GOVERNMENT AFFAIRS WEEKLY

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IN THIS REPORT…

NEXT WEEK IN WASHINGTON…

* The Family Medicine Congressional Conference will be held on April 7 and 8.
* On Tuesday, April 8, the House Energy & Commerce Subcommittee on Health will hold a hearing on the implementation of the *Tobacco Control Act.*
* On Wednesday, April 9, the Senate HELP Subcommittee on Primary Care & Aging will hold a hearing on "Addressing Primary Care Access and Workforce Challenges: Voices from the Field."

1. ONE-YEAR SGR PATCH PASSES CONGRESS; SIGNED INTO LAW

On Monday, March 31, the Senate passed the *Protecting Access to Medicare Act* (HR 4302) by a vote of 64-35. The House had passed the measure on Thursday March 27. On Tuesday, April 1, President Obama signed the bill into law. It contains several provisions that will affect family medicine, including:

- A one-year delay of the SGR cut: instead of a 24% SGR cut on April 1, 2014, a continuation of the 0.5% positive update through 2014, and a 0.0% update from January 1, 2015 through March 31, 2015.
- A one-year delay of the transition to ICD-10 from October 1, 2014 to October 1, 2015.
- A one-year extension of the work GPCI floor to support physicians in rural areas.
- A requirement that CMS reduce reimbursements for overvalued services during the years 2017-2020; whether the savings achieved will be distributed to other services in the Medicare fee schedule will depend on whether the savings meets a specific target.
- And a requirement starting January 1, 2017 that physicians ordering advanced imaging services consult with a ~~q~~qualified decision support mechanism" and provide certain information from the support tool to the professional furnishing the imaging service.

The Senate held three hours of debate before passing HR 4302. During the debate Sen. Ron Wyden (D-OR) sought twice to have the Senate vote on his permanent SGR repeal bill, *The Commonsense Medicare SGR Repeal and Beneficiary Access Improvement Act* (S. 2157), but was unsuccessful both times. After Sen. Wyden's bill failed to proceed to a vote, Senator Hatch

sought to put to a vote his permanent SGR repeal bill, the *Responsible Medicare SGR Repeal and Beneficiary Access Improvement Act* (S. 2212). Both the Wyden and Hatch bills include the bipartisan SGR repeal-and-replace language that the AAFP supports (HR 4015 / S. 2000), but are financed differently. The Wyden bill would pay for the $180 billion cost by capping spending for overseas contingency operations to correspond with anticipated drawdowns in military operations over the next 10 years. The Hatch bill would be financed by repealing the individual mandate of the *Affordable Care Act*. Each financing option is a non-starter with the other party and hence not politically viable.

Enactment of HR 4302 represents a setback for the permanent repeal-and-replace movement that during this Congress has advanced further than ever in the SGR's 16-year history. Past Congressional behavior strongly suggests that with the new SGR deadline pushed to April 2015, lawmakers may not successfully address the SGR issue this fall. Meanwhile, because the bipartisan agreement (HR 4015 / S. 2000) will lapse at the end of this session of Congress in the fall, the committees with jurisdiction over Medicare must file a new bill in 2015—a bill that would need approval by several incoming chairs and ranking members who did not help craft HR 4015 / S. 2000. Despite these hurdles, the AAFP released a statement after the Senate vote calling upon Congress to intensify the efforts to enact permanent SGR repeal legislation this year. The AAFP also sent a similar letter to Congressional Leaders after the measure was signed into law.

2. AAFP URGES CONGRESS TO HIKE INVESTMENT IN TITLE VII, AHRQ AND NHSC

House and Senate appropriators remain committed to moving the FY 2015 spending bills quickly to improve their chances of becoming law in a midterm election year with a tight legislative calendar. The AAFP continues to collaborate with the Council of Academic Family Medicine and other coalitions to support our funding priorities. The AAFP and 107 other organizations signed a March 26 letter to House and Senate Appropriations Committee members to support restoring the discretionary budget authority for the Health Resources and Services Administration (HRSA) to the FY 2010 level of $7.48 billion in FY 2015. On March 27, the AAFP joined 56 organizations which make up the Health Professions and Nursing Education Coalition (HPNEC) in sending a letter to House and Senate Labor-HHS Subcommittee leadership recommending $520 million for Titles VII and VIII. On April 4, anticipating the April 9 hearing before the Senate HELP Subcommittee on Primary Care and Aging on ~~"~~Addressing Primary Care Access and Workforce Challenges: Voices from the Field," the National Health Service Corps (NHSC) Stakeholders sent a letter to House and Senate appropriators and authorizers urging them to help ensure a sustained, long-term investment in the NHSC.

3. HOUSE BUDGET COMMITTEE ADVANCES RYAN BLUEPRINT

On April 2, the House Budget Committee approved a draft fiscal year 2015 budget resolution that would call for $5.1 trillion in cuts to federal spending over the coming decade by a party-line vote of 22 to 16. The budget resolution offered by House Budget Committee Chairman Paul Ryan (R-WI) lays out some general principles for spending cuts and tax reform without targeting particular programs. It would adhere to the discretionary budget authority of $1.014 trillion for FY 2015 under the budget deal brokered by Chairman Ryan and Senate Budget Chairman Patty Murray (D-WA). The nonbinding spending blueprint calls for repealing most of the *Affordable Care Act* and converting Medicaid into a block grant program. The budget proposal calls for a gradual increase of the eligibility age for Medicare beginning in 2024. It also again proposes to change the Medicare program into a premium support system so that seniors could buy their own coverage.

During the debate, Democrats offered several amendments including one offered by Rep. Jim McDermott, MD (D-WA) and others to protect access to primary care in Medicaid. The

amendment, which failed, sought to ensure those relying on Medicaid have access to primary care.

Although some Republicans applauded the new direction, others were concerned about the spending cuts and major changes to entitlement programs. House Appropriations Chairman Hal Rogers (R-KY) described the budget, which he will support, as ~~"p~~retty draconian." The House will vote on it next week, but the Senate is unlikely to even consider a budget resolution this year.

4. MEDPAC REVIEWS PRIMARY CARE TEAMS AND BONUS PAYMENTS

On Thursday, April 3, the 17-member Medicare Payment Advisory Commission discussed two matters pertaining to primary care: team-based care and incentive payments to primary care providers.

Commissioners considered the findings related to interviews of 10 primary-care teams (5 physician-led teams and 5 nurse-led teams) in 9 different states. The survey concluded that there is ~~"h~~igh variability" in terms of structure, staffing, and activities, suggesting that there may not be an appropriate one-size-fits-all model for team-based primary care. During deliberations at least one commissioner was troubled by the lack of any concrete definition for team-based primary care. Yet a consensus emerged that translating the clearly defined roles of hospital and surgical teams to primary care does not make sense; primary care is a much broader set of activities than a specific surgical procedure; therefore, it is more challenging to posit what a primary-care team should look like and how it should operate. Several commissioners agreed that instead of paying bonuses to practices merely for working in teams, Medicare ought to incentivize outcomes that necessitate the formation of high-performing teams.

MedPAC continued ongoing deliberations about how Medicare should reward primary care after the Primary Care Incentive Payment (established in Section 5501 of the *Affordable Care Act*) expires at the end of 2015. Instead of recommending an extension of the current bonus payments, the commission is considering recommending a per-beneficiary payment for primary care. The commissioners deliberated over design issues including the amount of the payment, how to finance the payment, the method of attribution, and whether any additional requirements should be imposed to receive the payment.

Staff noted that Medicare paid $664 million in PCIP bonus payments in 2012, which, if converted to per-beneficiary payments, would amount to $2.60 per beneficiary per month. Given this small amount, most commissioners agreed that Medicare ought to attribute patients prospectively with no additional practice requirements. The commissioners also discussed whether the $2.60 figure could be enhanced over time by reducing other overvalued services within the Medicare physician fee schedule. MedPAC will publish a chapter on per-beneficiary payment in June, leading up to a formal recommendation to Congress in March 2015, assuming continued consensus.

5. FOR HEALTH INSURANCE COVERAGE, FULL TIME WOULD BE 40 HOURS A WEEK

The House on Tuesday, April 2, passed the Save *American Workers Act* (HR 2575) in an effort to raise the *Affordable Care Act*'s definition of full-time employment from 30-hours to 40-hours a week, increasing the threshold under which businesses will be required to offer employees health insurance or pay a penalty. The vote of 248 to 179 included 18 Democrats in spite of the White House veto threat against the measure.

6. COALITION LETTER SENT TO FDA ON SURGEON GENERAL'S REPORT

The AAFP signed onto a coalition letter with other physician and public health associations sent to the FDA on March 27 that discusses the recently issued report by the Surgeon General titled,

–The Health Consequences of Smoking – 50 Years of Progress." The letter calls on the FDA to act upon the report and require changes in the design and composition of cigarettes to eliminate the increased risk of disease and death identified by the Surgeon General.

7. FAMILY MEDICINE NOMINATES THREE TO GME COUNCIL

In a letter sent March 31 to the HRSA from the Council of Academic Family Medicine (CAFM), Kristen H. Goodell, MD; Joseph W. Gravel, Jr., MD; and Beulette Y. Hooks, MD were nominated to the Council on Graduate Medical Education. HRSA requested nominations for this committee which provides advice to the Department of Health and Human Services and Congress on a range of issues such as the supply and distribution of physicians, current and future shortages or excesses of physicians in medical and surgical specialties and subspecialties, and the nature and financing of medical education training.

8. REGULATORY BRIEFS

- On April 2, CMS announced that the agency will provide the public with access to information about the number and type of health care services that individual physicians and certain other health care professionals delivered in 2012, and the amount Medicare paid them for those services, beginning not earlier than April 9. With this data, CMS says it will be possible to conduct a wide range of analyses that compare 6,000 different types of services and procedures provided, as well as payments received by individual health care providers.
- On April 3, CMS and the FDA made separate announcements related to the recent U.S. Supreme court case ruling on *U.S. v. Windsor*. CMS announced that the Social Security Administration (SSA) is now able to process requests for Medicare Part A and Part B Special Enrollment Periods, and reductions in Part B and premium Part A late enrollment penalties for certain eligible people in same-sex marriages. The FDA announced new guidance titled *–The Meaning of "Spouse" and "Family" in FDA's Regulations after the Supreme Court's Ruling in United States v. Windsor—Questions and Answers: Guidance for Industry, Consumers, and FDA Staff."*
- On April 3, CMS released the 2012 Medicare Physician Quality Reporting System and Electronic Prescribing Incentive Program Experience Report and cited increased participation in both programs. In 2012, 435,931 professionals (out of 1,201,363) participated as individuals or as part of a group practice in PQRS, a 36 percent increase from 2011. Among those participating, 367,228 of these individuals qualified for an incentive payment, and the total incentive payments in 2012 were approximately $168 million. In 2012 under the eRx program, 344,676 professionals (out of 778,904) participated, representing a 22 percent increase from 2011. Among those participating, 227,447 of these individuals met the eligibility criteria to receive an incentive payment, and the total incentive payments in 2012 were approximately $335 million.