GOVERNMENT AFFAIRS WEEKLY

AAFP Division of Government Relations — 2021 Massachusetts Avenue, NW — Washington, DC 20036

November 18, 2011

IN THIS REPORT…

1. AAFP Supports Schwartz Bill Repealing SGR, Reforming Medicare Payment
2. Options for Dual Eligibles Examined by Medicaid Commission
3. CMS Releases Application for the Medicare Shared Savings Program
4. Three Payment Demonstration Projects Announced Targeting Improper Payments
5. Joint Letter on Health Professional Study Sent to HRSA
6. AAFP Participates in Annual Meeting on HIT
7. FamMedPAC Brings AAFP's Message to Key Legislators
8. Air Force Surgeon Promotes Tar Wars to Military Families
9. Regulatory Briefs

NEXT WEEK IN WASHINGTON…

* November 23 is the deadline for the Joint Select Committee on Deficit Reduction to pass a plan to avoid an automatic across-the-board sequester.

1. AAFP URGES PASSAGE OF SGR REPEAL, MOVE AWAY FROM FEE-FOR-SERVICE

In a statement released on November 16, the AAFP announced its support for a legislative proposal drafted by Rep. Allyson Schwartz (D-PA) to repeal the flawed Medicare Sustainable Growth Rate (SGR) formula and set out comprehensive reform of the Medicare payment system. In a letter also dated November 16, Rep. Schwartz urged members of the Joint Select Committee on Deficit Reduction and the bipartisan House and Senate leadership to support her *Medicare Physician Payment Innovation Act.* As drafted, the Schwartz proposal would repeal the SGR and stipulate payment rates for the next ten years. For several years, the payment rate for primary care services would be 2-percent higher than the rate for non-primary care services. It also would encourage physicians over time to move away from solely fee-for-service and toward new payment models, like ACOs and Patient Centered Medical Homes that include payments like care coordination fees and shared savings that are not based on fee-for-service alone. If they do not transition from fee-for-service payments, physicians' payments would decline by 2 percent in 2018 with a decrease of an additional 1 percent each year until 2021 when it would be 5 percent lower.

2. MEDICAID ADVISORY COMMISSION CONSIDERS DUAL ELIGIBLES

On November 17-18, the Medicaid and CHIP Payment and Access Commission met in Washington, DC. MACPAC is tasked with reviewing state and federal Medicaid and CHIP access and payment policies and making recommendations to Congress and the states. The Commission heard testimony from MACPAC staff, CMS, and representatives from programs in Ohio, Tennessee, Texas, and Virginia on meeting the needs of high cost and high risk populations. The discussion reflected different states' approaches to serving dual eligibles and high-cost, high-risk populations with managed care. Additional research, statistics and graphs will be published in MACPAC's March 2012 report.

3. 2012 MEDICARE SHARED SAVINGS PROGRAM APPLICATIONS NOW AVAILABLE
The Centers for Medicare & Medicaid Services recently posted the application for the 2012 Medicare Shared Savings Program (SSP), which include Accountable Care Organizations (ACO). These are due to CMS by January 20, 2011 for the April 1, 2012 start date and by March 30, 2012 for the July 1, 2012 start date. CMS also created a slide presentation discussion the application process which includes an overview of the advanced payment model application.

4. THREE CMS DEMONSTRATIONS DESIGNED TO PREVENT IMPROPER PAYMENTS
On November 15, the Centers for Medicare & Medicaid Services announced three new payment demonstration projects aimed to reduce improper payments beginning on January 1, 2012.

- Recovery Audit Prepayment Review: Allows Medicare Recovery Auditors (RACs) to conduct prepayment reviews on certain types of claims that historically result in high rates of improper payments. These reviews will focus on seven states with high populations of fraud- and error-prone providers (FL, CA, MI, TX, NY, LA, IL) and four states with high claims volumes of short inpatient hospital stays (PA, OH, NC, MO).
- Part A to Part B Rebilling: Allows hospitals to rebill for 90 percent of the Part B payment when a Medicare contractor denies a Part A inpatient short stay claim as not reasonable and necessary due to the hospital billing for the wrong setting. Currently, when outpatient services are billed as inpatient services, the entire claim is denied in full. This effort will be limited to 380 hospitals nationwide that volunteer to participate. This demonstration is expected to lower the appeals rate which will protect the trust fund and reduce hospital burden. Beneficiaries will be held harmless with respect to changes in hospital coinsurance liability.
- Prior Authorization for Certain Medical Equipment: Requires prior authorization for certain medical equipment that has a high error rate for Medicare beneficiaries residing in seven states with high populations of fraud- and error-prone providers (CA, FL, IL, MI, NY, NC and TX). This effort will be implemented in two phases. During the first phase (the first three to nine months), the Medicare Administrative Contractors will conduct prepayment reviews on certain medical equipment claims. The second phase, for the remainder of this three-year demonstration, will use prior authorization techniques.

As part of this announcement, CMS also made public the final 2011 improper pavement error rates for various programs. The 2011 error rate is:

- 8.6 percent for the original Medicare FFS program. This represents an error rate by claim type of:
  - 7.9 percent for inpatient hospitals,
  - 61 percent for durable medical equipment,
  - 9.2 percent for physician, lab, and ambulance services, and
  - 4.4 percent for non-inpatient hospital facilities.
- 8.1 percent for the Medicaid program, a drop from 9.4 percent, which was the 2010 rate.
- 3.2 percent for the Medicare Part D program. This is the first time a payment error measure will be reported for the Part D program.
- 11 percent for the Medicare Part C program, a 3 percent reduction from the 2010 Part C composite rate of 14.1 percent. This improvement is attributed to an emphasis on contract-level risk adjustment data validation audits designed to recover overpayments to Part C plans.

5. FAMILY MEDICINE COMMENTS ON HRSA DATA COLLECTION EFFORT
On November 14, the AAFP joined with the Council of Academic Family Medicine (CAFM), in a comment letter sent to the Health Resources and Services Administration in response to a proposed Performance Data Collection project that, if approved, would be conducted by their

Bureau of Health Professions which administers the Title VII health professions grants. In the letter, we applaud HRSA for proposing to streamline and update the reporting and information collection process, but suggest more needs to be done such as developing a centralized system for tracking programs' outcomes.

6. AAFP PARTICIPATES AT ANNUAL MEETING ON HIT

The Office of the National Coordinator (ONC) for Health Information held its annual meeting this week in Washington and representatives from the AAFP Center for Health Information Technology, TransforMED and Government Relations attended. The meeting drew 1200 grantees and stakeholders who listened to remarks by Aneesh Chopra, who heads the US Technology Office in the White House; Farzad Mostashari, MD, current National Coordinator for HIT at ONC; and David Blumenthal, MD, former National Coordinator. All emphasized the important strides that had been made in the HIT field and the success of most of their initiatives; e.g., 100,000 primary care providers had signed up through the regional extension centers to adopt HIT. Rick Gilfillan, MD, a family physician and Acting Director of the CMS Center for Innovation, emphasized his family medicine background and outlined the various Center initiatives. The Director of the AAFP's Center for Health Information Technology, Steven Waldren, MD, participated in a panel session on optimizing the patient-centered medical home.

Conference topics included meaningful use, privacy, e-prescribing, EHR adoption, consumer e-health, as well as the role of the regional extension centers.

7. FamMedPAC BRINGS AAFP'S MESSAGE TO KEY LEGISLATORS

Government Relations staff attended four meetins this week for key Congressional leaders. AAFP continues to urge Congress to halt the pending Medicare physician payment cuts and to replace the flawed SGR formula with payment formulas that recognize the value of primary care. Staff continues to ask the Joint Committee on Deficit Reduction to include a fix to the SGR in any proposal it brings forward. FamMedPAC participated in events for the following U.S. Representatives:

- **Rep. James Clyburn (D-SC)**, the Assistant Democratic Leader in the House and a member of the Deficit Reduction Committee, is pushing for the Super Committee to include a permanent fix to the physician payment formula.
- **Rep. Elliot Engel (D-NY)**, a member of the Health Subcommittee of the House Energy and Commerce Committee, believes the Super Committee will reach agreement on a deficit-reduction proposal.
- **Rep. Dave Camp (R-MI)**, Chair of the House Ways and Means Committee and a member of the Deficit Reduction Committee, believes it will be clear by next Monday whether or not the Deficit Reduction Committee will succeed or fail.
- **Rep. Lois Capps (D-CA)**, a member of the Health Subcommittee of the House Energy and Commerce Committee, is a primary care stalwart.

8. AIR FORCE SURGEON GENERAL PROMOTES TAR WARS TO MILITARY FAMILIES

The Surgeon General of the Air Force highlighted AAFP and Tar Wars, by name, in a memo to Air Force Medical Service clinicians urging participation in youth-based tobacco education programs. As part of the White House Initiative for Military Families, AAFP is partnering with the Defense Department to improve tobacco prevention and cessation programs for military families. Lt. General Charles B. Green urged commanders to include Tar Wars and other programs as part of the Air Force's Build Patient-Centered Care and Focus on Prevention to Optimize Health strategy.

9. REGULATORY BRIEFS

- On November 14, the Centers for Medicare & Medicaid Services (CMS) announced the Health Care Innovation Challenge. As part of this effort, up to $1 billion is available to a wide range of entities to fund compelling new models of service delivery and payment improvements that hold the promise of better health, better health care, and lower costs through improved quality for patients in Medicare, Medicaid, and Children's Health Insurance Program (CHIP). CMS will give priority to projects that can deploy care improvement models within six months of award through new ventures or expansion of existing efforts to new populations of patients, in conjunction (where possible) with other public and private sector partners.

  Letters of intent are due December 19, applications are due January 27, 2012, and awards will be announced in March 2012. Awards range from $1 million to $30 million over a three-year period. To learn more about the Health Care Innovation Challenge and information about the application process please read the Funding Opportunity Announcement. To read an overview of the Health Care Innovation Challenge, including important deadlines, CMS created a fact sheet. To submit a Letter of Intent to apply to the Health Care Innovation Challenge, visit the LOI page.

- On November 17, the U.S. Department of Health & Human Services' Office for the National Coordinator for Health Information Technology announced that over 100,000 primary care providers have committed to working with their Regional Extension Center (REC) to participate in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. As part of the *Health Information Technology Economic and Clinical Health Act*, a nationwide network of 69 RECs comprised of local nonprofits were created *to provide guidance and resources to help eligible professionals make the transition from* paper records to certified EHRs.