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 Monday, June 18, the Alliance for Health Reform will hold a panel discussion on Retail Health Clinics with Rick Kellerman, former AAFP president. (info@allhealth.org)
* On Tuesday, June 19, the White House will host a discussion with physicians including several AAFP members entitled, How HIT Can Improve Care Quality and Patient Health
* On Thursday, June 21, the House Energy and Commerce Health Subcommittee will hold a hearing on the National Institutes of Health to review its reforms, priorities and progress.

1. SENATE COMMITTEE VOTES TO HIKE PRIMARY CARE TRAINING BY $10 MILLION

The Senate Appropriations Committee voted 16 to 14 to advance the fiscal year 2013 spending bill for labor, HHS and education programs on June 14 (S 3295). The bill provides $158.8 billion in discretionary funds, $2 billion more than the FY 2012 level as allowed for in the *Budget Control Act* enacted last August as called for in the President's FY13 budget request.

The bill would increase the funding for Title VII Primary Care Training programs in FY 2013 to $48.962 million for the primary care training and enhancement programs (a $10 million increase over FY 2012-enacted level, but below the President's request of $50.962 million). However, the report to accompany the bill says "(t)he Committee … includes bill language allowing HRSA to determine the funding amount for this activity." It is not clear whether HRSA's General Counsel will consider this language to supersede the authorizing law which directs that 15 percent of the funds be directed to training physician assistants. The President's budget proposed that all of the increase go to PAs.

The bill provides $27.2 million for the Title VII Area Health Education Center program and $22.9 million for the Title VII Centers of Excellence for level funding in FY 2013. It includes funding for the Agency for Healthcare Quality and Research at $376 million, which exceeds the FY 2012 level of $369 million. It also includes $3 million for the National Health Care Workforce Commission. In the bill, the Children's Hospital GME account is restored to level funding of $265.2 million which is above the President's request of $88 million.

The House is expected to bring a draft appropriation bill before the subcommittee next week.

2. SENATE FINANCE HOLDS ROUNDTABLE ON MEDICARE PHYSICIAN PAYMENT

On June 14, the Senate Finance Committee held a roundtable discussion on Medicare physician payment policy. The senior Republican on the committee, Senator Orrin Hatch (R-UT), stated that the fee-for-service system provides little incentive to manage care properly. He recommended that the flawed SGR system must be replaced by a more stable method to pay physicians who treat Medicare patients.

Dana Gelb Safran, Sc.D. discussed the Alternative Quality Contract (AQC) which employs a population-based global budget together with significant financial incentives for performance on a broad set of quality and outcome measures. The model establishes provider accountability for clinical quality, patient health outcomes, and overall medical spending and cost growth. In signing an AQC, a provider group agrees to accept accountability for the full continuum of care provided to their patients. In the first year (2009) of the AQC, participating groups made unprecedented improvements in the quality of patient care and achieved a 2-percent slower rate of growth in medical spending (NEJM); slower growth than the non-AQC BCBSMA network providers.

Mr. Peter Edwards, of Humana, noted that the company embraces the following principles: (1) Value-based reimbursement direction (including such programs as physician rewards models, shared risk arrangements and ACOs); (2) Shared responsibility for outcomes; (3) "Bricks-and-Mortar" relationships (including direct relationships with primary care physicians and clinics); (4) Strong physician industry relationships to vet new payment ideas and approaches (including specific engagement with the AAFP, AMA, ACP, AMGA and the MGMA); 5) Physician/provider/ health plan collaboration, focused on providing continuous input on Humana policies and processes; (6) Clinically focused activity; and (7) Health Information Technology (including relationships to promote connectivity with the leading electronic medical records vendors).

Lonny Reisman, of Aetna, testified that successful provider collaborations depend on payment models that incentivize improvements in quality and cost of care. Aetna ties provider reimbursements to improved population health and reductions in the total cost of care. Reisman cited the example of InterMed's Independent Physician Association, NovaHealth (Portland, ME) which, in collaboration with Aetna, averaged 45 percent fewer acute admits, 50 percent fewer acute days, and 56 percent fewer readmissions in 2011 compared to statewide unmanaged, risk-adjusted Medicare populations.

Chet Burrell, President and CEO of CareFirst BlueCross BlueShield described the Patient-Centered Medical Home (PCMH) as an innovative program designed to give primary care providers new incentives and tools for higher quality and lower cost care. He emphasized that the PCMH program is a model that is easily scalable. Last week, CareFirst announced the results of its first full year of the PCMH initiative. With nearly 3,600 participating primary care providers, providing care for nearly a million of CareFirst's members, the company believes CareFirst's PCMH program is the largest and one of the most ambitious of its kind anywhere in the nation, reporting that nearly 60 percent of eligible PCMH Panels (small teams of primary care physicians and nurse practitioners) earned increased reimbursements for their performance in 2011. The CareFirst PCMH allows primary care providers (PCPs) to serve as the "quarterback" of a team of health professionals who focus on providing coordinated care for those patients who need it most. Incentives to PCPs, including an immediate 12-percent increase in their fees as well as additional compensation for the development and monitoring of patient-specific care plans for their sickest patients, reinforce the central role of primary care in helping members manage their health risks as well as guide their care when they experience major illness.

Darryl Cardoza is the CEO of Hill Physicians Medical Group, one of the nation's largest independent physician associations (IPAs) with more than 3,500 participating primary care physicians and specialists across Northern California, serving 300,000 patients was the next panelist. Hill Physicians employs innovative physician payment models to reduce practice variability, improve quality and moderate escalation of costs. For example, the IPA pays primary care physicians using a hybrid model of fee-for-service and performance based compensation. The fee-for-service component encourages physician access and availability for patients. The fee-for-service rate is lower than the Medicare fee schedule and less than what is required to sustain a viable practice. However, this rate is supplemented by a quarterly primary care management fee ("PMF") that results in network physicians being paid at an average rate that is considerably higher than Medicare. The amount earned varies based on individual practice performance. Performance metrics are established for quality of care, using industry standard, evidence-based measures, such as HEDIS measures, and for utilization performance, using measures based on services provided in the practice, referrals to specialists, use of diagnostic services, E.R. usage, and inpatient utilization. Additionally, physicians are evaluated based on their participation in activities that support care coordination and the Hill Physicians organization and infrastructure as a whole, including regular meeting attendance to review data, use of e-solutions to foster communication and coordination of care, and continuing education. Specialists are paid in a variety of ways including fee-for-service, case rate and capitation.

3. AAFP URGES APPROPRIATORS TO FUND CENTER FOR TOBACCO PRODUCTS

In a June 14 letter to the House Appropriations Committee, the AAFP joined other organizations to support the FDA's oversight of tobacco products and to urge the committee to fully fund the FDA's Center for Tobacco Products. The letter also expressed concern regarding ongoing efforts to weaken the FDA's authority to regulate cigars.

4. FamMedPAC ON PACE TO REACH FUNDRAISING,CAMPAIGN CONTRIBUTION GOALS

Donations to FamMedPAC in the 2012 election cycle are running well ahead of the same period during the previous election cycle. Since January of 2011, the PAC received $740,505 in donations from 2,301 AAFP members. The average donation is $322. For the same time during the 2010 election cycle, the PAC received $540,793 from 1,681 AAFP members, with the same average donation of $322. With the direct marketing program ramping up in July and the Congress of Delegates and Scientific Assembly meeting still to come, the PAC is on pace for its best election cycle and could reach the $1 million mark by the end of the year.

The PAC made $512,200 in campaign contributions to 100 candidates and committees. The PAC currently has $450,000 cash on hand and should reach $1 million in campaign contributions by Election Day.

FamMedPAC supported the following legislators this week:

- Rep. Steve Stivers (R-OH), a freshman, who served in the Ohio legislature and worked closely with the Ohio AFP chapter. Rep. Stivers is very interested in healthcare issues, and was joined at the event several physician Members of Congress.
- Rep. Nancy Pelosi (D-CA), the Minority Leader of the House.
- Rep. Jim Clyburn (D-SC), the Assistant Minority Leader of the House.
- Rep. Earl Blumenauer (D-OR), a member of the Health Subcommittee of the House Ways and Means Committee. Dr. Elizabeth Steiner attended an event in Oregon for Rep. Blumenauer.
- Rep. Tom Price (R-GA), a physician and member of the Health Subcommittee of the House Ways and Means Committee. Rep. Price held an event during the AMA meeting in Chicago. Dr. Rick Wherry, a member of the FamMedPAC Board of Directors attended.

5. CHAPTER REPORTS

- *Connecticut AFP Fights for Children's Vaccine Access*
  The Connecticut AFP joined the Connecticut Medical Society and Connecticut Chapter of the American Academy of Pediatrics to oppose a proposal from the administration of Governor Dannel Malloy (D) that would effectively limit the ability of physicians to provide vaccinations to children. Currently, the State Vaccine Supply Program provides limited quantities of 11 of the 16 CDC-recommended child vaccines. Family physicians purchase additional doses, as well as those not provided by the SVSP, on the private market. The Malloy Administration proposed that, beginning October 1, physicians may only use childhood vaccines obtained through the SVSP, which is subject to appropriations from the state legislature. The proposal increases the SVSP to cover only 14 of the 16 CDC-recommended vaccines and does not provide immunizations for all children who need them. A special session of the legislature approved the proposal on June 12 as part of HB 6001. The bill awaits the Governor's signature

- *Pennsylvania House Honors Chapter*
  The Pennsylvania House of Representatives unanimously approved a resolution recognizing the Pennsylvania AFP and family physicians for, "outstanding contributions… in this Commonwealth." State Representative Matt Baker (R) sponsored the resolution, which notes that family physicians are, "dedicated to the dignity and well-being of all Pennsylvanians by providing accessible, continuing, comprehensive and quality health care."

6. REGULATORY BRIEFS

- On June 11, CMS released the latest monthly statistics on use of preventive services, including that 14.3 million people with original Medicare received at least one preventive service during the first five months of 2012 and 1.1 million took advantage of the Annual Wellness Visit.
- On June 12, CMS announced a second opportunity to apply for the Advance Payment ACO Model, which is designed for physician-based and rural providers who have come together voluntarily to give coordinated high quality care to their Medicare patients. Through the Advance Payment ACO Model, participants will receive upfront and monthly payments, which they can use to invest in care coordination infrastructures. The Innovation Center announced that beginning August 1, 2012, it will be accepting applications for an additional round of Advance Payment ACOs that would begin on January 1, 2013. Organizations interested in the Advance Payment ACO Model should start their application process by submitting a Notice of Intent to apply for the Medicare Shared Savings Program performance period that begins January 1, 2013. This Notice of Intent is due June 29, 2012.
- On June 13, CMS announced that Mississippi, Georgia, Missouri and Iowa were approved for the Balancing Incentive Program. With this award, states must create a single-entry point for Long Term Supports and Services (LTSS), develop and implement a core standardized assessment, and commit to conflict-free case management of services. Mississippi is the first State to receive 5% enhanced rate, while Georgia, Missouri and Iowa each will be receiving a 2-percent enhanced rate.
- On June 14, CMS released a proposed rule that seeks comments on the Medicare Secondary Payer (MSP) program. Specifically, the proposed rule addresses options for beneficiary obligations with respect to MSP claims involving automobile and liability insurance (including self-insurance), no-fault insurance, and workers' compensation when future medical care is claimed or the settlement, judgment, award, or other payment releases (or has the effect of releasing) claims for future medical care. Comments on the proposal are due August 14, 2012.