

December 9, 2011

IN THIS REPORT...

1. House GOP Releases Tax and Jobs Bill that Increases Physician Payments by 1%
2. HHS Appropriations Measure Remains Barrier to Finalizing FY 2012 Spending Law
3. House New Democrat Coalition Releases Principles for Nation's Health Care System
4. AAFP Supports Tweaks to Medicare Enrollment and Electronic Prescribing Standards
5. AAFP Suggests Questions to HRSA Regarding Proposed Nursing Survey
6. AAFP Applauds Proposed Tricare Tobacco Cessation Program
7. Medicare to Cover Obesity Screenings by Primary Care Providers
8. FamMedPAC Closing Out Busy 2011
9. AAFP Grassroots Remain Active
10. Regulatory Briefs

NEXT WEEK IN WASHINGTON...

- * On December 13 from 2-3 pm ET, HHS will conduct a webinar on the Health Care Innovation Challenge; details below in Regulatory Briefs.
- * On December 15, the Senate Aging Committee will hold a hearing on Physician Payments by Pharmaceutical and Medical Device Industries
- * The continuing resolution funding the federal government expires on December 16; Congress likely will remain in session the following week.

1. HOUSE GOP RELEASES TAX AND JOBS BILL THAT INCREASES PHYSICIAN PAYMENTS BY 1 %

Today, the House GOP released a bill entitled *The Middle Class Tax Relief and Job Creation Act of 2011*. A summary of the health provisions can be accessed [here](#). Of keen interest to family physicians, the proposal forestalls the 27.4 percent cut to physician payment and increases them by 1 percent for 2012 and 2013. During this time, the Medicare Payment Advisory Commission, Government Accountability Office and Department of Health and Human Services (HHS) would write reports for Congress so that legislators could create a new payment system. The House Committees on Energy and Commerce, Ways and Means and the Senate Finance panel also would be directed to study the issue.

The bill contains a number of controversial provisions, including requiring the President to issue a permit for the Keystone XL pipeline within 60 days, which Mr. Obama has promised to veto. Offsets for the SGR patch including cutting exchange subsidies included in the Affordable Care Act; cutting the Prevention Fund from \$17.8 billion fund to \$8 billion; and increasing by 15 percent Medicare premiums for beneficiaries with high incomes. In addition, however, the bill requires equal payments for identical E & M services provided in hospitals and physician offices. Last, the proposal increases spending by \$300 million to allow physician-owned hospitals to open if they were under construction, but did not receive Medicare numbers by December 31,

2010. The proposal will be part of a year-end omnibus measure; on Monday, the House Rules Committee will at 5 pm to write a rule for the legislation.

2. HHS APPROPRIATIONS MEASURE REMAINS BARRIER TO FINALIZING FY 2012 SPENDING LAW

With one week left in the current stopgap spending measure or “continuing resolution” (CR), it looks likely that Congress will not be able to reach an agreement on the bill to fund the Departments of Labor, HHS and Education. The Senate’s HHS bill sought to provide level-funding for Title VII Primary Care Medicine Training Grants and continue health reform trust funds, but the House proposed to eliminate the Title VII Section 747 program and strip key funds from “Obamacare.” Five Democrats who serve on the House Labor-HHS-Education Appropriations Subcommittee, Ranking Member Rosa DeLauro (CT), Nita Lowey (NY), Jesse Jackson, Jr. (IL), Lucille Roybal-Allard (CA) and Barbara Lee (CA) circulated a Dear Colleague letter to ask “as Congress works to finalize the FY12 spending bills, we urge you to oppose the proposed cuts—and support at least level funding—for the health professions/nursing education programs.” The final bill must be filed in the House by Monday night in order to get full passage by December 16, when the current CR funding the government expires. Discussions are ongoing as of this report.

3. HOUSE NEW DEMOCRAT COALITION RELEASES PRINCIPLES FOR NATION’S HEALTH CARE SYSTEM

Meanwhile, on the other side of the aisle, the House New Democrat Coalition, considered a centrist group, released *Principles for Supporting Innovation in our Nation’s Health Care System*. The proposal recommends repealing the SGR and “providing physicians a transition period to fully adapt to new payment models,” allowing the CMS Innovation Center to speed up efforts to find alternatives to the fee-for-services system, collaborating with stakeholders, permitting the Center for Medicare and Medicaid Services (CMS) to offer different types of payment and delivery models and examine and support training of health care providers, including physicians.

Other parts of the document recommend cooperation between public and private payers, modernizing the Food and Drug Administration approval process and promoting adoption of interoperable health information technology (HIT). Specifically, the document emphasizes the need to assist small practices in purchasing HIT systems and meeting meaningful use standards.

4. AAFP SUPPORTS TWEAKS TO MEDICARE REGULATIONS

The AAFP sent CMS a [letter](#) on December 7 in response to the proposed “Medicare and Medicaid Program; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction.” This rule proposes several reforms in Medicare and Medicaid regulations that CMS identified as unnecessary, obsolete, or excessively burdensome on health care providers and beneficiaries. The AAFP specifically supported proposals that:

- Eliminate the re-enrollment bar in instances when physicians have not responded in a timely manner to requests for revalidation of enrollment or other requests for information initiated by CMS.
- Eliminate the current Medicare requirement that automatically deactivates a physician who has not submitted a Medicare claim for 12 consecutive months. Instead, CMS would temporarily deactivate rather than permanently revoke these physicians’ billing privileges.
- 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.

5. AAFP SUGGESTS QUESTIONS TO HRSA REGARDING PROPOSED NURSING SURVEY

In a [letter](#) sent December 8, the AAFP suggested multiple questions to the Health Resources and Services Administration (HRSA) in response to their proposed project entitled the “National Sample Survey of Nurse Practitioners.” The intent of the survey is to gather more reliable data on nurse practitioner practice patterns, location and scope of services provided. In the response, the AAFP agreed with HRSA that only limited data on the nurse practitioner workforce are currently available to policy makers and the health care community. AAFP emphasized continued support for effective nurse-physician interactions in clinical settings through policies that engendered cooperation in patient care and a climate of mutual respect and trust.

6. AAFP APPLAUDS PROPOSED TRICARE TOBACCO CESSATION PROGRAM

In a [letter](#) sent November 21 to the U.S. Department of Defense (DoD), the AAFP signed onto a coalition letter regarding the DoD’s proposed rule to begin tobacco cessation coverage in TRICARE, the military health insurance program. The letter congratulated the DoD on implementing a requirement that will help members of the military and their families quit smoking and urged the DoD’s Pharmacy and Therapeutics Committee to include all FDA-approved tobacco cessation medications.

7. MEDICARE TO COVER OBESITY SCREENINGS PERFORMED BY PRIMARY CARE

On November 29, CMS [announced](#) that Medicare added coverage for preventive services to reduce obesity. Screening for obesity and counseling for eligible beneficiaries by primary care providers (family medicine, internal medicine, geriatric medicine, or pediatric medicine; or nurse practitioner, clinical nurse specialist, or physician assistant) in settings such as physicians’ offices are covered under this new benefit. For a beneficiary who screens positive for obesity with a body mass index (BMI) ≥ 30 kg/m², the benefit would include one face-to-face counseling visit each week for one month and one face-to-face counseling visit every other week for an additional five months. The beneficiary could receive one face-to-face counseling visit every month for an additional six months (for a total of 12 months of counseling) if he or she had achieved a weight reduction of at least 6.6 pounds (or 3 kilograms) during the first six months of counseling. In a September 28 [letter](#), the AAFP had strongly supported this CMS proposal and discussed this announcement in a recent AAFP News Now [article](#).

8. FamMedPAC CLOSING OUT BUSY 2011

As Congress prepares to adjourn for 2011, FamMedPAC is providing year-end support to Members on key committees and in positions of leadership, and ramping up our fundraising efforts heading into the important 2012 election year. The PAC received over \$410,000 in contributions this year from more than 1,600 AAFP members, with three weeks still remaining in 2011. Our goal of raising \$1 million by the 2012 election is in reach. The PAC contributed over \$300,000 to 87 candidates and committees this year. Over the last two weeks, the PAC supported the following Members of Congress:

- **Rep. Ron Kind (D-WI)**, a Member of the Health Subcommittee of the House Ways and Means Committee.
- **Sen. Sheldon Whitehouse (D-RI)**, a Member of the Senate Health, Education, Labor and Pensions Committee.
- **Rep. Brett Guthrie (R-KY)**, a new Member of the Health Subcommittee of the House Energy and Commerce 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, whose daughter is a family physician, is running for Senate in Nevada.
- **Rep. Barbara Lee (D-CA)**, a Member of the House Appropriations Committee.

9. AAFP Grassroots Remain Active

The Family Medicine Matters campaign continues to be active. Members are still sending letters to their lawmakers, urging them to repeal the SGR and protect GME and Title VII funding. As of today, 2,384 members have sent 6,031 letters. Last Monday, the Products and Services email linked to the campaign web page, leading to an increase in participation.

10. Regulatory Briefs

- On November 14, CMS [released](#) a notice that announced a new application deadline for the Advance Payment Model for certain accountable care organizations participating in the Medicare Shared Savings Program scheduled to begin in 2012. Applications for the performance period beginning on April 1, 2012 will be accepted from January 3, 2012 through February 1, 2012.
- On November 17, CMS posted [revised frequently asked questions](#) regarding the Primary Care Incentive Program.
- On November 17, the HHS announced that the Medicaid Electronic Health Record incentive [program](#) launched in Arkansas, Delaware, Montana, New Jersey, New York, and North Dakota.
- On November 18, HHS [announced](#) an expanded website intended to give small business owners the ability to review health insurance plan choices.
- On November 18, the CMS Innovation Center announced the [first round of awards](#) for the Community-Based Care Transitions Program ([CCTP](#)), which aims to reduce hospital readmissions, test sustainable funding streams for care transition services, maintain or improve quality of care, and document measureable savings to the Medicare program. Awards went to seven community-based organizations. The CCTP is authorized to spend up to \$500 million through 2015. CMS continues to accept applications as funding permits.
- On November 22, CMS reminded primary care physicians and non-physician practitioners that they may confirm their 2012 Primary Care Incentive Payment eligibility by identifying their NPI on their contractor [websites](#).
- On November 22, HHS awarded \$9 million to help expand 52 Senior Medicare Patrol (SMP) programs continue fighting Medicare fraud. The SMP program is operated by the Administration on Aging (AoA) in close partnership with CMS and the HHS Office of Inspector General. A list of the grants awarded to each SMP may be found [online](#). Further information about the SMP program can be accessed on the [AoA website](#).
- On November 28, CMS published the permanent version of the [final 2012 Medicare physician fee schedule](#). In early November, the AAFP created a [summary](#) of this important regulation for members.
- On November 29, HHS awarded nearly \$220 million in [grants](#) to 13 states to help them create [Exchanges](#). States receiving these funds include: Alabama, Arizona, Delaware, Hawaii, Idaho, Iowa, Maine, Michigan, Nebraska, New Mexico, Rhode Island, Tennessee, and Vermont. HHS also released several [FAQs](#) providing states answers to questions so they can work to set up these new marketplaces. Including these awards, 29 states are making progress in creating Affordable Insurance Exchanges.
- On December 5 from 2pm – 3:30pm ET, CMS will conduct a national conference call on Medicare's recently announced [Prepayment Review and Prior Authorization Demonstration Project for Power Mobility Devices](#). To participate, dial 1-866-501-5502 and use conference ID 29845811.
- On December 20 from 1:30p – 3pm, CMS will hold a national conference call on the Physician Quality Reporting System & Electronic Prescribing Incentive Program. [Registration](#) is required.

- On November 30, HHS [announced](#) a delay until October 1, 2013 (fiscal year 2014) the proposed start of Stage 2 meaningful use requirements under the Medicare electronic health record incentive program. Stage 2 was scheduled to begin on October 1, 2012.
- On November 30, CMS [announced](#) the bidding timeline for Round 2 and the national mail-order competitions of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding [Program](#).
- On December 2, CMS put on display a [final rule](#) regarding the medical loss ratio requirements for health insurers. This regulation becomes effective January 1, 2012. According to the CMS [press release](#), the final rule addresses technical issues involved in the way insurers calculate and report their MLR and the mechanism for distributing rebates to enrollees in group health plans. Of particular interest to physicians, CMS will allow part of a health plan's ICD-10 conversion costs to be considered as quality improvement activities.
- On December 5, CMS [issued](#) the final rule regarding the Availability of Medicare Data for Performance Measurement. Beginning in 2012, the Affordable Care Act requires HHS to provide standardized extracts of Medicare Parts A, B and D claims data to qualified entities on request. CMS estimates the average cost for a qualified entity for the first year of the program will be \$40,000, compared to the \$200,000 estimate from the proposed rule. CMS estimates 25 qualified entities will request data for an average of 2.5 million beneficiaries. The rule requires the qualified entities to confidentially share measures, measurement methodologies and measure results with providers and suppliers at least 60 calendar days prior to making measurement results public, compared to 30 business days in the proposed rule.
- On December 6, CMS [released](#) updated statistics on Medicare beneficiary use of preventive services. Up to that date, 2.65 three million people with Medicare received discounts on prescription drugs and more than 24.2 million received free preventive care. To compare previous releases, CMS had announced:
 - August 4: 17 million beneficiaries used preventive services, and 900,000 received Part D assistance.
 - September 8: 18.9 million beneficiaries use preventive services, and 1.3 million received Part D assistance.
 - October 6: 20.5 million beneficiaries used preventive services, and 1.8 million received Part D assistance.
 - November 4: 22.6 million beneficiaries used preventive services, and 2.2 million received Part D assistance.
- On December 7, the HHS Secretary issued a [statement](#) regarding the emergency contraceptive Plan B One-Step. It is currently labeled over the counter to women ages 17 years and older and is available by prescription only to women 16 years and younger. The FDA received an application to make Plan B One-Step available over the counter for all girls of reproductive age. HHS acknowledged that the science confirms the drug to be safe and effective with appropriate use. However, the switch from prescription to over-the-counter for this product requires that HHS have enough evidence to show that those who use this medicine can understand the label and use the product appropriately. In her statement, Secretary Sebelius indicated that she does not believe enough data was presented to support the application to make Plan B One-Step available over the counter for all girls of reproductive age.
- On December 13 from 2-3 pm ET, HHS will conduct a webinar on the Health Care Innovation Challenge, an initiative designed to test creative ways to deliver high quality medical care and reduce costs across the country. Another webinar is scheduled for 2-3pm ET on December 19. Click [here](#) to participate in this webinar or dial 877-261-8937 and enter code 31613148#.

- The Centers for Disease Control and Prevention (CDC) [announced](#) a series of webinars regarding the National Healthy Worksite Program, which is an initiative to establish and evaluate comprehensive workplace health programs to improve the health of workers and their families. Registration is required for each webinar, all times EST:
 - [December 20, 2–3 pm](#);
 - [January 13, 12–1 pm](#);
 - [January 20, 12–1 pm](#); and
 - [January 20, 3–4 pm](#).
- On December 21, CMS will host a national conference call titled, “Payment Standardization and Risk Adjustment for the Medicare Physician Feedback and Value Modifier Programs.” As discussed in the final 2012 Medicare physician fee schedule (MPFS), CMS provides confidential feedback reports to physicians and physician group practices about the resource use and quality of care they provide to their Medicare patients. Section 3007 of the Affordable Care Act requires CMS to apply a Value Modifier, which compares the quality of care furnished to the cost of that care, to physician payment rates under the MPFS starting with specific physicians and physician groups in 2015 and expanding to all physicians by 2017. [Registration](#) is required.
- Before December 27, CMS is accepting nominations for potential members to join the recently renamed Hospital Outpatient Panel (formally known as the Advisory Panel on Ambulatory Payment Groups). Membership has been expanded to 19 seats and CMS seeks 6 new members. More information on the application process can be found [online](#).
- On January 24 from 9-5p ET in Washington, DC, the Office of Minority Health within HHS will hold their [Meeting of the Advisory Committee on Minority Health](#). This meeting is open to the public, but preregistration is required.