AAFP
STRONG MEDICINE FOR AMERICA

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NEXT WEEK IN WASHINGTON…

* November 15 is the deadline to submit applications for the CMS Innovation Advisors Program.
* CMS will hold a call on the Medicare Shared Savings on November 15 from 1:30-3 pm ET; details in regulatory briefs.

1. DEFICIT PANEL NEGOTIATIONS INCLUDE CUTS TO MEDICARE, MEDICAID

As the November 23 deadline for producing a deficit reduction deal nears, Democrats on the Joint Select Committee have proposed $400 billion in cuts to Medicare and Medicaid spending, as part of a broader proposal to pare $2.3 trillion from the deficit over 10 years. The one-page proposal or “1 Trillion – 1 Trillion Framework” is not specific about spending cuts or revenue increases. The Medicare reforms call for $250 billion from providers and $100 billion from beneficiaries. Defense Department savings are expected to prevent the 27.4 percent Medicare provider reimbursement cut required by the SGR, but it is not clear whether this will allow for repeal, a short-term patch or something in between. The AAFP is continuing to advocate for repeal or a multi-year reprieve from the SGR.

The Medicaid savings set out in the framework include $5 billion in durable medical equipment spending cuts; $20 billion from increasing the rebate that drug companies must pay to Medicaid if a drug price rises more quickly than general inflation; $13 billion by limiting how states can tax providers to increase federal matching payments and $4 billion in savings from reducing payments to Medicaid disproportionate share hospitals.

Senator Pat Toomey (R-PA) who serves on the Committee proposed allowing for up to $300 million in net tax increases in exchange for a permanent reduction of the marginal tax rates set during the George W. Bush administration. The Toomey plan was rejected by the Democrats.

2. AAFP PRESIDENT-ELECT TAKES OUR MESSAGE TO HOUSE AND SENATE

AAFP President-Elect Jeff Cain, MD came to Washington on November 9 to meet with House and Senate offices to discuss physician payment, GME and prescription drug abuse. Dr. Cain asked that Congress repeal the SGR and include a differential payment for primary care in any transition period and that they protect primary care in the event of any cuts to GME. He also discussed the draft GME legislation, which would establish a budget-neutral pilot project to test innovative models for the use of GME for training of primary care physicians and options for addressing the prescription drug abuse problem, while stating AAFP did not support mandatory CME.

3. 2012 FINAL MEDICARE PHYSICIAN FEE SCHEDULE RELEASED

On July 1, the Centers for Medicare & Medicaid Services (CMS) released the proposed 2012 Medicare Physician Fee Schedule. This regulation addresses changes to the physician fee schedule and other Medicare Part B payment policies, implements certain provisions of the *Affordable Care Act* of 2010 (ACA) and the *Medicare Improvements for Patients and Providers Act* of 2008 (MIPPA). It also discusses payments for Part B drugs, the 2012 Physician Quality Reporting System (PQRS), the Electronic Prescribing (eRx) Incentive Program, the Physician Resource-Use Feedback Program, and implementation of the value-based payment modifier. In July, the AAFP prepared an extensive summary of this proposal. On August 29, the AAFP sent CMS a formal comment letter in response to the proposal.

On November 1, CMS released the final 2012 Medicare Physician Fee Schedule. CMS projects that total payments made under the 2012 fee schedule will be approximately $80 billion. The *Medicare and Medicaid Extenders Act* of 2010 provided for a 1-year zero percent update resulting in the 2011 conversion factor currently being $33.9764. Since this 1-year extension expires at the end of 2011, CMS estimated earlier this year that the statutory formula used to determine Medicare physician payments would result in a decrease of 29.5 percent. In the final rule, CMS updated their estimate for the conversion factor at $24.6712 which represents a decrease of 27.4 percent.

The AAFP urges Congress to prevent these drastic payment cuts and to end the practice of enacting retroactive “fixes.” In a statement issued when the final fee schedule was released, the AAFP continued to call on the Joint Select Committee on Deficit Reduction and the Congress as a whole to stabilize Medicare payments to physicians by repealing the flawed SGR formula and specify a payment rate for the next three to five years while demonstration programs generate data to determine the best payment method. To begin closing the gaping disparity between primary care and subspecialist services, the AAFP strongly recommends that the committee stipulate at least a 3 percent higher rate for primary care physicians.

On November 7, the AAFP released a summary of the final 2012 Medicare Physician Fee Schedule. CMS discusses many important issues in the final rule. Of particular interest to family physicians is that CMS finalized policy that:

- Does not refer evaluation and management codes to the AMA/Specialty Society Relative Value Scale Update Committee (RUC) for review since the majority of commenters expressed concern, *“over the possible inadequacies of the current E&M coding and documentation structure to address evolving chronic care management and support primary care and our ongoing research on how to best provide payment for primary care and patient-centered care management.”* Instead, CMS will allow time to study the effects of the Comprehensive Primary Care Initiative, the HHS Assistant Secretary for Planning and Evaluation research on balancing physician incentives and evaluating payment for primary care services, demonstration projects on care coordination, as well as other initiatives such as the Medicare Shared Savings Program to assess how to

value and encourage primary care. CMS indicates they continue "*to welcome ideas from the medical community for how to improve care management through the provision of primary care services.*" The AAFP comments to this proposal stated that it would not be productive to ask the RUC to revalue E&M services under the same structure, procedures, and methodology that it used to establish the current values.

- Consolidates the periodic reviews of work and practice expense RVUs and of potentially misvalued codes (high expenditure and high volume) into one annual process, a proposal the AAFP supported.
- Uses two bedroom rental data as a proxy for physician office rent for purposes of calculating work GPCI values, another proposal the AAFP supported.
- Adds three tobacco use cessation codes (99406, 99407, and G0437) to the approved Medicare telehealth services list, which are additions the AAFP supported.
- Increases slightly the work RVUs associated with the Annual Wellness Visit (AWV) since CMS added a Health Risk Assessment component to the 2012 AWVs. The AAFP urged an even larger increase.
- Links the 2015 Physician Quality Reporting System (PQRS) performance "adjustment" with 2013 performance.
- Does not require internal medicine, family medicine, general practice, or cardiology physicians to report on a "PQRS core measure" targeting cardiovascular conditions. However CMS is likely to require this in future PQRS reporting periods.
- Limits participation in the PQRS Group Practice Reporting Option (GPRO) to practices with 25 or more physicians.
- Allows CMS to post online the performance rates of the quality measures for group practices that submit under the 2012 PQRS GPRO.

4. HOUSE APPROPRIATIONS COMMITTEE MEMBER REP. YODER VISITS AAFP HQ

House Freshman Rep. Kevin Yoder (R-KS), who represents Leawood, visited the AAFP headquarters at our invitation to meet with AAFP Executive Vice President Doug Henley, MD and senior staff on Tuesday, November 8. Dr. Henley provided Rep. Yoder with an overview on the AAFP and the Patient-Centered Medical Home. He explained the importance of Title VII Section 747 and the National Health Service Corps to the family medicine workforce and the need to address both the Medicare SGR and the physician compensation disparity. Rep. Yoder recognized the value of family medicine and is looking forward to including family physicians in his health care discussion groups on an ongoing basis.

5. HHS FY 2012 SPENDING BILL STYMIED

Five weeks into FY 2012, legislation to fund the Department of Health and Human Services (HHS) has stalled. Partisan differences on spending levels, as well as funding to implement the *Affordable Care Act,* make enacting a FY 2012 bill difficult. Congress is expected to pass another stopgap bill to keep HHS operating through mid-December. The current continuing resolution for FY 2012 (PL 112-36) expires November 18.

The House and Senate versions of the annual HHS appropriations bill differ dramatically in their support for key family medicine spending priorities. The House version of the FY 2012 bill to fund the departments of Labor, HHS, and Education (HR 3070) strikes $8.6 billion for the Prevention and Public Health Fund authorized by the ACA and other funds associated with implementing the health reform law. The bill includes $153.4 billion in discretionary funding, which is $4 billion (2.5 percent) below the FY 2011 enacted level, and $600 million less than the Senate's FY 2012 bill (S 1599).

Title VII health professions programs would be cut drastically by HR 3070 which provides $87.5 million for all of the programs within Title VII or a $185 million (67.9 percent) cut from the FY

2011 funding level. It eliminates funding for the Primary Care Medicine grants (Section 747) as well as several other Title VII health professions education programs, including the Health Careers Opportunity Program (HCOP), Scholarships for Disadvantaged Students, Area Health Education Centers, and the allied health programs. The Senate Committee-passed bill provides level-funding for Title VII Section 747.

Family medicine organized a November 4 letter to the House of Representatives urging them to restore the Title VII Section 747 funding in the final FY 2012. The letter was signed by 15 primary care organizations. AAFP also signed the letter circulated by the Health Professions and Nursing Education Coalition (HPNEC).

The National Health Service Corps is also targeted for cuts in the House bill which eliminates $295 million in FY 2012 from the NHSC Fund created by the ACA. The House bill provides the NHSC with $142 million FY 2012, a $173 million (55 percent) cut below FY 2011. The Senate FY 2012 bill would provide the NHSC with $315 million. The Agency for Healthcare Research and Quality (AHRQ) would be cut by $47.8 million or 12.8 percent in the House bill to $324.3 million while the Senate would provide level funding.

6. AAFP SUPPORTS PATIENT'S ACCESS TO CLINICAL LAB RESULTS

In a letter sent November 9, the AAFP supported the CMS proposal that amends Clinical Laboratory Improvement Amendments (CLIA) and Health Insurance Portability and Accountability Act (HIPAA) regulations to specify that, upon a patient's request, the laboratory may provide access to completed test reports.

The AAFP supported these proposals despite a concern over possible instances in which a patient is not able to comprehend the test reports. In the comment letter, the AAFP stated that laboratory results are an integral part of the physician's diagnosis process and interpreting the results is the responsibility of the ordering physician. The majority of patients are not trained to interpret their results. However, the AAFP believes that all patients have the right to access their personal health information as doing so is more patient-centered since access to these results increases the patient's level of engagement and responsibility.

As a way to minimize potential patient confusion, the AAFP suggested working with stakeholders to develop a standardized statement that would be provided with the lab results to the patient. This statement would include an explanation that the clinical lab results are subject to a physician's interpretation and also include contact information regarding the physician who ordered the tests.

7. CMS ADDS TWO NEW PREVENTIVE SERVICES VISITS

On November 8, the Centers for Medicare & Medicaid Services (CMS) expanded coverage by adding two separate preventive services for Medicare beneficiaries. Under the first coverage decision, CMS will cover one face-to-face visit each year to allow patients and their providers (general practitioner, family practice practitioner, general internist, obstetrician, gynecologist or nurse practitioner, clinical nurse specialist, or physician assistant) to determine the best way to help prevent cardiovascular disease. The visit must be furnished in settings such as physicians' offices. During these visits, providers may screen for hypertension and promote a healthy diet as part of an overall initiative to reduce the burden of cardiovascular disease in the United States. This coverage decision reinforces CMS' commitment to the work of the Million Hearts initiative.

CMS also finalized a national coverage determination (NCD) on screening for sexually transmitted infections (STIs) and high-intensity behavioral counseling for the prevention of STIs for individuals at increased risk for such infections. The counseling component will include up to

two counseling sessions per year, furnished by a primary care practitioner defined for purposes of this NCD as a physician of family medicine, internal medicine, geriatric medicine, or pediatric medicine or a nurse practitioner, clinical nurse specialist, or physician assistant.

8. CMS RELEASES SEVERAL OTHER FINAL 2012 PAYMENT RULES

On October 31 and November 1, the Centers for Medicare & Medicaid Services (CMS) released 3 additional final regulations that implement payment policies in 2012. CMS finalized 2012 Medicare payment policies for:

- Home health - Payments to home health agencies (HHAs) are estimated to decrease by approximately 2.31 percent or $430 million in 2012, the net effect of a 1.4 percent payment update, the wage index update, and the case-mix coding adjustment. CMS finalized an additional 1.32 percent reduction for 2013.
- Dialysis Facilities – Payments to entities paid under the End Stage Renal Disease (ESRD) Prospective Payment System (PPS) will increase by 2.1 percent in 2012. The final rule also contains incentives for improved quality of care and better outcomes for beneficiaries diagnosed with ESRD through improvements to the ESRD Quality Incentive Program (QIP). This final rule also:
  - Extends certain payment rate increases for ground ambulance services and certain rural area designations for purposes of air ambulance payment; and
  - Establishes a minimum lifetime requirement for equipment to be considered "durable" for purposes of coverage as durable medical equipment.
- Hospital Outpatient Departments (HOPDs) and Ambulatory Surgical Centers – Payment rates will increase under the Outpatient Prospective Payment System by 1.9 percent in 2012 while rates to ASCs increase by 1.6 percent in 2012. The final rule also establishes a quality reporting program for ASCs, establishes an independent advisory review process to consider requests that specific outpatient services be subject to a level of supervision other than direct supervision, and expands the measures to be reported under the Hospital Outpatient Quality Reporting Program.

9. SENATE HELP PANEL EXPLORES HEALTHCARE DELIVERY REFORM

On November 10, the Senate HELP Committee held a hearing *entitled Improving Quality, Lowering Costs: The Role of Health Care Delivery System Reform.* The chief witness was Jonathan Blum, Deputy Administrator and Director of CMS. He described, in detail, each program established by the Affordable Care Act that would improve healthcare delivery reform, including the Comprehensive Primary Care Initiative. His statement in support of the CMS Innovation Center projects was in contrast to a letter sent this week to HHS Secretary Sebelius by Sens. Michael Enzi (R-WY), Tom Coburn (R-OK) and Orrin Hatch (R-UT), which expressed concern that the $10 billion in funds for the center were being spent with "little or no value provided."

The second panel included Chris Koller, Commissioner, Office of the Health Insurance Commissioner, RI; Gary Kaplan, MD, Chairman and CEO, Virginia Mason Medical Center; Seattle, WA; Greg Poulsen, Senior Vice President and Chief Strategy Officer, Intermountain Healthcare; and Mark Fendrick, MD , Professor, Department of Internal Medicine and Department of Health Management and Policy, University of Michigan, and Co-Director, University of Michigan Center for Value-Based Insurance Design. All described their research or efforts to improve healthcare delivery. Of particular interest to family medicine, Commissioner Koller spoke at length about the importance of primary care to better health. He also strongly urged the committee to "invest in primary care."

The AAFP distributed a copy of our statement for the record at the hearing. In addition to our own press release saying that "Primary care enhances the performance of health care systems. It is not the solution to every health-related problem, but few, if any, health-related problems can

be adequately addressed absent excellent primary care," we also released a joint press statement with ACP and the AOA.

10. FAMMEDPAC SUPPORTS KEY CALIFORNIA SENATOR

FamMedPAC attended a small reception in Washington this week for **Senator Diane Feinstein (D-CA),** a member of the Senate Appropriations Committee. AAFP is working with the Senator to preserve funding for Title VII primary care training programs in the ongoing budget debate.

11. REGULATORY BRIEFS

- On October 27, the Agency for Healthcare Research & Quality awarded $4.5 million in grants to establish Research Centers for Excellence in Clinical Preventive Services at three universities (Northwestern University in Chicago, the University of North Carolina at Chapel Hill, and the University of Colorado Anschutz Medical Campus in Aurora). Research at the centers will focus on health equity in the use of clinical preventive services, understanding risks and harms associated with clinical preventives services, and how primary care practices, public health resources and the larger health care system can improve the delivery of evidence-based clinical preventive services.
- In a letter sent October 31 to HHS, the AAFP joined others in response to the proposed "Establishment of Exchanges and Qualified Health Plans". This letter is in addition to the AAFP only comment letter sent September 28.
- On October 31, the HHS Office of Minority Health released final standards for data collection on race, ethnicity, sex, primary language and disability status, as required by the *Affordable Care Act*. The standards apply to population health surveys sponsored by HHS, where respondents either self-report information or a knowledgeable person responds for all members of a household. HHS will implement the standards in all new surveys and at the time of major revisions to current surveys. Proposed standards were published in June. The agency plans to integrate questions on sexual orientation and gender identity into national data collection efforts by 2013.
- On October 31, President Obama signed an executive order designed to combat drug shortages. The order asks the FDA and the Department of Justice to work more closely with drug makers so officials know in advance when production problems or discontinuations will cause shortages. As part of this effort, the Administration sent a letter to drug manufacturers reminding them of their legal responsibility to report the discontinuation of certain drugs to the FDA. The Administration also released a report from the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) that assesses the underlying factors that lead to drug shortages.
- On November 1, the Negotiated Rulemaking Committee on Designation of Medically Underserved Populations and Health Professional Shortage Areas, created by the *Affordable Care Act*, issued their final report to HHS that contains recommendations regarding methodologies used to identify medically underserved areas and populations and HPSAs. HHS is not bound by the report but could recommendations to draft regulations.
- On November 2, the Centers for Disease Control and Prevention published a notice containing a list of potentially life-threatening infectious diseases, including emerging infectious diseases, to which emergency response employees may be exposed in responding to emergencies, guidelines describing circumstances in which employees may be exposed to these diseases, and guidelines describing the manner in which medical facilities should make determinations about exposures.
- On November 4, CMS released updated statistics on Medicare beneficiary use of preventive services. Up to that date, more than 2.2 million people with Medicare saved more than $1.2 billion on Part D prescriptions, for an average of $550 per person. More than 22.6 million beneficiaries had taken advantage of at least one free Medicare

preventive benefit, including the Annual Wellness Visit. 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 November 7, a federal judge in DC issued a preliminary injunction blocking a requirement that cigarette packaging include graphic warning images, a concept that AAFP has supported.
- On November 10, the HHS Secretary Kathleen Sebelius issued a statement regarding Veterans Day. In it, she thanks veterans for their service and highlights the administration's commitment "*to welcoming 8,000 of our veterans into the growing health care work force. Partnering with the Departments of Defense, Labor, and Veterans Affairs, we will hire these veterans to fill crucial roles as health care providers at community health centers. We will also fast-track veteran medics into jobs in community health centers and other parts of the health care system by expanding opportunities for veterans to train as physician assistants.*"
- November 15 is the deadline to submit applications for the CMS Innovation Advisors Program. CMS seeks applicants for the Innovation Advisors Program which aims to help professionals deepen skills that will drive improvements to patient care and reduce costs. Applications for the Innovation Advisors Program are available online and questions can be answered by emailing IAP@orau.org. The Innovation Advisors Program will select and develop as many as 200 individuals from across the nation in its first year. The first group of Innovation Advisors will start their six-month intensive orientation and applied research period in December 2011. Innovation advisors will be expected to commit up to 10 hours per week to the Innovation Advisor Program during the initial six months of their fellowships, with part of that time devoted to seminars and instruction. The rest of that time will be devoted to implementing the improvement project they propose in their initial application. The Innovation Advisors who are selected will meet regularly to exchange insights, report on successes and discuss common challenges. Successful applicants will receive a $20,000 stipend.
- CMS will hold a free national call on the Medicare Shared Savings on Tuesday, November 15, 2011 from 1:30-3 pm ET. CMS is expected to discuss the Medicare Accountable Care Organization final rule and the Advance Payment Model. A question and answer session will follow the presentation. Registration for this call is required.

12. GRASSROOTS EFFORTS CONTINUE TO PAY OFF

As of today, 1,503 members have sent 3,229 letters to Congress. The letters continue to ask for:

- Protection of primary care GME funding;
- Repeal of the SGR with a temporary rate for the next 3 to 5 years and a 3 percent increase for primary care;
- Appropriations of $140 million for Title VII, Section 747.

13. ARIZONA CHIROPRACTORS BACK DOWN ON SCOPE EXPANSION

You may be forgiven for thinking this headline is a repeat. Following letters of opposition from the Arizona AFP and the AAFP, Arizona chiropractors this week withdrew their application to the legislature for an expansion of their scope of practice. Prior to the October 31 hearing of the

joint interim committee charged with vetting scope expansion requests, the chiropractors backed down on their push for prescriptive authority. This follows on the heels of Arizona psychologists withdrawing their application for prescriptive authority a few days prior to the chiropractors doing so.