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 of Representatives is in recess in anticipation of the Independence Day holidays.
* On Tuesday, June 28, the Partnership for Medicaid will conduct a briefing for Congressional staff on the state of Medicaid. AAFP Board Member, Dr. Conrad Flick, will discuss the North Carolina Medicaid program (NC Community Care).
* On Tuesday June 28, CMS will hold the Physicians Open Door Forum conference call, details in regulatory briefs

1. AAFP URGES DEBT CEILING PANEL TO MAKE PRIMARY CARE A TOP PRIORITY

The AAFP called on Congress and the White House to reform Medicare physician payment and increase the family physician workforce to reduce the federal deficit in a letter sent on June 20. Vice President Joe Biden and a bipartisan, bicameral group of lawmakers have been negotiating a plan to address the deficit as the federal debt ceiling deadline approaches, although the future of this group is in doubt with the abrupt departure on June 23 of the House Majority Leader, Rep. Eric Cantor (R-VA). The letter argues that reducing health care costs requires making primary care physicians more foundational to health care delivery. To do so, it urged the group to support a fee schedule that includes a payment rate for primary care services delivered by primary care physicians that is at least 3 percent higher than payment for non-primary care. In addition, the letter recommended an increase in the Medicare Primary Care Incentive Payment and cites COGME's recommendation that the average incomes of primary care physicians "must achieve at least 70 percent of median incomes of all other physicians." The letter also supports investment in Title VII primary care training, the National Health Service Corps and comparative effectiveness research and calls for medical liability reform and student debt relief.

2. SENATE COMMITTEE HEARS ABOUT THE ECONOMICS OF HEALTH REFORM

The Senate Finance Committee convened a hearing on Thursday, June 23 on health care entitlements that featured a single panel of witnesses.

- Former HCFA administrator Bruce Vladeck (now CMS)
- Former CBO director Doug Holtz-Eakin
- Former Kentucky Governor Ernie Fletcher, MD (R)
- Massachusetts Governor Deval Patrick(D)

The witnesses debated whether the Medicare Trust Fund's solvency is a function of the country's overall economic performance, or whether it is an unsustainable drain on the federal budget. On the one hand, according to Mr. Vladeck, the US has a revenue problem, not a Medicare problem. He argued that federal revenues as a percentage of GDP are currently the lowest since before the Korean War and that Medicare solvency could be achieved without the drastic cuts proposed by the House GOP budget plan. Mr. Holtz-Eakin, on the other hand, asserted that Medicare is the most predictable crisis in the history of the US. For example, Medicare ran a cash flow deficit of $280 billion in 2010. He stated that there are greater problems ahead, since reportedly 60 percent of physicians are not taking new Medicare patients.

He advocated for changing Medicare to a private insurance program in which the federal government would subsidize the premiums at a capped rate. Such premium support would put the government on a budget and let beneficiaries know what they would get. To further control costs, states also need Medicaid block grants, for the same reasons.

The two governors debated the value of Medicaid and whether states needed the flexibility of a block grant. Gov. Patrick said states have enough flexibility with Medicaid and are not using all that is available. Massachusetts is one of three states that is currently fiscally strong—Medicaid block grants would cost Massachusetts $23 billion over ten years and that is unaffordable. The state has increased coverage and is now working on cost-containment. They are experimenting with getting away from fee-for-service. In his view, Accountable Care Organizations (ACOs) are part of the solution.

Gov. Fletcher, who was a family physician, said the emphasis must be placed on wellness and prevention. Government should provide goals, guidelines and a budget. In his view, ACOs do not provide right incentives.

3. HOUSE COMMITTEE DEBATES MEDICARE SOLVENCY

On Wednesday, June 22, the House Ways and Means Health Subcommittee conducted a hearing on the Medicare Trustees report. The two witnesses appearing were trustees Charles Blahous and Robert Reischauer. The Medicare Trustees determine whether there is an aggregate imbalance between projected program income and expenditures and if and when Trust Fund assets might be exhausted. According to the Trustees report, the HI Trust Fund is projected to be exhausted by 2024, which compares with 2029 in the 2010 report.

There are two trust funds: the Hospital Insurance [HI] Trust Fund, which is comprised of funds provided by a payroll tax, and the Supplementary Medical Insurance [SMI] Trust Fund, which is made up of premiums and general tax revenues for Part B and Part D. The general revenues level in the SMI Trust Fund is reestablished annually to match the expected costs of keeping it solvent. Financial strains on the SMI side are indicated by rising requirements of general government revenues and enrollee premiums.

Most questioning from committee members reflected the typical partisan messaging that prevails in the 112th Congress. Specifically, the Democratic members emphasized that the Medicare HI Trust fund is stronger because of health reform and Republican members said that health reform has undermined the Medicare program. Republicans also argued, but could not get the witnesses to agree, that the Medicare changes reflected in the House GOP budget resolution is a "premium support" program and not a "voucher" system.

Several Democrats pointed out (and witnesses agreed) that the Trustees' solvency reports historically mirror the economic strength of the country. Republicans erroneously complained that the Trust Fund report does not consider the SGR issue and that it would be insolvent sooner if it did. The Trustees pointed out that SGR is part of Part B and therefore part of the SMI Trust Fund and not integral to the HI Trust Fund solvency report. Republicans also argued that medical liability reform would create considerable savings for the Medicare program. Dr. Reischauer pointed out that a number of studies have demonstrated that professional liability problems do not represent a huge cost driver, but agreed that reform would help in slowing the rate of growth in Medicare expenditures.

4. HOUSE COMMITTEE CONSIDERS IMPROVING CARE FOR "DUAL ELIGIBLES"

On June 21, the House Energy and Commerce Subcommittee on Health held a hearing entitled, "Dual-Eligibles: Understanding This Vulnerable Population and How to Improve Their Care." Witnesses included representatives from CMS, the Texas Health and Human Services Commission and Community Care of North Carolina. The goal of the hearing was to discuss how to improve care for these sick and elderly patients. The CMS representative described the efforts of the newly established Medicare-Medicaid Coordination Office, while the representatives from Texas and North Carolina talked about their individual state programs.

5. MEDICARE BEGINS PREVENTION CAMPAIGN

On June 20, the Centers for Medicare & Medicaid Services (CMS) released a report on Medicare beneficiary utilization of prevention benefits and launched the Share the News, Share the Health educational campaign designed to increase physician and beneficiary awareness of the preventive services offered by Medicare. In the report, CMS indicates that 5.5 million traditional Medicare beneficiaries (1 out of 6) received one or more of Medicare's preventive benefits this year. Over 2.3 million beneficiaries received a screening mammogram, 1.5 million received a bone mass measurement, and 780,000 have received an annual wellness visit. The *Affordable Care Act* eliminated Part B coinsurance and deductibles for certain recommended preventive services and added the Annual Wellness Visit.

6. AAFP COMMENTS ON PROPOSED INFLUENZA VACCINATION STANDARDS

On June 20, the AAFP sent a formal comment letter to the Centers for Medicare & Medicaid Services (CMS) in response to their proposed *Medicare & Medicaid Programs; Influenza Vaccination Standard for Certain Participating Providers and Suppliers*. This proposed rule discusses policies that would require certain Medicare and Medicaid providers and suppliers to offer all patients an annual influenza vaccination, unless it is medically contraindicated or the patient or patient's surrogate declined. The AAFP concurred with the overall intent of the regulation, but urged CMS to include in the final rule a requirement that immunizations made outside of the primary care physicians' office should be, to the greatest extent possible, electronically communicated back to that physician. The AAFP also voiced concerns that CMS is significantly underestimating the time it takes to administer vaccines and that rural health clinics and federally qualified health centers could have financial difficulties complying.

7. AAFP URGES CONTINUED ACCESS TO MEDICAID FOR CHILDREN

On June 20, the AAFP joined the American Academy of Pediatrics, the American Medical Association and other national and local organizations committed to ensuring children have

access to healthcare services in a coalition letter to the Health & Human Services Secretary in response to the proposed *Methods for Assuring Access to Covered Medicaid Services.* The AAFP is currently preparing more extensive comments to this regulation to submit before the comment period ends on July 5.

8. AAFP ENCOURAGES REVIEW OF PHYSICIAN SIGNATURE REQUIREMENTS

In a letter sent June 23, the AAFP encouraged CMS to reevaluate its Medicare signature requirements. The AAFP stated that the current signature requirements place an overwhelming compliance burden on physicians, are unnecessarily time-consuming for physicians and their practice support staff, and that CMS should develop a comprehensive yet understandable policy. This letter stems from Resolution #311 adopted by the 2010 Congress of Delegates.

9. AAFP SUGGESTS ELIMINATION OF 3 DAY HOSPITALIZATION REQUIREMENT

The AAFP sent a letter to the CMS Innovation Center urging the elimination of the 72-hour hospitalization requirement prior to skilled nursing home placement for Medicare beneficiaries. The AAFP stated that the hospitalization requirement for Medicare beneficiaries wastes valuable resources and that the AAFP believes this arbitrary waiting period is not in the best interest of the beneficiary's medical needs, nor is it in alignment with CMS' goal to reduce avoidable hospitalizations. This letter stems from Resolution #511 adopted by the 2010 Congress of Delegates.

10. REGULATORY BRIEFS

- On June 22, the U.S. Department of Health and Human Services announced up to $500 million in Affordable Care Act funding will be awarded to help hospitals, healthcare provider organizations and others improve care and stop millions of preventable injuries and complications related to healthcare acquired conditions and unnecessary readmissions. Solicitations for proposals are available on the Federal Business Opportunities website.
- On Tuesday, June 28, 2011 from 2pm - 3pm ET, the Centers for Medicare & Medicaid Services will conduct the next "Physicians Open Door Forum" conference call. CMS is expected to discuss claims reprocessing, physician practices displaced due to flooding in Missouri, the advanced beneficiary notice, the advanced diagnostic imaging program, and the electronic prescribing incentive program. To participate dial 1-800-837-1935 and reference ID 59680265.

11. FAMMEDPAC MEETS WITH KEY CONGRESSIONAL LEADERS

Several important lawmakers heard from family medicine this week, thanks to FamMedPAC. The debt ceiling talks, increased support for primary care, the looming cuts in Medicare physician payments under the SGR formula, funding for Title VII programs, and implementation of the *Affordable Care Act* were discussed at six different PAC events. The PAC participated in meetings with the following Congressional legislators:

- **Rep. Pat Tiberi (R-OH)**, who serves on the House Ways and Means Committee.
- **Rep. Michael Burgess (R-TX)**, who is a physician on the Health Subcommittee of the House Energy and Commerce Committee.
- **Rep. Kevin Yoder (R-KS)**, a freshman Representative whose district includes Leawood, Kansas, the location of the AAFP headquarters. Rep. Yoder serves on the House Appropriations Committee.
- **Sen. Orrin Hatch (R-UT)**, the Ranking Republican on the Health Subcommittee of the Senate Finance Committee.
- **Rep. Eric Cantor (R-VA)**, the Majority Leader of the House. The luncheon meeting took place just after Rep. Cantor announced he no longer was participating in the debt

ceiling/deficit reduction talks headed by Vice President Biden. Rep. Cantor made the point that the SGR would not be part of any deficit reduction legislation.

- **Rep. Bill Owens (D-NY)**, a second term Representative from up-state New York. New York AFP Executive Director Vito Grasso is meeting with Rep. Owens next week to deliver the PAC check.

The PAC participated in a meeting with the Republican Senate Campaign Committee (RSCC) to consider how the RSCC could hear from physicians on health reform.

12. MINNESOTA AFP HELPS DEFEAT LEGISLATION

As the 2011 session wrapped up, the **Minnesota Academy of Family Physicians** celebrated defeat of several measures that it opposed.

- HF 188 would have exempted bars from the clean indoor air requirements. It would have allowed smoking in bars that are completely separated from restaurants by walls and closable doors. The bill never received a hearing.
- HF 1553 would have repealed Minnesota law that allows minors to receive health care for mental health, chemical dependency, and reproductive health without needing parental consent. This has been law in Minnesota since 1974.
- SF 1017 would have modified the state's newborn screening law to prohibit the Department of Health from keeping any blood samples for more than 24 months, and then only if the parent agreed with keeping it at all. This would have put the testing labs out of compliance with federal CLIA laws and would have ended the state's newborn screening registry. The bill was originally included in the omnibus HHS budget bill, but was eventually removed because of opposition.