GOVERNMENT AFFAIRS WEEKLY

AAFP Government Relations — 1133 Connecticut Avenue, Suite 1100, NW — Washington, DC 20036

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IN THIS REPORT…

NEXT WEEK IN WASHINGTON…

* The Senate Finance Committee, on Wednesday, April 17, will hold a hearing on the President's proposed budget for FY 2014 for the programs administered by the Department of Health and Human Services; Secretary Sebelius will testify. On Thursday, April 18, the House Energy and Commerce Committee will hold its hearing on the HHS budget and the Secretary will testify.

1. WHITE HOUSE RELEASES FY 2014 BUDGET: CALLS FOR SGR FIX, GME CUTS

On Wednesday, April 10, President Obama released his budget request for FY 2014 which calls for a "period of payment stability lasting several years" in Medicare physician payments to allow the development of "accountable payment models" that can replace the SGR. The Administration's budget also reiterated last year's call for cuts to Medicare indirect medical education payment and for the elimination of two health-training programs: the Area Health Education Centers (AHEC) program and the Health Careers Opportunity Program.

The President's budget proposed a freeze for Title VII Section 747 family medicine training grants. It requested $51 million for the Primary Care Training and Enhancement program which is below the FY 2012 request of $140 million but above the current level of $39 million. The

Administration's budget called for using all of the $12 million increase for training physician assistants. The AAFP will continue to press for additional funds for family medicine training.

> *Additional information about the impact of the President's plan for FY 2014 on AAFP priorities is available on page 8 of this weekly report.*

2. SENATE FINANCE HOLDS CONFIRMATION HEARING FOR CMS ADMINISTRATOR

The AAFP sent the entire Senate Finance Committee a letter on April 4, expressing full support of President Obama's re-nomination of Marilyn Tavenner to serve as Administrator for the Centers for Medicare & Medicaid Services (CMS). On April 9, the Senate Finance Committee convened a confirmation hearing which revealed considerable bipartisan support for her nomination.

During the hearing, Ms. Tavenner indicated CMS wants innovation to thrive especially through Accountable Care Organizations and coordinated care. And she stated she fully expects Medicare Advantage to continue to grow. She agreed with Senator Johnny Isakson (R-GA) that it was particularly important to permanently resolve the SGR problem by taking advantage of the recently reduced CBO score.

Senator John Thune (R-SD) complained about a reinterpretation of the policy on physician supervision of outpatient therapeutic services in critical access hospitals. Ms. Tavenner indicated she would add rural representation to the panel convened to study this issue.

She also agreed to look into an issue raised by Senator Chuck Schumer (D-NY) who complained that a rural residency program in upstate New York, through misclassification decision in 2011, had its residency slots reduced by three. Sen. Schumer stated that CMS agreed the decision was wrong but was concerned that there is no appeal mechanism.

There was very little dissent displayed throughout the hearing and all signs point to quick confirmation of Ms. Tavenner.

3. HEALTH CARE LAW COSTS IN THE SPOTLIGHT

On Friday, April 12, the cost of running insurance markets established by the 2010 health care law was discussed at a House Ways and Means hearing that featured Health and Human Services Secretary Kathleen Sebelius. Administration officials said on Thursday, April 11 that the government will need $2 billion next year to run the federal "exchange," or marketplace, that uninsured residents of 26 states will rely on for coverage because those states have refused to create their own such market. HHS is hoping Congress will allocate $1.5 billion for this. However, House Republicans noted their intentions to shut off sources of financing for FY 2014, which starts October 1, just as the exchange is scheduled to begin operation. The health care law's tax on medical devices and GOP proposals for a new system of paying Medicare physicians were also topics for discussion.

4. GUN VIOLENCE AND MENTAL HEALTH MEASURE APPROVED

On April 17, the Senate Health, Education, Labor and Pensions (HELP) Committee quickly approved a bipartisan measure (S.689) which would reauthorize and improve programs related to mental health and substance use disorders and new grant programs. The measure will likely be offered as an amendment to the larger Senate gun control measure, the *Safe Communities, Safe Schools Act* (S. 649), which the Senate will begin debating next week.

5. HOUSE HEALTH SUBCOMMITTEE CONDUCTS HEARING ON MEDICARE

On April 11, the House Energy and Commerce Subcommittee on Health held a hearing titled "Strengthening Medicare for Seniors: Understanding the Challenges of Traditional Medicare's

Benefit Design." The sole witness was Glenn M. Hackbarth, J.D., who is the chairman of the Medicare Payment Advisory Committee (MedPAC).

MedPAC has been considering ways to reform the traditional benefit package with the objectives of protecting beneficiaries against high out-of-pocket spending and creating incentives for beneficiaries to make better decisions about their health care. MedPAC's June 2012 recommendations for reforming the program's benefit design suggested that Congress should direct CMS to develop and implement a fee-for service (FFS) benefit design that would replace the current design and would include:

- An out-of-pocket maximum;
- Deductible(s) for Part A and B services;
- Replacing coinsurance with co-payments that may vary by type of service provider;
- Secretarial authority to alter or eliminate cost-sharing based on the evidence of the value of services, including cost-sharing after the beneficiary has reached the out-of-pocket maximum;
- No change in beneficiaries aggregate cost-sharing liability; and,
- An additional charge on supplemental insurance.

At the hearing, Chairman Hackbarth summarized his written testimony by outlining the wide range of MedPAC recommendations to the Congress designed to improve the coordination, quality of care, the equity of payment and program integrity, and to reduce spending.

Representatives asked Commissioner Hackbarth about the pros and cons of previous MedPAC recommendations and the impact of the *Affordable Care Act* on Medicare beneficiaries. Prior to and related to this hearing, Subcommittee Chairman, Rep. Joe Pitts (R-PA) and Rep. Michael Burgess, MD (R-TX) released a paper outlining their solutions from "escaping from rigid federal mandates, prioritizing affordability and access."

6. AAFP RECOMMENDS CMS CREATE SEPARATE, PRIMARY CARE E/M CODES

In a letter sent on March 27, the AAFP recommended that the Centers for Medicare & Medicaid Services (CMS) creates, as part of the 2014 Medicare physician fee schedule, separate, primary care evaluation and management (E/M) codes for office or other outpatient services to new and established patients and value them higher than existing codes for non-primary care E/M services.

In the letter, the AAFP argues that the complexity of the ambulatory E/M services that primary care physicians must "fit" into the time available for the average patient visit is sufficiently distinct to merit dedicated codes and higher relative values than currently assigned to existing office or other outpatient E/M codes. The letter then discusses the development of a concept called "complexity/density" to describe and quantify this phenomenon.

The AAFP also argued that current construct of the RVUs of the current office or other outpatient E/M services is flawed and does not reflect the increased complexity and intensity of primary care E/M services.

7. AAFP SUPPORTS NEW SCHOOL LUNCH AND BREAKFAST NUTRITION STANDARDS

On March 28, the AAFP sent a brief letter to the Food and Nutrition Service, an agency of the U.S. Department of Agriculture, conveying our support on their revised "National School Lunch Program and School Breakfast Program: Nutrition Standards for All Foods Sold in School." These revisions were developed based on recommended changes from the Institute of Medicine's 2007 report titled "Nutrition Standards for Foods in Schools: Leading the Way toward

Healthier Youth." After expressing support, the AAFP referenced our policies on school nutrition and healthy eating in schools.

8. AAFP SUPPORTS MEDICAL LOSS RATIO POLICY ON MEDICARE PARTS C AND D

On April 4, the AAFP sent the Centers for Medicare & Medicaid Services (CMS) a letter in response to a proposed rule that, as required by the *Affordable Care Act*, establishes the medical loss ratio (MLR) requirement for Medicare Advantage (Part C) and Medicare Prescription Drug Plans (Part D). The MLR is expressed as a percentage, generally representing the percentage of revenue used for patient care, rather than for such other items as administrative expenses or profit. The AAFP response supported implementation of MLR requirements for Part C and D sponsors as a way to help ensure that health care finances are focused on patient care.

9. AAFP REACTS TO PROPOSED USE OF CLINICAL QUALITY MEASURES

The AAFP wrote the Centers for Medicare & Medicaid Services (CMS) a comment letter dated April 5 on a proposed regulation pertaining to the use of clinical quality measures reported under the Physician Quality Reporting System (PQRS) and the Electronic Health Record (EHR) Incentive Program. In this proposed regulation, CMS sought input regarding ways in which:

- An eligible professional (EP) might use the CQM data reported to specialty boards, specialty societies, regional health care quality organizations, or other non-federal reporting programs to also report under the PQRS and EHR Incentive Program.
- The entities already collecting CQM data for other reporting programs might submit this data on behalf of EPs and group practices for reporting under the PQRS and the EHR Incentive Program.
- CMS can implement section 601(b) of the *American Taxpayer Relief Act of 2012* which provides for treating an EP as satisfactorily reporting data on quality measures if the EP is participating in a qualified clinical data registry.

To assist CMS create policy that appropriately uses clinical quality measures, the AAFP cited our policies on physician performance measurement, electronic health records, physician level clinical performance measures, data stewardship, and transparency before answering several specific questions posed by CMS in their proposal.

10. AAFP AND OTHERS URGE CREATION OF CCC CODES

The AAFP joined 17 other national medical organizations and urged the Centers for Medicare & Medicaid Services (CMS) to implement complex chronic care coordination (CCCC) codes within the 2014 Medicare physician fee schedule. A document sent to CMS outlines the importance of the CCCC codes since it would:

- increase access to CCCC services for the patients who are most likely to benefit;
- reimburse practices who are capable of, and may already be, providing these services; /
- allow those practices who would like to provide CCCC services with the policy guidance and the financial wherewithal to develop the infrastructure needed for CCCC.

11. AAFP COMMENTS ON CMS PROPOSED REGULATORY BURDEN REDUCTION RULE

In a regulatory comment letter sent to the Centers for Medicare & Medicaid Services (CMS) on April 8, the AAFP reacted to the proposed rule, titled "Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden". This regulation touches on a variety of issues and the AAFP's response supports the CMS proposal to remove a requirement that Critical Access Hospitals in extremely remote areas physically receive physician supervision every two weeks. However, the AAFP urged CMS to be more specific in the final rule about what CMS considers a "sufficient period of time." The proposed rule also modifies CMS regulations governing proficiency testing referrals under the Clinical Laboratory Improvement Amendments (CLIA) of 1988. The changes CMS proposes are intended to reduce confusion on the part of

laboratories and lessen the risk of noncompliance and the AAFP supported these changes since it allows CMS to be more lenient in areas where a violation was unintentional.

12. REGULATORY BRIEFS

- On March 28, Centers for Medicare & Medicaid Services (CMS) announced the availability of a Medicare Chronic Conditions Dashboard, which is designed as a tool to get current data on where multiple chronic conditions occur, which services they require, and how much Medicare spends helping beneficiaries with multiple chronic conditions.
- On April 1, CMS released the 2011 PQRS and eRx Incentive Program Experience Report. This report summarizes the reporting experience of eligible professionals (EP) in 2011, historical trends, and preliminary results for the 2012 program year. Highlights of the report include that for all medical specialties:
    - 280,229 EPs participated individually in the 2011 PQRS and a total of $261,733,236 in PQRS incentive payments was paid by CMS for the 2011 program year.
    - 282,382 EPs participated in the 2011 eRx Incentive Program, which was a 116 percent increase from total participants in 2010. A total of $285,049,103 in eRx incentive payments was paid for the 2011 program year.
    - 135,931 EPs were subject to the 2012 eRx payment adjustment because they either did not qualify for an exemption, meet exclusion criteria for the adjustment, or did not meet eRx reporting requirements in the first half of 2011.
    - Of particular interest to family physicians, Table A2 in the report's appendix details the distribution of incentive amounts by specialty for the 2011 PQRS. For family practice:
        - 21,377: EPs who received incentive
        - 80.4%: percent of participating EPs incentive eligible
        - 22.6%: percent of EPs incentive eligible
        - $0.20: minimum incentive amount
        - $449.82: median incentive amount
        - $670.18: mean incentive amount
        - $14,054.53: maximum incentive amount
        - $14,326,479.39:total incentive amount
        - 6.0% percent of national total incentive amount
    - Table A31 details distribution of incentive amounts by specialty for the eRx incentive program. For family practice:
        - 29, 389: EPs who received an incentive
        - 69.8%: percent of participating EPs incentive eligible
        - 34.0%: percent of EPs incentive eligible
        - $1.04: minimum incentive amount
        - $655.83: median incentive amount
        - $924.19: mean incentive amount
        - $17,726.64: maximum incentive amount
        - $27,161,094.08: total incentive amount
        - 10.1%: percent of national total
- On April 1, CMS announced the final 2014 payment rates for Medicare Advantage and Prescription Drug Plans. CMS will increase payments by 3.3 percent despite initially proposing a 2.3-percent cut in February. CMS attributes the change to a revised estimate that assumes Congress will act to prevent the scheduled 24.4-percent reduction in Medicare physician payment rates in 2014.
- On April 9, CMS announced that nearly 800 suppliers were awarded contracts as part of Round 2 of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. This program is designed to provide

certain medical equipment and supplies to beneficiaries in 91 communities across the country beginning July 1, 2013. CMS also announced 18 suppliers that accepted contracts to provide mail-order diabetic testing supplies at competitively bid prices nationwide. Additional details can be found in the related CMS press release and fact sheet.

13. SENATE HELP EXAMINES THE COSTS OF GUARANTEED ISSUE

The Senate HELP Committee held a hearing to look at, "A New Open Marketplace: The Effect of Guaranteed Issue and New Rating Rules" on Thursday, April 11. Witnesses included; Gary Cohen, Director, Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services (CMS); Kevin Counihan, CEO of the Connecticut Health Insurance Marketplace, West Hartford, Connecticut; Sabrina Corlette, Research Professor Georgetown Health Policy Institute, Center on Health Insurance Reform; Stacy Cook, Carroll, Iowa; and Chris Carlson, Principal and Consulting Actuary, Oliver Wyman Consulting, Milwaukee, Wisconsin.

Chairman of the HELP Committee, Senator Tom Harkin (D-IA), briefly reviewed provisions of *The Affordable Care Act* and spoke of the impact on all consumers of health care. Senator Lamar Alexande (R-TN) took a different posture sharing what he called "his reality" that prices will go up, costs to employers will increase, some might lose their jobs as employers find it makes more economic sense to hire part time workers. He went on to say that he felt that *The Affordable Care Act* was a "historic mistake."

During questioning Gary Cohen from CMS was asked how his work has been affected by states that have not cooperated with the state-sponsored exchanges. He said that CMS is working hard to find a way to craft together arrangements that will work, and approaching the task both regionally and state by state. Senator Tim Scott (R-SC) shared his concern that there will be a long-term cost of the new law. Mr. Cohen answered that the government is dealing with the issue of cost right now when people show up at an emergency room with complicated medical needs and no insurance. The cost of uncompensated care is significant. Senator Pat Roberts (R-KS) shared his concern that the application to participate in the plan is now 21 pages long, quite complicated and cumbersome. Mr. Cohen said that there will be navigators hired to help people with paperwork requirements for participation. Senator Roberts asked that the public be given adequate time during the comment period to allow for an examination of the paperwork requirements.

The hearing ended with a rather animated discussion of whether or not Congress was told by the President that costs would go up upon implementation. Senator Al Franken (D-MN) said that expansion of coverage and richer benefits will have an impact, but that the President talks about bending the cost curve. Senator Alexander said that we should be prepared for a sticker shock once the full program is in place.

14. ARKANSAS INNOVATES WITH MEDICAID EXPANSION

A plan to expand Medicaid coverage in Arkansas by using Medicaid expansion dollars to buy private health insurance passed by a wide majority in the state House on Thursday, April 11 but it may not have been wide enough to ultimately succeed. Although a bipartisan group of members voted 62-37 in support of the plan, a three-fourths vote is needed to fund it.

A vote on funding the proposal is expected as part of a broader appropriations debate. The outcome of the plan in Arkansas is being eyed closely by Medicaid expansion stakeholders because the state has led the way on the use of the expansion dollars to buy private insurance plans for uninsured residents.

15. STUDY: STRONG PUBLIC SUPPORT FOR STATES TO ACCEPT MEDICAID FUNDS
This week, the Georgetown University Center for Children and Families and the National Women's Law Center released survey results which found that people overwhelmingly (by a ratio of 3:1) support their states accepting federal dollars to expand Medicaid. The survey reinforces findings from numerous state polls that show widespread public support for accepting federal funds allocated by the *Affordable Care Act* to cover more people through Medicaid. In addition, the survey demonstrates that a majority of the public would be concerned if their state turns down the federal dollars. Specifically, when they learn that some lower-income people could fall into a "coverage gap" without affordable health coverage options if their state turns down the funds – while higher income people will be eligible for new tax credits to buy insurance on the health exchanges – most feel this is a good reason for their state to accept the federal dollars.

16. CMS RELEASES PROPOSED RULE ON INSURANCE MARKETPLACE NAVIGATORS
The Centers for Medicare & Medicaid Services (CMS) released a proposed rule outlining the standards that must be met by Navigators in Federally-facilitated and state partnership marketplaces. Navigators will provide unbiased and impartial information to consumers about health insurance, the new health insurance marketplace, qualified health plans, and public programs including Medicaid and the Children's Health Insurance Program, and will serve an important role ensuring that people understand the health coverage options available to them. Navigators will provide fair and impartial assistance to consumers as they learn about the new marketplace, and review their health coverage options.

17. HHS ANNOUNCES MARKETPLACE GRANT AWARDS
The Department of Health and Human Services (HHS) awarded five states with a combined $275.6 million to continue building health insurance marketplaces. States include Hawaii, Illinois, Arkansas, New Hampshire, and Rhode Island. These funds will be used to develop technical infrastructure and to facilitate marketplace implementation ahead of open enrollment in October 2013.

18. CMS ISSUES FUNDING OPPORTUNITY ANNOUNCEMENT FOR NAVIGATORS
CMS announced the availability of new funding to support Navigators in Federally-facilitated and state partnership marketplaces. The funding opportunity provides up to $54 million in total funding. Letters of Intent are due on May 1, 2013 and completed Grant Applications are due on June 7, 2013.

PRESIDENT OBAMA'S FY 2014 BUDGET – IMPACT ON AAFP PRIORITIES

Medicare SGR
The President's FY 2014 budget assumes an adjusted baseline to prevent cuts in Medicare physician payments and calls for a "period of payment stability lasting several years" to allow the development of "accountable payment models" that can replace the SGR. The White House will have to work with Congress to find the savings to replace the SGR.

Medicare Savings (-$371 Billion over 10 years)
The FY 2014 budget request also proposes "to better align payments with costs and strengthen incentives for providers to deliver high quality care."

Graduate Medical Education (-$11 Billion over 10 years)
The President's budget points to the MedPAC finding that GME payments significantly exceed the actual added patient care cost, so it proposes to reduce the IME adjustment by 10 percent.

Children's Hospitals Graduate Medical Education Program (-$177.171 million)
The FY 2014 President's budget request of $88 million is about one-third of the $265 million FY 2012 enacted level, which will allow for support of the direct medical expenses for GME.

Title VII §747 – Primary Care Training and Enhancement (+$12 million)
The President's budget requested an increase for Title VII §747 from nearly $39 million in FY 2012 to $51 million in FY 2014. As in the FY 2013 request, the increase is meant for PAs. HRSA's budget justification indicates that the FY 2014 request supports a new initiative that, sustained over five years (FYs 2014-2018), will increase the primary care workforce by 2,800 primary care providers (1,400 primary care PAs, and 1,400 advanced practice RNs).

Title VII §751 – Area Health Education Centers (-$27 million - *eliminated*)
According to HRSA's budget justification, "While the AHEC Program continues to focus on exposing medical students and health professions students to primary care and practice in rural and underserved communities, there is a higher priority to allocate Federal resources to training programs that directly increase the number of primary care providers. It is anticipated that the AHEC Program grantees will continue their efforts to provide interprofessional/interdisciplinary training to health professions students with an emphasis on primary care. These activities may be supported through other funding sources."

Title VII §739 – Health Careers Opportunity Program (-$15 million - *eliminated*)
The FY 2014 budget is prioritizing investing in programs that have a more immediate impact on the production of health professionals, and no funds are requested for this program.

National Health Service Corps (+$5 million)
The President's FY 2014 budget requests that the NHSC be provided the mandatory funds provided under the *Affordable Care Act*. This is a program increase, from $300 million in FY 2013 to $305 million in FY 2014.

Agency for Healthcare Research and Quality (+$29 million)
The President's budget requests a program level for AHRQ of $434 million, an increase of $29 million above the FY 2012 level.

Student Loan Relief Tax Break
The budget also seeks to provide a tax break on income for student loan forgiveness and for certain scholarship amounts for participants in the IHS Health Professions Program.