GOVERNMENT AFFAIRS WEEKLY

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

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SPECIAL REGULATORY REPORT…

1. AAFP comments sent to CMS on MACRA RFI
2. Regulatory Briefs

NEXT WEEK IN WASHINGTON…
* Congress is in recess until November 16.
* On Tuesday, November 17, the Energy and Commerce Health Subcommittee will hold a hearing to examine the regulation of diagnostic tests and laboratory operations.

1. AAFP SENDS DETAILED RESPONSE TO MACRA REQUEST FOR INFORMATION

On October 1, 2015, the Centers for Medicare & Medicaid Services published a request for information regarding implementation of the Merit-Based Incentive Payment System (MIPS), promotion of Alternative Payment Models (APM), and incentive payments for participation in eligible APMs. In a 53-page response sent to CMS on November 9, the AAFP reiterated full support for the *Medicare Access and CHIP Reauthorization Act* (MACRA) since it:

- Repealed the faulty SGR.
- Set the health care system on a path away from episodic, fee-for-service payments toward more comprehensive, value-based payment.
- Encouraged the US health care delivery systems to place greater emphasis on the value of comprehensive, continuous, coordinated, and connected primary care.

However, the AAFP response also expressed the importance of not building the MIPS and APM programs upon the biased and inaccurate relative value data currently used in the fee-for-service system. The letter strongly recommended that more be done to ensure Medicare pays appropriately for primary care physician services. To achieve this goal, the AAFP urged CMS to use its authority and take administrative actions to increase the values of primary care services in the Medicare program.

In summary, the AAFP response focused on the need for:

- Measure Harmonization - The AAFP supports reasonable and achievable quality improvement programs that promote continuous quality improvement and measure patient experiences. However, the AAFP opposes an approach that requires physicians to report on a complex set of measures that do not impact or influence the quality of care provided to patients. The AAFP strongly urges CMS to streamline, harmonize, and reduce the complexity of quality reporting in the MIPS and APM programs. All measures used must be clinically relevant, harmonized among all public and private payers, and minimally burdensome to report.
- Definition of the Patient Centered Medical Home - The AAFP encourages CMS to consider the Joint Principles of the Patient-Centered Medical Home and the key

functions of the Comprehensive Primary Care (CPC) initiative as criteria for determining what constitutes a PCMH. The Joint Principles, when aligned with the five key functions of the CPC initiative, capture the true definition of a PCMH and its performance thresholds. Furthermore, we do not believe a physician should be required to pay a third party to secure the recognition necessary to participate in a Medicare program.

- Comprehensive Primary Care Payment Reform - The AAFP strongly supports moving a larger percentage of payments from the traditional fee-for-service model toward APMs, a position also supported by Family Medicine for America's Health. With respect to primary care, CMS should establish an APM that is a PCMH model based on the Joint Principles of the Patient-Centered Medical Home and the key functions of the CPC initiative. Furthermore, the AAFP proposes that payments for primary care services under this advanced primary care delivery model be made on a per-patient basis through the combination of a global payment for direct patient care services and a global care management fee.
- Appropriate Virtual Groups - The AAFP believes there is promise in the use of virtual groups as a means of allowing solo and small practices to aggregate patient populations, align resources, and form a structure to help improve performance while maintaining independence. We believe virtual groups should be limited to physicians in the same discipline—or closely aligned disciplines—and connected by a reasonable geographic boundary.
- Prospective Patient Attribution - The AAFP encourages CMS to use a prospective attribution model, which dramatically increases patient engagement with a usual source of primary care and does not have to limit patient choice. In addition, providing physicians with a prospective list of patients for which they are responsible facilitates proactive population management, which leads to improved outcomes. The AAFP also urges CMS to include a reconciliation process in whatever methodology it adopts. Under such a reconciliation process, a family physician should be able to review, add, or remove patients from the list received from CMS.
- Meaningful Use - The AAFP believes several barriers exist to meet successfully the requirements of the MIPS quality performance category. The most significant barrier is the poorly designed meaningful use program and its lack of interoperability standards, which prohibit the sharing of patient information. Physicians face significant challenges with their EHRs and meeting current meaningful use standards. Until this program is improved and the EHR issues are resolved, it is difficult to foresee a large percentage of physicians—particularly physicians in small and independent practices—being successful in MACRA programs.
- Clinical Practice Improvement Activities - The AAFP encourages CMS to offer physicians multiple options for completing clinical practice improvement activities. If a practice is a recognized PCMH, then the AAFP recommends that CMS immediately provide this practice with the maximum score and not require further verification. If an Eligible Provider (EP) completes an accredited Performance Improvement Continuing Medical Education (PI-CME) activity, as defined by the AAFP, AMA, AOA, AAPA or other nationally recognized credit systems with a formally defined PI-CME activity category, then CMS should immediately provide this practice with substantial points toward the score for the Clinical Practice Improvement Activities Performance Category. However, if the practice is not a recognized PCMH, and the EP has not completed an accredited PI-CME activity during the time frame under evaluation, then other options could be considered for clinical practice improvement activities. Such options could include participation in clinical practice improvement activities required by hospitals and health systems, specialty certifying boards or societies, state Medicaid or payers.
- Health Disparities - The AAFP supports reducing health disparities as a part of care delivery and urges CMS to move forward with expanding its risk-adjustment

methodology in quality measures to incorporate social and economic factors such as race, income, education, and region. Risk-adjusting for socioeconomic status ensures the measures are fair and sets the standard for comparison of physician performance by adjusting for factors outside of a physician's control. Not adjusting could lead to misleading conclusions about physician performance. As a result, further disparities in care could be magnified. Through HealthLandscape, the AAFP has developed the Community Vital Signs tool that could assist practices of all sizes understand the social and economic status of their patient population.

2. REGULATORY BRIEFS

- On November 10, CMS announced the 2016 premiums and deductibles for the Medicare inpatient hospital (Part A) and physician and outpatient hospital services (Part B) programs.
    - Most people with Medicare Part B will be "held harmless" from any increase in premiums in 2016 and will pay the same monthly premium as last year, which is $104.90. Beneficiaries not subject to the "hold harmless" provision will pay $121.80, as calculated reflecting the provisions of the *Bipartisan Budget Act* signed into law last week. Medicare Part B beneficiaries not subject to the "hold-harmless" provision are those not collecting Social Security benefits, those who will enroll in Part B for the first time in 2016, dual eligible beneficiaries who have their premiums paid by Medicaid, and beneficiaries who pay an additional income-related premium. These groups account for about 30 percent of the 52 million Americans expected to be enrolled in Medicare Part B in 2016.
    - Medicare Part A covers inpatient hospital, skilled nursing facility, and some home health care services. About 99 percent of Medicare beneficiaries do not pay a Part A premium since they have at least 40 quarters of Medicare-covered employment. The Medicare Part A annual deductible that beneficiaries pay when admitted to the hospital will be $1,288.00 in 2016, a small increase from $1,260.00 in 2015.
- On November 12, CMS announced that it has awarded 16, two-year Special Innovation Projects, to 10 regional Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs). The Special Innovation Projects address healthcare quality issues such as early detection and management of sepsis, advance care planning, colorectal cancer screening, and disease management in rural settings among other critically important healthcare quality issues. CMS published a related blog about these awards.
- On November 12, the Secretary of Housing and Urban Development (HUD) announced a proposed rule that, if finalized, would make public housing properties smokefree thereby protecting over a million Americans from secondhand smoke. The AAFP and others sent HUD a letter on March 27, 2015 asking for this and the AAFP will comment on this newly released proposed rule.
- CMS will host the following free educational calls, registration is required:
    - National Partnership to Improve Dementia Care and QAPI, December 1, 1:30pm
    - Medicare Quality Reporting Programs: 2016 Physician Fee Schedule, December 8, 1:30pm
    - ESRD QIP: Access PY 2016 Performance Score Report and Certificates, December 9, 2:30pm