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…
On Wednesday, October 12, there are 4 health-related Congressional hearings scheduled:

* Senate Health, Education, Labor and Pensions (HELP) Committee will hold a hearing on the state of chronic disease prevention.
* Senate Special Committee on Aging will hold a hearing on finding consensus in the Medicare reform debate.
* The House Energy and Commerce Subcommittees on Health and on Commerce, Manufacturing and Trade will hold a joint hearing titled "Food Marketing: Can 'Voluntary' Government Restrictions Improve Children's Health?"
* The House Veterans' Affairs Committee will hold a hearing titled "Failures at the Miami VA Medical Center: Window to a National Problem."

1. MEDPAC RECOMMENDS ENDING SGR AND PAYING PRIMARY CARE MORE

On October 6, the Medicare Payment Advisory Committee (MedPAC) formally adopted four recommendations designed to repeal the sustainable growth rate (SGR). Chairman Glenn Hackbarth indicated the report will be sent immediately to Congress. The Commission's recommendations are:

- Congress should repeal the SGR and replace with it a 10-year statutory payment update. This update would freeze the payment rate for primary care for ten years. It also would decrease the payment rate for non-primary care physician by 5.9 percent each year for three years (totaling about 17 percent) and then freeze it for another seven years.

- Congress should instruct the Secretary of HHS to collect data regularly for work, time and other variables from efficient practices and make the first data available in three years. Practitioners who provide overpriced services should be negatively affected.

- Congress should instruct the Secretary to use the data to reduce overpriced services with the goal of achieving 1 percent savings per year.

- Congress should instruct the Secretary to increase shared savings opportunities for physicians in 2-sided ACOs; for example, CMS could compute shared savings based on 2011 fee-for-service (FFS) rates, which would make the incentives more attractive.

MedPAC also indicated that Congress could elect to enact these recommendations without budgetary offsets or with offsets outside the Medicare program. Since neither of those options are in MedPAC's purview, the commission offered some suggested offsets from the Medicare program that could be spread broadly across stakeholders. The commission was emphatic in saying it would not endorse such cuts in the absence of repeal of the SGR.

The recommendations would establish a new baseline for physician payment for the next ten years. However, MedPAC would continue its annual review of payment adequacy and patient access. And, if adequacy or access were deemed insufficient, MedPAC could recommend an override. Nevertheless, Congress would have to consider and pass such a recommendation.

2. AAFP TEAMS UP WITH US REP. ALLYSON SCHWARTZ

AAFP Key Contacts reached out to 22 members of the House of Representatives, encouraging them to sign on to a "Dear Colleague" letter from US Rep. Allyson Schwartz (D-PA). The letter urges the Joint Select Committee on Deficit Reduction to repeal the SGR. Rep. Schwartz, along with 113 Representatives, sent this bipartisan letter to the "super committee" on October 6.

3. PATIENTS RECEIVED PREVENTIVE CARE, DISCOUNTS FROM HEALTH REFORM

HHS officials on Thursday unveiled statistics that show more than 20 million Medicare beneficiaries have benefited from provisions in the federal health reform law. According to the statistics, 20 million Medicare beneficiaries have received preventive health care services. In addition, 1.8 million beneficiaries who reached the Medicare Part D "doughnut hole" received prescription drug discounts totaling $1 billion through August, or $540 per person.

According to the Congressional Budget Office, the federal government will spend $3.6 billion through 2019 providing beneficiaries the no-cost annual wellness visits.

4. IOM RECOMMENDS METHODS FOR DETERMING ESSENTIAL BENEFITS

The Institute of Medicine (IOM) released today its recommendations to the US Department of Health and Human Services on how to define the Essential Health Benefits (EHB) package required of all plans offered on state health insurance exchanges. IOM specifically charged the committee appointed to study the issue to not define the EHB. Instead, the goal was to produce a set of criteria and methods to help HHS and states define the EHB by balancing comprehensiveness and affordability.The committee's recommendations were determined through analysis of economic, ethical, population health and evidence-based practice implications.

IOM attempted to determine whether the market basket of health care services should reflect as much as patients may typically need or what may be a sustainable level of affordability. The committee opted for the latter approach and recommended that HHS use the typical *small* employer benefits package as a starting point. This benefit package should be adjusted to reflect the 10 general categories of benefits specified for EHB under the *Affordable Care Act*, and then modified using the criteria set forth by IOM. The preliminary package will then be adjusted to ensure that the average mid-range plan with the essential benefits that is offered on exchanges will be comparable in premium cost and actuarial coverage to those purchased by small employers.

Notably, the IOM recommended that HHS allow states flexibility within the EHB. The hope is that, within parameters outlined by HHS, states will be able to better balance the competing interests of covered benefits, benefit design and benefit administration within their insurance markets.

IOM further recommended that such state EHB determinations, as well as HHS initial guidance and future EHB updates, be public, deliberative processes. The hope is to have the public discussing the trade-offs between cost of benefits and effectiveness of services prior to any final changes to EHB. To help inform such discussions, the IOM committee recommends the appointment of a National Benefits Advisory Council. The Council would advise on the data collected and research plans, make annual recommendations on updates to the EHB, as well as on the continued use of public deliberation.

5. PRESCRIPTION DRUG ABUSE ISSUE REVIEWED BY SENATE PANEL

On October 4, the Senate Homeland Security's Subcommittee on Federal Financial Management, Government Information, Federal Services and International Security held a hearing on the "Costs of Prescription Drug Abuse in the Medicare Part D Program." Testifying before the panel were CMS's Jonathan Blum, GAO's Gregory Kutz and executive director of the National Health Care Anti-Fraud Association, Louis Saccoccio.

The primary purpose of the hearing was to discuss a recent GAO investigatory report on fraud and abuse within the Medicare Part D program. The report found that in 2008, 170,000 Medicare Part D beneficiaries acquired a number of frequently abused drugs, such as oxycodone, from five or more physicians, at a cost of $148 million. In its report, GAO recommended that CMS limit the number of drugs provided to individuals found to engage in "doctor shopping" for abusive drugs, among other suggestions.

6. FamMedPAC PROMOTES AAFP AGENDA TO KEY MEMBERS OF CONGRESS

FamMedPAC supported three Members of Congress this week at separate fundraising events in Washington, D.C. The main topics of discussion were the Medicare physician payment formula and the likelihood that the Deficit Reduction Committee will address the SGR in its proposals. Government Relations staff attended events for the following Members:

- **Rep. Charles Boustany (R-LA)**, a cardiac surgeon, serving on the House Ways and Means Health Subcommittee.
- **Rep. Eric Paulsen (R-MN)**, also a member of the House Ways and Means Committee.
- **Rep. Steny Hoyer (D-MD)**, the Minority Whip of the House and a member of the leadership of Congress.

7. REGULATORY BRIEFS

- On September 29, the Health Resources & Services Administration (HRSA) awarded $32 million in *Affordable Care Act (ACA)* grants to help 904 community health centers achieve recognition as patient-centered medical homes. The funds will support activities such as care planning and team-based models of service delivery. In addition, HHS' Substance Abuse and Mental Health Services Administration awarded $15 million from the ACA's Prevention and Public Health Fund to improve coordination of health care services at publicly funded community-based behavioral health settings, including mental health centers and public health departments.
- On September 30, the Centers for Medicare & Medicaid Services (CMS) announced $1.5 million in performance awards to State Health Insurance Assistance Programs (SHIPs), which are local agencies that assist people with Medicare and their caregivers.

- On September 30, the Centers for Disease Control and Prevention (CDC) announced awards of approximately $9 million for comprehensive workplace health programs. Viridian Health Management was selected to work with 70 to 100 small, mid–size, and large employers in seven regions across the country to help them develop or expand their workplace health programs. Interested companies will apply and will be selected based on several factors. Research Triangle Institute (RTI) will coordinate and administer a national evaluation of the program. At the end of this project in 2013, the CDC will disseminate the findings and provide recommendations for how to successfully implement and expand successful workplace health programs.
- On September 30, CMS announced that the 2010 Physician Quality Reporting Initiative (PQRI) feedback reports are available for download online. CMS also published a guide for understanding the 2010 PQRI incentive payment and a guide for understanding the 2010 PQRI feedback report. In 2011, the PQRI program name changed to Physician Quality Reporting System (PQRS).
- Pentagon officials recently announced that military retirees enrolling in the TRICARE Prime health plan after October 1 will begin paying slightly higher annual fees. The fiscal 2012 plans will cost $260 per year for individual members (an increased $2.50 per month) and $520 per year for member families (an increased $5 per month). Active duty service members receive health care with no out-of-pocket costs.
- On October 1, CMS launched the web-based Medicare Plan Finder that allows beneficiaries, their families, trusted representatives, and senior program advocates to look at all local drug and health plan options that are available for the 2012 benefit year. According to the CMS announcement, "The annual enrollment period begins earlier this year, on October 15th, and runs through December 7th. People with Medicare will have seven weeks to review Medicare Advantage and Part D prescription drug coverage benefits and plan options, and choose the option that best meets their unique needs. The earlier open enrollment period also ensures that Medicare has enough time to process plan choices so that coverage begins without interruption on January 1, 2012."
- On October 3, CMS released the *Proposed Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2013*. In addition to implementing provisions called for in the *Affordable Care Act*, of particular interest to physicians, the proposed rule allows physicians to request reconsiderations on their patient's behalf without obtaining a signed authorized representative form, enables prescribers to order trial fills for initial prescriptions and requires prescription drug plans to submit prescription drug event (PDE) records to include prescribers' National Provider Identifiers (NPIs).
- On October 6, for the third month in a row, HHS released statistics showing Medicare beneficiary utilization of preventive services offered under the *Affordable Care Act*. Per the latest statistics:
    - Nearly 20.5 million people with Medicare received an Annual Wellness Visit or received other preventive services with no deductible or cost sharing this year, compared with 18.9 million in the beginning of September and 17 million in early August.
    - Nearly 1.8 million people with Medicare have received discounts on brand-name drugs in the Medicare Part D coverage gap, compared with 1.4 million in early September and 900,000 in the beginning of August.
- On October 18 from 1:30-3pm ET, CMS will host a national call on the Physician Quality Reporting System & Electronic Prescribing Incentive Program. Registration is free and required.
- November 1st is the deadline to request a hardship exemption in order for physicians and group practices to avoid the 2012 Medicare Electronic Prescribing (eRx) Incentive

Program penalty. CMS recently created a related document and quick reference guide to help practices determine if they are subject to the 2012 eRx payment penalty.

8. CALIFORNIA GOVERNOR SIGNS FAMILY MEDICINE SUPPORTED BILLS

On October 6, California Governor Jerry Brown (D) signed into law three bills supported by the **California Academy of Family Physicians**. SB 220 and AB 210 require that every individual and group health insurance policy provide coverage for maternity services, while SB 299 prohibits employers from refusing to maintain and pay for coverage under group health plans for women who take maternity leave. The CA AFP asked their Key Contacts to urge Gov. Brown to sign the bills.