

May 10, 2013

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NEXT WEEK IN WASHINGTON...

- * The Family Medicine Congressional Conference will be held on May 14 and 15.
- * Senate Finance Committee will hold a Medicare physician payment reform hearing on May 14.
- * Senate Appropriations Committee will hold a hearing on FY 2014 NIH funding on May 15.
- * The House will hold another largely symbolic vote to repeal the *Affordable Care Act*.
- * The Congressional Budget Office will update its budget projections on May 14 which could change the cost of SGR repeal.

1. CONGRESSIONAL COMMITTEES TACKLE SGR REPEAL

House Ways and Means Subcommittee on Health

The House Ways and Means Health Subcommittee held a hearing on Tuesday, May 7 to examine options for repealing the Medicare Sustainable Growth Rate (SGR) formula and reforming the physician payment system to reward quality and value. The subcommittee heard [testimony](#) from representatives of the American College of Physicians, the American College of Surgeons and others. Subcommittee Chairman Kevin Brady (R-TX) emphasized that SGR repeal need not be a partisan exercise and stressed that getting the measures right is essential if payments are to be based on quality.

Subcommittee Ranking Member Jim McDermott, MD (D-WA) concurred that there is bipartisan support for SGR repeal and emphasized the need for strong primary care. However, Rep. McDermott said that the cuts to offset the cost of repeal are an expected area of disagreement. Chairman Brady indicated that he and Rep. McDermott are concerned about the ability of rural physicians to transition to a new payment model. Two witnesses expressed confidence that a five-year transition period, establishment of clinical affinity groups, use of the Internet, and some regionalization should enable success.

Rep. Peter Roskam (R-IL) asked about defensive medicine adding to the cost of care and was told that Health Partners does not consider it to be a “big deal in our market.” The biggest issue is enough time with patients to get all their information. Fee for service is a deterrent to this.

Rep. Tom Price, MD (R-GA) stressed the need for “pressure valve releases” such as balance billing. ACS was not vocally supportive and ACP said the concept should be tested first to ensure that patients are not adversely affected.

Rep. Bill Pascrell (D-NJ) expressed disappointment that the Workforce Commission has not been funded and expressed interest in learning how to incentivize primary care to alleviate that shortage. Rep. Allyson Schwartz (D-PA) who is on the full committee but not the subcommittee also stressed primary care and the team-based approach.

Senate Finance Committee

Meanwhile, on Friday, May 10, the Chair and the senior Republican member of the Senate Finance Committee wrote to physician groups, including AAFP, asking for specific recommendations to improve the Medicare physician payment system. The Committee leaders asked for our suggestions by the end of the month. The letter, along with the upcoming hearing, signals renewed interest on the committee to address repeal of the SGR and how to replace it.

2. AAFP SUBMITS FY 2014 REQUEST TO SENATE APPROPRIATIONS

On May 2, the AAFP transmitted [testimony](#) to the Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education urging committee members to invest in our nation’s primary care physician workforce. The AAFP asked the subcommittee to promote the efficient, effective delivery of health care by providing adequate appropriations for primary care focused programs at the Health Resources and Services Administration and the Agency for Healthcare Research and Quality. The Appropriations Committee Chair, Senator Barbara Mikulski (D-MD), hopes to produce bipartisan bills which use the overall funding level set in the Senate budget resolution of \$1.058 trillion rather than the lower House budget’s \$966 billion. The House Labor, HHS, and Education Subcommittee will have a further lowered allocation because the House budget shifts the defense FY 2014 sequestration cuts to non-defense discretionary functions. As a result, the House overall spending cap will be \$17 billion below current year spending and will mean additional cuts in many programs. Neither Subcommittee is expected to produce a FY 2014 spending bill before late July.

3. AAFP ENCOURAGES ADEQUATE TRAINING OF INSURANCE NAVIGATORS

In a letter sent on May 6, the AAFP encouraged the Centers for Medicare & Medicaid Services (CMS) in response to a proposed rule that regulates health insurance “navigators” and other consumer assistance personnel in health insurance marketplaces to develop comprehensive evaluation and monitoring programs to ensure that all consumers in the marketplaces will have access to appropriate, affordable, high quality health insurance.

4. PHYSICIAN GROUPS REQUEST MORE INFORMATION ON PARITY PAYMENT

A May 7 [letter](#) to CMS from the AAFP and six other physician groups expresses strong support for the [Medicaid primary care payment increase](#), and requests additional information to share with states in order to effectively communicate the provisions of the payment increase to physicians.

5. IMMIGRATION BILL DRAWS HEALTH REFORM AMENDMENTS

Several Republicans have submitted amendments to the immigration bill that the Judiciary Committee has begun debating that would reinforce bans against granting Medicaid, health insurance credits and other government benefits to immigrants on the road to permanent residency.

Senator Jeff Flake (R-AZ), who is part of the group of Senators who drafted the bill, filed an amendment requiring HHS to conduct regular audits to make sure the immigrants with “provisional” status are not collecting federal means-tested benefits.

An amendment from Senator Ted Cruz (R-TX) provides that “aliens who have entered or remained present in the United States while not in lawful status shall not be eligible for means-tested benefits.” Senator Jeff Sessions (R-AL) has filed amendments prohibiting an undocumented immigrant from achieving provisional status if the immigrant is deemed likely to receive government benefits. Several of the amendments specifically single out Medicaid, CHIP and the *Affordable Care Act* insurance tax credits. Another amendment would require undocumented immigrants to have employer-sponsored health coverage to achieve provisional status.

6. FamMedPAC ENJOYING STRONG FUNDRAISING, SUPPORTS KEY LEGISLATORS

Donations to the PAC are on a good pace in 2013, with \$218,502 received from 893 AAFP members. The average donation is \$245. The PAC made \$198,000 in campaign contributions since the first of the year. \$106,500 went to 24 Democratic candidates and committees, with \$91,500 going to 25 Republican candidates and committees. The PAC supported the following legislators this week:

- **Rep. Nita Lowey (D-NY)**, the Ranking Democrat on the House Appropriations Committee.
- **Rep. Kevin McCarthy (R-CA)**, the Majority Whip in the House.
- **Rep. Lois Capps (D-CA)**, a Member of the Health Subcommittee of the House Energy and Commerce Committee.

7. WEST VIRGINIA GOVERNOR EXPANDS THE MEDICAID PROGRAM

West Virginia Governor Earl Ray Tomblin (D) announced that the state would expand its Medicaid program. The increased access to coverage will enable approximately 91,500 working West Virginians to join the program, which significantly reduces the uninsured rate in the poor state. Currently, one in four West Virginians are uninsured. The Governor did mention his reservations about expansion, stating that if the program becomes unstable, particularly after three years, or if the federal government changes its promised funding allocations, state leadership could change its mind and change or reverse the expansion. Gov. Tomblin joins 22 other governors across the country (plus D.C.) in expanding their state medicaid programs.

8. OKLAHOMA GOVERNOR: NO TO EXCHANGE & MEDICAID EXPANSION

Oklahoma Governor Mary Fallin is unlikely to pursue Medicaid expansion in 2013, but the state will continue to carefully consider options to extend affordable coverage options to its residents. The Governor also rejected participation in the insurance marketplace. Oklahoma joins a long list of states who have informed HHS recently that their states refuse to create health insurance marketplaces, leaving the job up to the federal government. Now including Oklahoma, 17 states have decided not to operate health insurance marketplaces.

9. IDAHO TO BUILD INSURANCE MARKETPLACE IN SIX MONTHS

Idaho has formed a 19-member insurance exchange board, which has been in constant contact with the federal exchange office in deliberation on how the state can build its own marketplace by borrowing pieces of the federal plan structure. The state plans to have its state marketplace up and running by the October 1, 2013 deadline, which is also when open enrollment begins. Only 16 states, and the District of Columbia have decided to operate their own exchanges, of these, only three are conservative states (including Idaho). The ID exchange board has a number of hurdles ahead of it, including setting bylaws and creating procurement policy before the state can contract with competing vendors to help develop and run the new marketplace.

10. OREGON RELEASES MEDICAID EXPERIMENT REPORT FINDINGS

Two years of data from the Oregon Medicaid experiment were released on May 2 in the *New England Journal of Medicine*. The experiment is based on a randomized controlled study comparing health outcomes of Oregon residents who received Medicaid coverage through a statewide lottery to residents who did not receive such coverage through the lottery. Findings show that Medicaid coverage does four important things for beneficiaries -- improves access to needed health care, encourages use of preventative health services, improves overall mental health, and provides patients with financial security and peace of mind.

11. UPTON/HATCH RELEASE MAKING MEDICAID WORK REPORT

Last week, House Energy and Commerce Committee Chairman Fred Upton (R-MI) and the senior Republican on the Senate Finance Committee, Senator Orrin Hatch (R-UT), introduced their *Making Medicaid Work* plan. The plan recommends legislation to grant states more control over their Medicaid expenditures, and to correct the lack of access to quality preventative care or physicians. The 20-page plan would allow states to implement patient-centered reforms in Medicaid along with developing block grants to enact per-capita caps. The state-specific per-capita caps would be determined by the state's average medical expenditures. Among other things, the plan gives states the opportunity to develop new benchmark options, enact value-based insurance design (V-BID), and encourage new premium assistance models that offer limited benefits to reduce costs.

12. REGULATORY BRIEFS

- On April 24, CMS [announced](#) release of a [proposed rule](#) that, once final, increases financial rewards paid to Medicare beneficiaries and other individuals whose tips about suspected fraud lead to the successful recovery of funds. Under the proposed changes, the first person who provides specific information leading to the recovery of funds may be eligible to receive a reward of 15 percent of the amount recovered, up to \$9.9 million, if CMS recovers \$66 million or more. CMS currently offers a reward of 10 percent up to \$1,000 under the current incentive reward program. The proposed rule also implements several provider enrollment safeguards such as allowing CMS to deny enrollment to providers, suppliers, and owners who are affiliated with an entity that has unpaid Medicare debt. CMS will accept public comments through June 28.
- On April 26, CMS [announced](#) release of a proposed rule impacting hospitals paid under the Inpatient Prospective Payment System (IPPS) and Long-Term Acute Care Hospital Prospective Payment System (LTCH PPS). The proposed rule, which applies to approximately 3,400 acute care hospitals and approximately 440 LTCHs, generally affects discharges occurring on or after October 1, 2013. Under the proposed rule, CMS projects that Medicare aggregate payments to acute care hospitals for discharges occurring in FY 2013 would increase by a projected \$27 million FY 2014 relative to FY 2013. This includes a hospital rate update of 0.8 percent. Medicare payments to LTCHs in FY 2014 are projected to increase by \$62 million or 1.1 percent. CMS will accept comments on the proposed rule through June 25, 2013 and will respond to them in a final rule to be issued by August 1, 2013.
- On April 29, CMS [announced](#) release of a proposed rule that estimates a 1.1 percent (\$180 million) increase in hospice payments for 2014. The proposed rule will be published on May 10 and CMS will accept comments on it through July 9.
- On, April 30, CMS [announced](#) simplified and shortened applications for health care coverage that will be provided as part of the health insurance marketplaces that are scheduled to be up and operating by Jan. 1 2014. CMS describes the shortened forms as "consumer friendly," saying they are "much shorter than industry standards for health insurance today." Enrollment for the marketplaces starts on Oct. 1, 2013 and consumers can apply online, by phone or by filling out a paper application. There are 3 marketplace

consumer applications the [Individual Short Form, Family](#), and [Individual without Financial Assistance](#). For more information about the health insurance marketplace, visit: www.HealthCare.gov.

- On May 1, CMS [announced](#) release of a proposed rule outlining 2014 Medicare payment rates for skilled nursing facilities (SNFs). CMS estimates that aggregate payments to SNFs will increase by \$500 million, or 1.4 percent, from payments in FY 2013. Public comments on the proposals will be accepted until July 1.
- On May 2, CMS proposed a rule for FY 2014 Medicare payment policies and rates for the inpatient rehabilitation facilities (IRFs) Prospective Payment System (PPS), as well as updates and changes for the IRF Quality Reporting Program (QRP). CMS estimates that aggregate payments to IRFs will increase by \$150 million, or 2.0 percent. Comments on the proposals will be accepted until July 1, 2013.
- On May 8, HHS posted data online to provide consumers with information on what hospitals charge. In the [press release](#), HHS gave an example of average inpatient charges for services a hospital may provide in connection with a joint replacement range from a low of \$5,300 at a hospital in Ada, OK, to a high of \$223,000 at a hospital in Monterey Park, CA. As part of this announcement, HHS also made approximately \$87 million available to states to enhance their rate review programs and further health care pricing transparency.