GOVERNMENT AFFAIRS WEEKLY

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NEXT WEEK IN WASHINGTON…

* Senate Appropriations Subcommittee and Committee to debate FY 2013 Labor-HHS-Education spending bill on Tuesday and Thursday respectively.

1. FAMILY DOCTORS LEAD WHITE HOUSE CONVERSATION ON CARE COORDINATION

Eight AAFP members joined about 140 other physicians from across the country at an afternoon program hosted by the White House and the Department of Health and Human Services Secretary Kathleen Sebelius. The Director of CMS's Innovation Center, Dr. Richard J. Gilfillan, a family physician, moderated a panel of four physicians, two of whom also were family physicians. They talked about their experience with delivery system reform and then entertained questions and comments from the audience. Secretary Sebelius commented that the current payment system does not align well with best strategies for care delivery and while the SGR is broken, it is really the system that is broken. Liz Fowler, Special Assistant to the President for Healthcare and Economic Policy, closed the program by asking participants to educate their patients and dispel inaccuracies about the *Affordable Care Act*.

2. AAFP DISAGREES WITH MEDICAID BONUS INCLUDING SUB-SPECIALISTS

The AAFP sent the Centers for Medicare & Medicaid Services (CMS) a letter on June 6 in response to the proposed "Medicaid Program; Payments for Services Furnished by Certain Primary Care Physicians and Charges for Vaccine Administration under the Vaccines for Children Program." In it, the AAFP generally supported the CMS mechanism to administer this additional payment but disagreed with the agency's proposal to allow sub-specialists to qualify for it.

This regulation implements a provision from the *Affordable Care Act* that increases Medicaid payment rates to Medicare levels for primary care physicians in 2013 and 2014. The *Affordable Care Act* specifies that family practice, general internal, and pediatric physicians qualify for the payment rate increase. However the CMS proposal would also include sub-specialists that are board certified under one of those three specialty designations or, if not board certified, provide at least 60 percent of their annual Medicaid charges as specified Evaluation & Management (E&M) codes and vaccine administration codes.

The AAFP's response acknowledged that the *Affordable Care Act* and CMS recognize the growing crisis in Medicaid beneficiaries' access to needed primary care services and the importance of supporting primary care payments as a step toward encouraging more medical students to choose primary care specialties. In the proposed rule, CMS says it is "particularly interested in ensuring that primary care physicians receive the benefit of the increased payment," a goal shared by the AAFP.

However since CMS proposes to include sub-specialists, the AAFP expressed concern that including them will "add unwarranted costs." Instead, the AAFP urged CMS to define primary care physician in accordance with recommendations by the Task Force on Primary Care Valuation. These recommendations are detailed in a March 12, 2012 letter to CMS and urge CMS to identify primary care physicians by the definitional elements, which include first contact, continuity, and comprehensiveness of care.

3. CPCI PAYERS ANNOUNCED, PHYSICIAN APPLICATIONS ACCEPTED UNTIL JULY 20

On June 6, the CMS Innovation Center announced that from a pool of payer applicants, 45 commercial, federal and state insurers in seven markets signed memorandums of understanding with CMS and thus will participate in the Comprehensive Primary Care initiative (CPCI). According to CMS, the CPCI is a four year "multi-payer initiative fostering collaboration between public and private health care payers to strengthen primary care." CMS will pay 75 primary care practices in each of the 7 regions a care management fee, initially set at an average of $20 per beneficiary per month, to support enhanced, coordinated services. Simultaneously, participating commercial, state, and other federal insurance plans are also offering an enhanced payment to primary care practices that provide high-quality primary care.

Applications from physician practices will be accepted until July 20. To check eligibility, CMS posted an application pre-screen tool. CMS asks that practices complete the application pre-screening tool if interested in applying. Upon completing the tool, applicants meeting the minimum level eligibility requirements will receive an email with further details about the upcoming application and how to apply to the program. If a primary care practice has multiple sites, each physical site that is located in the selected market is eligible to apply and must apply separately.

The following markets and payers will participate in the CPCI:

- Arkansas: Statewide (4 Payers)
  - Arkansas Blue Cross and Blue Shield
  - Arkansas Medicaid
  - Humana
  - QualChoice of Arkansas
- Colorado: Statewide (9 Payers)
  - Anthem Blue Cross Blue Shield of Colorado
  - Cigna
  - Colorado Access
  - Colorado Choice Health Plans
  - Colorado Medicaid
  - Humana
  - Rocky Mountain Health Plans
  - Teamsters Multi-Employer Taft Hartley Funds
  - UnitedHealthcare

- New Jersey: Statewide (5 Payers)
    - Amerigroup
    - AmeriHealth New Jersey
    - Horizon Blue Cross Blue Shield of New Jersey
    - Teamsters Multi-Employer Taft Hartley Funds
    - UnitedHealthcare
- New York: Capital District-Hudson Valley Region. Counties within this region include: Albany, Columbia, Duchess, Greene, Orange, Putnam, Rensselaer, Rockland, Schenectady, Sullivan, Ulster, Westchester (6 Payers)
    - Aetna
    - Capital District Physicians' Health Plan
    - Empire Blue Cross
    - Hudson Health Plan
    - MVP Health Care
    - Teamsters Multi-Employer Taft Hartley Funds
- Ohio and Kentucky: Cincinnati-Dayton Region. Counties within this region include the Ohio counties of Adams, Brown, Butler, Champaign, Clark, Clermont, Clinton, Greene, Hamilton, Highland, Miami, Montgomery, Preble, Warren and the Kentucky counties of Boone, Campbell, Grant, Kenton (10 Payers)
    - Aetna
    - Amerigroup (Ohio only)
    - Anthem Blue Cross Blue Shield of Ohio
    - Humana
    - UnitedHealthcare
    - CareSource (Ohio only)
    - HealthSpan
    - Medical Mutual
    - Centene Corporation (Ohio only)
    - Ohio Medicaid within the Ohio Department of Job and Family Services
- Oklahoma: Greater Tulsa Region. Counties within this region include: Adair, Atoka, Cherokee, Craig, Creek, Delaware, Hughes, Lincoln, Mayes, McIntosh, Muskogee, Noble, Nowata, Okfuskee, Okmulgee, Osage, Pawnee, Payne, Pittsburg, Pushmataha, Rogers, Sequoyah, Tulsa, Wagoner, Washington (3 Payers)
    - Blue Cross and Blue Shield of Oklahoma
    - CommunityCare
    - Oklahoma Health Care Authority
- Oregon: Statewide (7 Payers)
    - CareOregon
    - ODS Health Plan
    - Oregon Health Authority
    - Providence Health Plans
    - Regence Blue Cross Blue Shield of Oregon
    - Teamsters Multi-Employer Taft Hartley Funds
    - Tuality Health Alliance

To prepare members for the application process, the AAFP, TransforMED, and CMS staff will offer a free webinar titled, “Applying for the CPC Initiative–Maximizing your Chances of Success” on June 13 at 2pm ET.

4. HOUSE PASSES BILL REPEALING DEVICE TAX, HSA/FSA RESTRICTIONS

The House on Thursday, June 7 passed a compilation of *Affordable Care Act* repeal measures (HR 436, amended to include HR 5842 and HR 1004) to eliminate the 2.3 percent excise tax on medical devices and the restrictions on health savings and flexible spending account purchases. The 270 to 146 fell largely along party-lines, with 37 Democrats in support. The bill covered the loss of $29 billion in revenue by requiring repayment from people whose income over the course of a year made them ineligible for their health insurance subsidies. The White House indicated that the President would veto the bill, but it is unlikely that the Senate will act on it.

4. REGULATORY BRIEFS

- On May 30, CMS and Medscape posted a CME module titled, "CMS Value-based Purchasing Targets Complications, and Readmissions."
- On June 1, the Patient-Centered Outcomes Research Institute (PCORI) launched an application system where individuals can register to respond to funding announcements. PCORI will host a webinar on June 14 from 3-4:30pm ET for individuals interested in submitting applications.
- On June 4, PCORI posted its preliminary draft methodology report to set groundwork for conducting comparative effectiveness research.
- On June 5, CMS announced a new Office of Information Products and Data Analytics that will oversee CMS's portfolio of data management. The new Office of Information Products and Data Analytics "will help guide the agency's evolution from a fee-for-service-based payer to a 'value-based purchaser of care' that links payments to quality and efficiency of care, rather than sheer volume of services," said a HHS news release. As first steps under the new data and information initiative, CMS announced the release of several new data and information products:
    - Medicare Geographic Variation Trend Data
    - Medicare Enrollment Dashboard
    - Medicare & Medicaid Research Review (MMRR
    - CMS Data Navigator
- On June 7, HHS announced a new round of funding to support state-based Consumer Assistance Programs (CAP) grantees

5. CBO PROJECTS HIGHER HEALTH CARE SPENDING

The nonpartisan Congressional Budget Office released the most recent long-term budget outlook on June 5 which projected that per-capita spending for health care is likely to continue rising faster than spending per person on other goods and services for many years. The CBO outlook reports that under current law, "Medicare's sustainable growth rate mechanism would reduce payment rates for physicians by 27 percent in January 2013 and by additional amounts in later years." This differs from the estimated projection used in the April Medicare trustees' report of 30.9 percent. Ultimately, CMS will set the 2013 conversion factor which is expected to be tempered by Congressional action on the SGR.