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…

* April 14, AAFP member discusses the PQRS on a CMS call, details in regulatory briefs

1. MEMO ON MEDICARE ACCOUNTABLE CARE ORGANIZATIONS PROPOSED RULE

The AAFP Government Relations Division created a document regarding the *Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations* proposed rule which was released last week. The AAFP will submit extensive comments on this regulation prior to the June 6 comment period close date.

2. NEGOTIATIONS ON FY 2011 SPENDING REMAIN DEADLOCKED

Despite days and nights of high-level negotiations, the federal government appears headed for a shutdown of undetermined duration. The impasse is reportedly over whether Planned Parenthood will be stripped of federal funding for the rest of the current fiscal year. Federal agencies have contingency plans to determine which functions would continue and who would keep working. Generally, payments made from trust funds, such as Medicare and Medicaid, not subject to annual appropriations will be made despite the shutdown. But, federal workers and government contractors who process claims might be designated as non-essential and prevented from staying on the job. Some of the federal funding for the implementation of health reform is mandatory spending, so theoretically it might continue, but the salaries of the federal workers charged with implementing health reform are funded by discretionary dollars.

HHS will allow the Payment Management System to continue processing grant drawdown requests, so that payments can be made for excepted programs. Grantees receiving annually appropriated awards prior to a shutdown may be able to continue drawing funds from prior awards during an appropriations hiatus. HHS grantees could not drawdown funds if they were under a restriction that required federal staff action. HHS will maintain grants.gov to continue to

post funding opportunity announcements and accept and process grant applications for fully funded and excepted programs.

3. HOUSE BUDGET COMMITTEE PASSES AUSTERE FY 2012 PLAN

The House Budget Committee on Wednesday, April 6 passed the GOP's fiscal year 2012 budget proposal on a party line vote of 22-16. The Chairman of the House Budget Committee, Rep. Paul Ryan (R-WI), proposed to control the cost of Medicaid by turning that program into a block-grant to states with a cap on the federal payment and to address the costs of Medicare by providing beneficiaries with lump-sum "premium support" payments to buy private insurance.

The Committee-passed resolution also proposes to roll back discretionary spending on programs such as Title VII to pre-2008 levels and freeze it there for five years. In addition, it assumes the repeal of the *Affordable Care Act* and calls for a ten-year unspecified "fix" for the Medicare physician payment formula without determining how to pay for the fix. Democrats planned to offer 21 amendments to the proposal, all of which were defeated in party-line votes. Among the amendments defeated were efforts to reverse the Medicare cuts and to provide NIH with $1.6 billion more funding.

The measure is scheduled to be considered by the House of Representatives next week.

4. SENATE CLEARS 1099 REPORTING REPEAL FOR OBAMA'S SIGNATURE

The Senate voted on Tuesday, April 5 to repeal the *Affordable Care Act's* provision requiring businesses to file 1099 tax forms for purchases over $600. The 87 to12 vote on the *Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act* (HR 4) that passed the House on March 3. President Obama is expected to sign it.

5. MedPAC RECOMMENDS ELIMINATING MEDICARE SGR FORMULA

The Medicare Payment Advisory Commission on Thursday, April 7, called for eliminating the sustainable growth rate (SGR) formula used to set payment rates for physicians. Concerned about finding appropriate offsets for the $300 billion-plus cost of removing the formula. MedPAC Commissioners Ronald Castellanos and Bruce Stuart said lawmakers should write off the cost and add it to the national debt. They said ending the formula without an offset would be less costly than continuing to enact temporary payment fixes when the formula calls for lowering physician reimbursement.

Commissioners said that physicians must accept trade-offs in exchange for eliminating the SGR. For example, they recommended that physicians accept an extended period of very small pay increases. In addition, MedPAC Vice Chair Robert Berenson said that limits could be set on the growth of certain services and that payments could be reduced in a particular treatment area if the limits are exceeded. Commissioners also suggested establishing spending targets in high-volume regions of the U.S. and withholding a portion of payments until certain targets are met.

6. HOUSE COMMITTEE VOTES TO REPEAL HEALTH REFORM PROVISIONS

On Tuesday, April 5, the House Energy and Commerce Committee approved several bills to repeal or revise provisions of the *Affordable Care Act* (ACA). The bill to repeal the mandatory funding of the Prevention and Public Health Fund (HR 1217) passed on a vote of 26 to 16. The Committee also approved, 21-14, a bill (HR 1216) to strip the entitlement funding from the Teaching Health Center graduate medical education programs. AAFP and Council on Academic Family Medicine sent a letter on Wednesday, March 30 to members of the Energy and Commerce Committee expressing our opposition to HR 1216 and HR 1217. The Committee also approved, 31-20, a bill sponsored by Rep. Fred Upton (R-MI) to repeal mandatory funding under the 2010 health care law for state insurance exchanges (HR 1213). The Democrats offered amendments to each of the measures, but all were rejected.

7. REGULATORY BRIEFS

- On March 31, the Centers for Medicare & Medicaid Services released a report announcing that the Early Retiree Reinsurance Program (ERRP) provided more than 1,300 employers across all 50 states with nearly $1.8 billion in reimbursements. Due to the widespread participation, CMS also announced the ERRP program will no longer be accepting applications after May 5, 2011, consistent with the law's guidance based on the availability of funding.
- On April 1, the Food and Drug Administration released two proposed regulations regarding calorie labeling on menus and menu boards, one for chain restaurants with 20 or more locations and the second for vending machine operators with 20 or more machines. Comments on both regulations are due in early July and the FDA indicated plans to issue final rules before the end of 2011. In an October 2010 letter, the AAFP urged the Food and Drug Administration to implement and begin prompt enforcement of these requirements as a way to help improve patients" knowledge of nutritional choices and help address the prevalence of obesity in the United States.
- On April 4, the Center for Medicare & Medicaid Services released final payment policies for the 2012 Medicare Advantage (Part C) and Medicare prescription drug (Part D) plans. 2012 Medicare Advantage plans will see an average net 0.4 percent increase in federal reimbursements. In the press release, CMS indicates the policy changes "will help hold insurance companies accountable, improve the quality of care, and ensure Medicare Advantage and Part D plans remains affordable."
- On April 6, Centers for Medicare & Medicaid Services announced a website dedicated to the Medicare Shared Savings Program: Accountable Care Organizations. It can be accessed at http://www.cms.gov/sharedsavingsprogram.
- Also on April 6, the Centers for Medicare & Medicaid Services announced revised data on the Hospital Compare website. For more than 4,700 hospitals, the agency posted hospital acquired condition data collected between October 2008 and June 2010. It is not adjusted for hospitals' patient populations or case-mix.
- On April 14 from 2:30-3:30 pm ET, the Centers for Medicare & Medicaid Services will host a free national conference call on the 2011 Physician Quality Reporting System and E-Prescribing Incentive programs. This call will focus on physician reporting success stories and will include AAFP member Dr. Michael O'Dell, a family physician with Truman Medical Centers in Kansas City, MO. To participate, dial 1-800-837-1935 and reference conference number 44767416.
- On April 19 from 1:30 – 3p ET, the Centers for Medicare & Medicaid Services will host a free national provider conference call on the 2011 Physician Quality Reporting System and Electronic Prescribing Incentive Program. A slide presentation will be posted prior to the call and registration is required before April 18.

8. FamMedPAC LISTS FIRST-QUARTER DONATION TOTALS BY STATE

Continuing the tradition of friendly competition, FamMedPAC is tracking by state the donations it receives from members. Below is the list of the top 10 states for donation totals and percentage of members donating to the PAC. Chapter Champions, AAFP Board members, and PAC Board members continue to promote the PAC as they attend Chapter meetings across the country.

11-12 Total Donations Ranking:
(1) Tennessee: $20,770.00
(2) Texas: $12,791.00
(3) Washington: $11,720.00
(4) Florida: $6,857.50

(5) South Dakota: $6,790.00
(6) North Carolina: $5,985.00
(7) Oklahoma: $4,876.50
(8) California: $4,870.00
(9) Pennsylvania: $4,410.00
(10) Massachusetts: $3,700.00

11 – 12 Chapter Percentage Ranking:
(1) South Dakota: 4.65%
(2) Connecticut 1.55%
(3) Hawaii: 1.15%
(4) New Mexico: 0.98%
(5) Massachusetts: 0.85%
(6) Alabama: 0.84%
(7) Delaware: 0.82%
(8) Washington: 0.80%
(9) Oklahoma: 0.74%
(10) District of Columbia: 0.70%

The first-quarter PAC Report is now available on the PAC web site: April 2011 PAC Report

IF YOU HAVE NOT YET RENEWED YOUR COMMITMENT TO FamMedPAC FOR 2011, PLEASE CLICK ON FamMedPAC Donation

9. WASHINGTON AFP TESTIFIES IN SUPPORT OF IMMUNIZATION BILL

Both chambers of the Washington state legislature approved a measure (SB 5005) requiring parents who want to exempt their child from school immunization requirements to sign and submit a form to the school district. The form must cite either medical, religious, or personal objections and must include a statement, signed by a health care provider—a licensed physician, naturopath, physician assistant, or advanced registered nurse practitioner—that the parent or guardian has been informed of the benefits and risks of the immunization to the child. The Senate is considering House amendments that added provisions to: (1) provide liability protection for providers who sign such forms; (2) allow providers to sign forms at any time before a child's enrollment; (3) allows for photocopies of the signed form; and (4) exempt parents who site religious reasons if they belong to a church with teachings that preclude a health professional from providing medical treatment to the child. Steve Albrecht, MD, President of the **Washington Academy of Family Physicians** and family physician Anthony Chen, MD, MPH testified in support of the measure.

10. ADJOURNING STATE LEGISLATURES ENACT HEALTH BILLS

Prior to adjourning on April 1, the Arkansas General Assembly enacted the following measures.

- HB 1905 – establishes the Arkansas Office of Health Information Technology, authorizing it to form the State Health Alliance for Records Exchange to promote efficient and effective communication among physicians, payers, pharmacies and labs and to eliminate redundancy and reduce administrative and billing costs.
- SB 65 – directs the Department of Human Services to increase eligibility for ARKids programs to 19 years of age, improve retention of coverage within the programs, and simplify and streamline the renewal process.

- SB 958 – creates an interim study on cultural competence that includes examining health disparities, equity factors in health systems, and culturally and linguistically competent care supported by policy, administration and practice.

Following the recent adjournment of the South Dakota Legislature, Governor Dennis Daugaard (R) signed a myriad of measures, including:

- HB 1246 –makes an appropriation to reimburse those who meet the requirements of the physician tuition reimbursement program.
- SB 38 – establishes network adequacy standards, quality assessment and improvement requirements, utilization review and benefit determination requirements, and grievance procedures for managed health care plans.
- SB149 – prohibits student athletes from returning to athletic activities until they no longer exhibit signs consistent with a concussion and receive evaluation by a licensed health provider trained in the evaluation and management of concussions.

Virginia Governor Bob McDonnell (R) recently signed a number of bills, including:

- HB 1459 / SB 771 – increases from $2 million to $2.05 million, on July 1, 2012, the cap on the recovery in actions against providers for medical malpractice; and increases the cap thereafter by $50,000 annually with the last increase on July 1, 2031. (The Governor vetoed this legislation, but the legislature voted to override the veto).
- HB 1847 – repeals the requirement for the Commissioner of Health to submit an annual report on health workforce activities.
- HB 2229 – changes the requirement for assessing physicians with three medical malpractice judgments or claims in a 10-year period to affect only actively practicing physicians; changes the amount required to trigger the assessment from $10,000 to $75,000; and allows the Board of Medicine to post the number of assessments on its website, rather than by a report to the General Assembly.
- HB 2253 / SB 828 – provides an exemption for the requirement that health professionals be licensed with the applicable regulatory agency in another state in order to treat a patient being transported to or from Virginia for care.
- HB 2292 – requires that health records, disclosure of which is authorized by a patient, are available electronically to the extent authorized by federal law, except if (i) the electronic format is not reasonable without additional cost to the health care entity, (ii) the records would be subject to modification, or (iii) the integrity of the records could be compromised in an electronic format.
- HB 2434 – states that the General Assembly intends for the state to create and operate its own health benefits exchange(s) that meet the requirements of the ACA; and requests the Governor and the State Corporation Commission's Bureau of Insurance to recommend the structure and governance of the state exchange by the 2012 legislative session.