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 House and Senate are in recess until September 6.
* On Tuesday August 9 2pm – 3pm ET, CMS will hold a Physician Open Door Forum; 1-800-837-1935 and reference #68641515 to participate.

1. DEBT CEILING RAISED, SPECIAL COMMITTEE TO FIND DEFICIT REDUCTION

After a difficult month-long negotiation process, the White House and the Congress agreed to legislation to raise the debt ceiling by $900 billion over the next few months. The *Budget Control Act* (S 365, PL 112-25) calls for $917 billion in cuts to discretionary spending over the next decade. The new law postpones the next debt ceiling fight to the end of 2012 by allowing the administration to raise the debt ceiling by an additional $1.2 trillion to $1.5 trillion with offsets to be found by a special committee made up of 6 lawmakers from each chamber and each party. If the committee cannot agree by a simple majority on the required cuts or if Congress fails to pass the cuts by December 23, then across-the-board spending cuts would be automatically triggered for defense and domestic programs, including a two-percent cut in Medicare physician payments starting January 1, 2013. All Medicare providers may face cuts from either the special committee or the automatic cuts. It is unclear whether the committee will take up the Medicare SGR at all. If the committee does consider revisions to the SGR, they might offer a short-term patch (at a cost of $20 billion a year) or SGR repeal (which would cost some $300 billion over ten years). AAFP will contact the committee's members when they are named sometime around August 16 to remind them that the long-term strength of the Medicare program depends on appropriate payment for physicians and that the federal government should invest in primary care as a way to help restrain health system costs.

The *Budget Control Act* may have assisted the House Appropriations Committee's efforts to agree on a fiscal year 2012 HHS spending bill before September 30 by providing higher spending levels than the House GOP had originally planned for some spending bills. Until the Labor-HHS Appropriations Subcommittee chairman, Rep. Dennis Rehberg (R-MT), releases his bill, we cannot know whether it will protect AAFP spending priorities such as Title VII primary care training grants and National Health Service Corps scholarships and loans.

A provision in the *Budget Control Act* explicitly calls for an end to student loan interest subsidies for graduate and professional students, beginning July 1, 2012. This cut was proposed by the White House as a way to pay for the Pell Grant shortfall and included in both the House and Senate plans. Pell Grants are awarded to low-income undergraduates based on need.

2. SUMMARIES AVAILABLE ON THREE PROPOSED INSURANCE REFORM EFFORTS

On July 20, HHS released a proposed rule regarding the Consumer Operated and Oriented Plans (CO-OPs) program. The *Affordable Care Act* (ACA) included a provision to offer assistance to individuals or groups interested in establishing non-profit CO-OPs. The goal of the provision is to have at least one in each state, with each becoming a "qualified health plan" eligible for purchase on the state exchanges. The ACA also provides loans to new, non-profit, member-run health insurance cooperatives to help cover start-up costs and solvency requirements. Health insurers and all units of government (federal, state and local) are barred from sponsoring or operating CO-OPs. Chapters or family physicians, singly or in groups, could potentially sponsor the creation of a CO-OP. The AAFP created a summary of the proposed rule and likely will submit comments on this regulation prior to September 16.

On July 11, HHS released a proposed rule on state based health insurance exchanges, which is an organization or agency that will facilitate in the purchase of health insurance coverage in the individual and small group markets. States may establish exchanges in various ways, and HHS must sign-off on state exchanges to ensure they meet the guidelines set forth in the ACA. States may choose to do nothing and let the federal government operate an exchange in the state. ACA requires plans offered on exchanges to begin coverage on January 1, 2014. For more information, review the our summary of this proposed rule.

On March 31, the Centers for Medicare & Medicaid Services released the "Medicare Shared Savings Program: Accountable Care Organization (ACO)" proposed rule. ACOs are intended to promote accountability for a patient population, coordinate items and services under Medicare Parts A and B, and encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery. The AAFP created a summary of the proposed rule and submitted related comments to CMS and separate comments to the Federal Trade Commission and U.S. Department of Justice.

3. REGULATORY BRIEFS

- In mid-July, the Centers for Medicare & Medicaid Services (CMS) posted a one page summary of Medicare Recovery Audit Contractor efforts through the end of June. Since October 2009, RACs have recouped $575.2 million in Medicare overpayments to health care providers and paid providers $109.6 million in underpayments.
- On July 29, the CMS put on display final regulations effecting 2012 payments in:
    - Skilled nursing facilities, which will receive a 11.1-percent payment reduction. Total 2012 federal payments are expected to be $3.87 billion.
    - Inpatient rehabilitation facilities that are slated to receive a 2.2-percent payment increase, receiving approximately $150 million more than in 2011.
    - Hospice facilities, which will receive a 2.5-percent increase. Estimated Medicare payments to hospices in 2012 are anticipated to increase by $10 million due to the update in the wage index data but to decrease by $90 million due to the additional 15 percent reduction due to the continue phase-out of the wage index budget neutrality adjustment factor.
- On August 1, CMS put on display the final regulation affecting 2012 payments in inpatient hospitals, which will receive a 1.1-percent increase or approximately $1.13 billion more than this year. The final rule affects 2012 Medicare payments to general acute care hospitals and long-term care hospitals for inpatient stays paid under the Inpatient Prospective Payment System (IPPS), as well as hospitals paid under the Long Term Care Hospital Prospective Payment System (LTCH PPS). Medicare payments to LTCHs in FY 2012 are projected to increase by $126 million or 2.5 percent in 2012 relative to 2011, due to a 1.8-percent increase in payment rates together with other policies adopted in the final rule.

- On August 1, HHS announced a new provision that requires new health insurance plans to cover women's preventive health services without charging copayments, coinsurance, or deductibles. Based on recommendations made by the Institute of Medicine, group and individual health policies with plan years beginning on or after August 1 are required to cover women's health preventive services without requiring co-payments, including contraception, well-woman visits, breastfeeding supplies and support, domestic violence screening, screening for gestational diabetes, human papillomavirus DNA testing for women 30 years and older, sexually transmitted infection counseling, and human immunodeficiency virus screening and counseling.
- On August 4, HHS announced that average Medicare prescription drug premiums will not increase in 2012, and that 17 million Medicare beneficiaries received preventive services in 2011, and that 900,000 Medicare beneficiaries that hit the prescription drug donut hole received a 50-percent discount.
- On Tuesday August 9 from 2pm – 3pm, CMS will conduct the Physician Open Door Forum. To participate dial 1-800-837-1935 and reference #68641515.
- On August 16 from 1:30 – 3pm ET, CMS will hold a call on the Physician Quality Reporting System & Electronic Prescribing Incentive Program. The agency will discuss the 2010 incentive payments and feedback reports for both the PQRS and the eRx programs. Registration is required. A slideshow presentation will be made available in advance of the call.
- On August 18 from 1:30 to 3pm ET, CMS will conduct a free call on the Medicare and Medicaid EHR Incentive Programs. Registration for this call is required and details will eventually be posted online.