

December 20, 2013

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### NEXT WEEK IN WASHINGTON...

- \* Congress is adjourned until January 7.

## 1. 'DOC FIX' GIVES LAWMAKERS THREE MONTHS OF BREATHING ROOM

Late on Wednesday, December 18, by a vote of 64-36, the Senate gave final approval to a two-year budget agreement that includes a 3-month extension of the Medicare physician fee schedule, with a 0.5-percent higher conversion factor. The bill (H J Res. 59) now goes to the President for his signature. The temporary provision averts a 24-percent cut in Medicare payments that would have begun on January 1 under the Sustainable Growth Rate (SGR) formula. The \$7.3 billion cost of the measure will be paid for through adjusted reductions in Medicaid payments to hospitals with many uninsured patients, lower payments to long-term-care hospitals and an extension of the Medicare sequester for FY 2023. Lawmakers hope to permanently repeal and replace the SGR before this patch expires on March 31.

## 2. SENATE AND HOUSE BEGIN WORK RECONCILING SGR-REPEAL BILLS

Both the Senate Finance Committee and the House Ways and Means Committee (amending a bill produced by the House Energy and Commerce Committee) have overwhelmingly approved similar but not identical bills – the *SGR Repeal and Medicare Beneficiary Access Act* (S. 1871) and the *Medicare Patient Access and Quality Improvement Act* (HR 2810). The 3-month extension of the Medicare physician fee schedule (with a 0.5-percent increase) means that the two committees have until March 31 to work out the differences in the bills. In addition, neither bill includes any budget offsets for the cost of repealing the SGR and moving payment to a value-based system. The Congressional Budget Office (CBO) found that the Finance Committee bill would cost \$148.6 billion over 10 years before the measure was amended during the debate by the Committee. As for the House version, the CBO estimated that the bill the House Energy and Commerce Committee approved in July would cost \$153.2 billion but the Ways and Means Committee probably increased the price tag by amending it to include 0.5 percent increases in the payment rate for each of three years.

The Senate committee measure already contains an amendment from Senators Debbie Stabenow (D-MI) and Roy Blunt (R-MO) addressing mental health. The amendment would

create a five-year demonstration project in up to 10 states to allow community behavioral health providers that meet certain standards to receive Medicaid reimbursement along the same lines as qualified health centers. According to a staff summary, the CBO estimates the proposal would cost \$1.6 billion over a decade.

The AAFP's Government Relations staff has prepared a digest of the main provisions of the legislation which is attached.

### **3. AAFP REITERATES PRIORITIES AS CONGRESS PREPARES FINAL SPENDING BILL**

On December 20, the AAFP and the Council on Academic Family Medicine sent a letter to the chairmen and ranking members of the House and Senate Appropriations Subcommittee on Labor, HHS and Education in support of primary care physician workforce and research programs. The letter reminded the lawmakers who have begun closed-door negotiations on the final FY 2014 omnibus spending bill of the importance of Title VII, Section 747 grants and the need for the work of the Agency for Healthcare Research and Quality to continue. The Senate filed its FY 2014 appropriations bill for the Departments of Labor, Health and Human Services, and Education, and Related Agencies (S 1284) in July, but the House failed to produce a bill. Since the current stopgap spending measure expires on January 15, there is little room for procedural missteps and delays.

### **4. COMMITTEE PASSES POISON CONTROL AND NEWBORN SCREENING BILLS**

The Senate Health, Education, Labor and Pensions Committee gave voice vote approval to the *Poison Center Network Act* (S 1719) that would reauthorize poison control activities for five years. The measure would authorize \$29 million annually for a poison control grant program, \$700,000 annually to maintain the nationwide toll-free poison control phone number, and \$800,000 annually for a national media campaign. The House Energy and Commerce Committee approved a companion bill (HR 3527) on December 11.

In a separate voice vote, the Senate panel also advanced an amended version of the *Newborn Screening Saves Lives Reauthorization Act* (S 1417) that would reauthorize various newborn-screening programs for five years.

### **5. AAFP SUPPORTS FDA'S DETERMINATION REGARDING TRANS-FAT**

In a December 19 [letter](#) to the Food and Drug Administration (FDA), the AAFP supported the FDA's tentative determination that partially hydrogenated oils (PHOs), which are the primary dietary source of industrially produced trans fatty acids, or trans-fat, are not generally recognized as safe (GRAS) for use in food. Citing new scientific evidence and findings from expert scientific panels, the FDA acknowledges that PHOs have been used in food for many years based on self-determinations by industry that such use is generally recognized as safe. However, if the FDA's tentative determination is finalized, food manufacturers would no longer be permitted to sell PHOs, either directly or as ingredients in another food product, unless the manufacturer received prior FDA approval.

According to the Centers for Disease Control and Prevention, eliminating PHOs from the food supply could prevent up to 20,000 coronary events and as many as 7,000 coronary deaths annually. The AAFP's support stems from a review of the scientific evidence and input received from family physicians serving on a medical advisory panel as part of the AAFP's initiative named Americans In Motion—Healthy Interventions (AIM-HI). This AAFP advisory panel found that PHOs:

- Contribute to obesity in children and adults;
- Have adverse effects on blood cholesterol levels;
- Put the population at risk for coronary heart disease; and
- Contribute to insulin resistance, a precursor to diabetes.

## **6. CMS RELEASES DATA ON MEDICARE USE OF PREVENTIVE SERVICES**

The Centers for Medicare & Medicaid Services (CMS) [released](#) data on December 17 showing that during the first eleven months of 2013, over 25.4 million people with original Medicare received at least one preventive service at no cost to them and over 3.5 million took advantage of the Annual Wellness Visit established by the *Affordable Care Act*. In contrast, during the same time period in 2012, an estimated 24.7 million people with original Medicare received one or more preventive services with no out-of-pocket costs, and almost 2.76 million received an Annual Wellness Visit. CMS also issued state-by-state [information](#).

## **7. HHS NAMES KAREN DESALVO NEXT NATIONAL COORDINATOR FOR HIT**

The Office of the National Coordinator for Health Information Technology has its next leader, according to a staff announcement made by Department of Health & Human Services (HHS) Secretary Kathleen Sebelius. City of New Orleans Health Commissioner and Senior Health Policy Advisor to Mayor Mitch Landrieu, Karen DeSalvo, MD, MPH, MSc, will take over the reins currently held by Acting National Coordinator Jacob Reider, MD.

# SGR-REPEAL LEGISLATION

December 2013

Digest of the *SGR Repeal and Medicare Beneficiary Access Act* (S. 1871) as approved by the Senate Finance Committee on December 12 and the *Medicare Patient Access and Quality Improvement Act* (HR 2810) as approved by the House Energy and Commerce Committee (on July 31) and amended and approved by the House Ways and Means Committee (on December 12). (*Discrepancies between the House and Senate versions relevant to physicians are noted in italic.*)

## A. SGR Repeal and Annual Updates

- Medicare SGR Formula repealed
- Annual updates for 2014-2023
  - *Ways and Means: 0.5% for each of 2014-2017; 0% for 2018-2023*
  - *Finance: 0% for 2014-2023*

**The AAFP will advocate for the Ways and Means provision that increases the payment rate.**
- Annual updates for 2024 and each subsequent year
  - 2% for items and services furnished by qualifying APM participant
  - 1% for all other items and services

## B. Changes in How Medicare Incentivizes Value in Physician Payment

### **1. Value-Based Performance Program (fee for service)**

- Beginning 1/1/17, VBP will be the default method for Medicare to pay physicians.
  - Eligible Professional (EP) will be paid under VBP unless he / she is
    - (1) qualifying APM participant (no reduction + 5% lump-sum bonus based on prior year)
    - (2) partially-qualifying APM participant who does **not** report on measures and activities (no reduction), or
    - (3) under the low-volume threshold (no reduction)
- Value-based adjustments under current-law programs (PQRS, VBM, and EHR incentive program) will sunset at the end of 2016, with substantial infrastructure of those programs used in the VBP.
- Physician payments during a calendar year will be adjusted based on a single composite score for past performance in four categories (CMS may adjust weights within certain parameters):
  - (1) quality (30 percent)
  - (2) resource use (30 percent)
  - (3) clinical improvement activities (15 percent)
  - (4) meaningful use of EHR (25 percent)
- The measures and activities for three of the four performance categories (quality, resource use, and EHR) will be largely imported from existing programs.
  - (1) quality: use quality measures established under PQRS and VBM
  - (2) resource use: use measures of resource use established under VBM

- (3) clinical improvement activities: CMS will establish qualifying activities under at least 6 subcategories ((a) expanded practice access, (b) population management, (c) care coordination, (d) beneficiary engagement, (e) patient safety and practice assessment, and (f) APM participation)
  - EP practicing in certified PCMH automatically gets full credit for this category; EP practicing in an APM automatically gets half credit.
- (4) EHR Meaningful Use: use standards under current law
- CMS will also establish new measures and activities
  - Starting 1/1/16 EPs will report new codes for resource use measurement (care episode groups; patient condition groups; and patient relationship category)
  - *W&M: in developing the measures and activities for the four performance categories, CMS must take into account non-patient-facing EPs (e.g. pathology, radiology, etc.)*
- Performance assessment
  - CMS will develop methodology of assessing performance for a year.
  - The performance standards for the four categories will be based on a blend of both achievement and improvement.
  - The performance period will be at least one year before the payment period (e.g., starting 1/1/16 at the latest for the first payment year).
    - *W&M: CMS will compute an EP's composite score consistent with future CMS estimates of impact of health status / risk factors on quality and resource use outcomes measures.*
    - *W&M: Resource Use does not count toward composite score until 1/1/2020.*

**The AAFP will advocate for these two provisions which allow for risk adjustment of the composite score and permit additional time for the inclusion of resource use in the development of the composite score.**

- CMS will announce VBP incentive payments to EPs no later than 60 days prior to start of payment year; VBP payments for a certain year apply only to that year.
- EPs may seek limited agency-level appeal of VBP incentive payment amount
- Distribution of VBP scores must be (1) continuous and (2) fill the entire range of scores.
- Payments for the applicable year will be adjusted as follows:
  - First, CMS will reduce all physician fees across-the-board based on calendar year (4% in 2017; 6% in 2018; 8% in 2019; 10% in 2020; 10-12% in 2021 and beyond);
  - Second, CMS will add on incentive payment based on composite score (to allow **maximum** payment of +4% in 2017; +6% in 2018; +8% in 2019; +10% in 2020; and +10-12% in 2021 and beyond).
  - Payments will be budget neutral
- Administration of VBP
  - CMS will have budget of \$200m over 4 years to administer the VBP.
  - CMS must consult with stakeholders in carrying out VBP.
  - Starting 1/1/15 CMS must report regular and timely confidential (FOIA-exempt) feedback to EPs

- CMS will make available technical assistance for 2014-2018 (\$25m per year) to help small practices of 10 or fewer, prioritized for (1) rural, (2) shortage area (HPSA), or (3) low scorers on VBP.
  - *W&M: expand to practices of 20 or fewer and \$50m per year*
  - **The AAFP will advocate for the greater funding of technical assistance and broader eligibility for it.**
  - *Finance: add additional priority category of Medically Underserved Area (MUA) (Menendez Amdt 3), and restrict \$10m of the annual \$25m for practices in HPSAs (Thune Amdt 4)*
- GAO will report twice on VBP (2018 and 2021)
  - *Finance: GAO will specifically evaluate the impact of TA funding on the ability of providers to improve within the VBP or successfully transition to APMs, with priority given to rural and HPSA-based practices. (Cornyn Amdt 9)*
- GAO report on quality measures (18 mos. post-enactment)
  - *Finance: GAO report on quality measures shall specifically address alignment of measures across payers (including private payer and Medicaid). (Toomey Amdt 2)*
- *Finance: GAO shall report to Congress on 10/1/19 and 10/1/21 on the transition of physicians in rural areas and HPSAs and physicians treating other underserved populations to APMs. The studies shall make recommendations on changes that could be made to overcome barriers for rural providers and those in HPSAs to participate in APMs. (Cornyn Amdt 10)*

## 2. Alternative Payment Model (APM)

- Features of an eligible APM
  - APM must either (1) require EP to bear more than nominal risk or (2) be a medical home expanded under CMMI
  - APM must (1) use certified EHR system and (2) provide payment based on quality measures comparable to those in VBP.
- Bonus Payment
  - annual lump sum payment of 5% of payment amount for Medicare-covered services for the preceding year.
  - paid independently of any other applicable bonus (e.g. PCIP)
- Qualifying APM Participant must meet following revenue thresholds:<sup>1</sup>
  - 2017-18: 25% of Part B revenue must come from eligible APM
  - 2019-20: 50% of Part B revenue; **OR** 50% of all-payer revenue excluding Tricare / VA (and 25% Part B)
  - 2021-on: 75% of Part B revenue; **OR** 50% of any revenue excluding Tricare / VA (and 25% Part B)
  - *Finance: Medicaid revenue may not count toward APM all-payer threshold “in a state in which no medical home or APM is available under the State program” (Grassley Amdt 15).*

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<sup>1</sup> The revenue thresholds for partial-qualifying APM are as follows:

- 2017-18: 20% of Part B revenue
- 2019-20: 40% of Part B revenue; **OR** 40% of all-payer revenue (20% Part B)
- 2021-on: 50% of Part B revenue; **OR** 50% of all-payer revenue (20% Part B)

- *Finance: ensure that payment and eligibility barriers to use telehealth do not exist in the APM. (Thune Amdt 5) – The AAFP will advocate for including this provision in the final legislation.*
- *Finance: HHS must report to Congress by 7/1/15 plan to integrate MA APMs that take into account a budget-neutral VBM. (Cantwell Amdt 4)*
- Add to list of CMMI APMs: (1) model for non-primary-care practitioners; (2) practices of 20 or fewer
  - *Finance: add (3) Medicaid (Grassley Amdt 15)*

### **3. Changes to Fee Schedule / RVU / GPCI**

- Establish new HCPCS code(s) for chronic care management (CCM) services
  - make budget-neutral payment starting in 2015
  - must be recognized medical home or comparable specialty practice
  - payment will be made to only one applicable provider during a period
  - annual wellness visit or initial preventive physical **not** precondition to payment
  - *Finance: HHS will conduct education / outreach campaign to EPs and beneficiaries on CCM services; report to Congress on same by 12/31/17 (Cardin Amdt 2) - The AAFP will advocate for this provision, since it provides additional information for family physicians who will be billing for chronic care management.*
- Maintain Accuracy in RVUs
  - Give CMS authority to collect data from providers (surveys, logs, EHR, etc.) and give incentive payments to fund. (\$2m annual budget)
  - Set 0.5% target for each of 2015-2018 to reduce overvalued codes; redistribute savings to the fee schedule in a budget-neutral manner; if target is missed make across-the-board pro-rata reduction to fee schedule
  - Phase-in any RVU reduction of 20%+ over two years
  - GAO Study on RUC, report within one year of enactment
- *W&M: Fix GPCI glitch unique to California (Reps. Sam Farr / Darrell Issa)*
- *Finance: Grassley Amdt. 13: Floor on the work geographic practice cost index would be kept at 1.0 permanently – The AAFP will advocate for including this in the final legislation because it would stabilize for rural family physicians one component of the complex payment formula.*

### **C. Other Provisions**

- Quality Measure Development
  - CMS will work with stakeholders (including physician societies) to develop quality measures; CMS must draft and post measure development plan and report annually. \$75m of funding over 5 years.
- Physician Compare Website
  - CMS will publish VBP performance information on individual EPs and aggregate performance data, with appropriate disclaimers.
  - CMS will publish information on the number of services provided by each EP, charges and payments for services, and a publicly available and unique identifier for each EP.

- Physician Compare will be searchable by (1) specialty type; (2) characteristics of services furnished; and (3) location of EP.
- \$6m for HHS to study impact of health status, socioeconomic status etc. on resource use and \$10m for CMS to develop methodology to risk adjust VBM payments based on this work.
- Appropriate Use Criteria (AUC)
  - CMS will establish a program of AUC for professionals who order advanced imaging services. CMS will publish AUC by 11/15/15. Beginning 1/1/17, ordering professionals must consult the AUC before ordering services and notate on claim to receive payment (though no requirement to follow the AUC). Exceptions exist for emergency, hospital inpatients, EPs in an APM, and hardship.
  - Outliers (EPs with low adherence to AUC) will require prior authorization starting 1/1/20.
  - CMS will have authority to expand AUC program to other Part B services (e.g. labs).
- Expand Availability of Medicare Claims Data
  - Make Medicare claims data available to qualified entities (QE) who may conduct data analyses for non-public use.
  - QE could provide or sell analysis to provider, supplier, hospital association, employer, etc. for the purposes approved by CMS including:
    - Help providers develop and participate in quality and patient care improvement activities
    - Population health management
    - Disease monitoring
    - Assisting employers with providing health insurance to employees
- *W&M: Med-mal safe harbor: Courts may not use any standard developed under this framework as the standard of care in a malpractice or products liability claim – **The AAFP will advocate for including this in the final legislation.***
- *W&M: Allows professionals who opt out of Medicare to automatically renew at the end of each two-year cycle; allows regular reporting of opt-out physician characteristics*
- *W&M: Medicare Non-participating Physicians Demonstration Project*
- *W&M: HHS shall submit recommendations on amending fraud and abuse laws to permit gain-sharing arrangements between physicians and hospitals*
- *W&M: provisions around the interoperability of EHR*
- *W&M: GAO Study and Report on the Use of Telehealth under Federal Programs*
- *Finance: reform Medicare fraud and abuse laws (PRIME Act) (Carper Amdt 1)*
- *Finance: allow Physician Assistants to provide and manage (but not order) hospice care services for Medicare beneficiaries: (Enzi Amdt 1)*