GOVERNMENT AFFAIRS WEEKLY

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IN THIS REPORT…

NEXT WEEK IN WASHINGTON…

* The House is likely to take up a short-term, stopgap funding measure next week that would avert a government shutdown at the end of this month. The measure is expected to last no more than two to three months and would continue spending at current levels.
* On Tuesday, September 10, the House Energy and Commerce Subcommittee on Health is scheduled to hold a hearing on the implementation of the *Affordable Care Act*.
* The Medicare Payment Advisory Commission (MedPAC) convenes on Sep. 12 and 13.

1. THE AAFP LAUNCHES INFORMATION WEB PAGE ON ACA IMPLEMENTATION

The AAFP has developed educational materials about health insurance provisions of the *Affordable Care Act (ACA)*. Open enrollment in health insurance marketplaces begins October 1, and physicians will be a trusted source of information for their patients. The materials provide clear information for members that will help them guide patients in the right direction should they have questions.

Additional ACA resources include information for chapters to support education, outreach, and state lobbying efforts as well as a presentation for family medicine faculty to educate students and residents on the impact of the ACA on primary care.

2. AAFP RESPONDS TO 2014 PROPOSED MEDICARE PHYSICIAN FEE SCHEDULE

In a letter sent August 29, the AAFP responded to the Centers for Medicare & Medicaid Services (CMS) proposed 2014 Medicare Physician Fee Schedule (MPFS). In it, the AAFP thanked the agency for offering short-term payment strategies that recognize "primary care and care coordination as critical components in achieving better care for individuals, better health for individuals, and reduced expenditure growth."

However, the proposed fee schedule included an estimate that the sustainable growth rate (SGR), which is the statutory formula used to determine Medicare physician payments, will decrease 24.4 percent in 2014 unless Congress intervenes. An AAFP analysis of the proposed cut shows the typical family physician would lose a total of $89,763 and a three-physician practice would lose $269,289 in revenue next year.

The AAFP encouraged CMS and Congress to work together to avert this devastating cut. The AAFP called on Congress to repeal the SGR and replace it with a formula that includes higher payment for primary care. We also recommended continuing efforts to develop a new and effective physician-endorsed payment model.

To improve the final 2014 Medicare physician fee schedule rule, the AAFP:

- Generally supported the CMS proposal to pay for CCCM services in 2015 and agrees that resources required to properly provide CCCM services to beneficiaries with multiple chronic conditions are not adequately reflected in the existing E/M codes;
- Reiterated our concern that the current office/outpatient E/M codes are not adequate for primary care and that CMS needs to create dedicated codes for primary care physicians;
- Urged CMS to ramp up and expand the Comprehensive Primary Care Initiative (CPCI) and pay a risk-adjusted care management fee for all Medicare beneficiaries as part of a blended-payment model for the patient-centered medical home (PCMH);
- Appreciated efforts to align the Physician Quality Reporting System (PQRS) with other quality improvement programs but questions the proposal to increase the number of reported PQRS measures from three to nine;
- Supported CMS' efforts to adjust relative value unit (RVU) amounts for procedures in order to pay more accurately for services; however, we also encourage CMS to not pay significantly more for services in the outpatient or ambulatory surgical center setting than in the physician office setting;
- Appreciated the increasingly significant steps to identify and address potentially misvalued codes, although we believe more should be done to ensure that Medicare is not reimbursing based on biased data that further exacerbates the undervaluation of primary care services;
- Advocated for the elimination of all geographic adjustment factors from the MPFS except for those designed to achieve a specific public policy goal;
- For purposes of Medicare Telehealth Services, concurred with a proposed change to define "rural" to include geographic areas located in rural census tracts within Metropolitan Statistical Areas (MSAs) in order to allow for the appropriate inclusion of additional HPSAs as areas for telehealth originating sites;
- Supported a technical correction that clarifies that those auxiliary personnel performing "incident to" services must furnish services in accordance with applicable state law;
- Supported removing the initial preventive physical examination (IPPE) as a prerequisite for abdominal aortic aneurysm (AAA) screenings to conform with the recommendation by the United States Preventive Services Task Force;
- Supported expanded coverage and access to colorectal cancer screening by allowing non-physician practitioners to order the screening fecal occult blood tests so long as they function under the direction and responsible supervision of a practicing and licensed physician;
- Commended the agency for the improvements made to the Physician Compare website and also urges CMS to extend the physician preview period and to translate physician quality scores into consumer friendly terms;
- Found CMS proposals to implement the value-based payment modifier as reasonable and appreciates CMS not initially subjecting penalties to groups of 10-99 eligible professionals; and
- Continued to support efforts to align quality reporting programs and innovation initiatives yet also expresses increasing concerns with Meaningful Use Stage 2 expectations.

3. AAFP EXPRESSES CONCERNS ON STAGE TWO OF "MEANINGFUL USE" REGS

In a letter sent August 7, the AAFP wrote HHS officials to express our increasing concerns with the regulatory expectations of Meaningful Use (MU), Stage 2. The letter discussed how the

current timeframe will outstrip the capacity of many certified electronic health record technology vendors and ambulatory family medicine practices. The AAFP agreed conceptually with a staged approach to enhanced care safety, quality, coordination, patient engagement, and population health through the effective implementation and use of health information technology. However, the letter also pointed out that 2014 brings a number of regulatory compliance issues for family physicians that may derail health IT adoption and substantially interfere with our shared progress toward achieving better care for patients, better health for communities, and lower costs through improvements to the health care system.

In the interest of advancing the policy priorities of MU and maintaining the momentum of health care transformation brought about by the CMS Electronic Health Record (EHR) Incentive Programs, the AAFP urged CMS not to delay the implementation of MU Stage 2 but to extend the timeframe for compliance by 12 months.

4. REACTIONS SENT ON TEACHING HEALTH CENTER CHART AND EVALUATION

In a letter sent August 29 to the Health Resources and Services Administration (HRSA), the Council of Academic Family Medicine and the AAFP commented on an information collection request about the Teaching Health Center Graduate Medical Education (THCGME) Program Eligible Resident/Full-Time Equivalent (FTE) Chart. The chart is a means for determining the number of eligible residents/FTEs in a potential teaching health center's (THC) primary care residency program. As HRSA contemplates revisions to the THCGME FTE chart, the organizations urged HRSA to ask teaching health centers about residents in post-graduate years 4 and 5 to accommodate combined programs and those with 4 and 5 year curricula. The letter suggested that HRSA expand the survey to capture the status of residents leaving the program, much in the same way that the Accreditation Council for Graduate Medical Education captures this information in the annual online data survey.

In a separate letter sent August 8, the same organizations commented on an evaluation of HRSA's Teaching Health Center Graduate Medical Education program, which is designed to establish and expand primary care residency training programs in community-based settings. The goals of this program are to increase the production of primary care doctors who are well prepared to practice in community settings, particularly with underserved populations, and to improve the number and geographic distribution of primary care providers. The letter discussed the importance of the program and asked HRSA to continue these evaluations annually.

5. AAFP URGES FDA TO BAN MENTHOL IN CIGARETTES AND TOBACCO PRODUCTS

In a letter sent to the FDA on August 7, the AAFP responded to a request for comments on menthol in cigarettes and tobacco products. The AAFP had previously urged the FDA to ban menthol as a flavoring agent. This comment letter expressed appreciation that the FDA is now refocusing efforts to understand the effect of menthol in cigarettes and tobacco products and the AAFP again advocated that the FDA use its authority to regulate tobacco and force manufacturers to remove menthol as a flavoring agent.