OKLAHOMA HOUSE APPROVES BILL TO LIMIT LIABILITY DAMAGES

With a 57-40 vote, the Oklahoma House of Representatives passed legislation (HB 2128)—supported by the **Oklahoma Academy of Family Physicians**—that would cap pain and suffering damages in medical liability suits at $350,000. However, this would not cap damages in wrongful death cases and would not alter what a plaintiff can receive for economic damages such as lost income or payment of medical bills. The bill now heads to the Senate, where a similar version, but with a cap of $250,000, was approved earlier this session.