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NEXT WEEK IN WASHINGTON...

- * The House Energy and Commerce Subcommittee on Health will hold a hearing on Wednesday, November 2, called "Do New Health Law Mandates Threaten Conscience Rights and Access to Care?"

1. AAFP SUMMARY OF FINAL MEDICARE ACO REGULATION

On October 20, the Centers for Medicare & Medicaid Services (CMS) released the Shared Savings Program: Accountable Care Organizations [final rule](#). This final rule differs significantly from the earlier proposal and reflects several AAFP recommended changes. The AAFP created a detailed [summary](#) of the regulation to help inform members about the Medicare Shared Savings Program. The final rule largely recognizes that small- to medium-sized physician practices cannot convert their administrative procedures and health record systems overnight, and the final rule is designed to provide both time and resources to make the program more attractive. CMS accepted the AAFP suggestions to finalize policies that:

- Allow Medicare ACO participants to avoid penalties if they do not meet savings targets by eliminating all down-side risk for low-risk ACOs participating in the Track 1 option;
- Eliminate the proposed retrospective beneficiary assignment method and instead use a preliminary prospective assignment method with beneficiaries identified quarterly;
- Significantly reduce — from 65 to 33 — the number of individual quality measures used to determine if an ACO qualifies for shared savings as well as provide quality reporting requirements for years two and three of the program;
- Technically allows primary care physicians to participate in more than one Medicare ACO (Tax identification numbers remain exclusive to a single ACO, while National Provider Identifiers may be associated with more than one ACO);
- Require only a “pay for reporting” approach to quality measure reporting for Performance Year 1 and phase in over 3 years the number of “pay for performance” measures used to calculate the Medicare ACO’s performance score;

- Encourage greater use of electronic health records, for overall Medicare ACO scoring purposes, by double weighting a quality measure that represents the percent of primary care providers who successfully qualify for the EHR Incentive Program payment;
- Allow Federally Qualified Health Centers, Rural Health Clinics, and Critical Access Hospitals to participate in the program;
- Give physicians access to up-front capital through an “advanced payment” program;
- Eliminate indirect medical education (IME) and direct graduate medical education (DGME) payments from spending estimates, as requested by the AAFP and the Council of Academic Family Medicine;
- No longer require Medicare ACOs to face a mandatory antitrust review from either the FTC or Department of Justice; and
- Offer multiple start dates within 2012.

CMS envisions the final rule will help create as many as 270 Medicare ACOs, significantly more than the 75 to 150 Medicare ACOs that CMS had estimated in conjunction with the proposed regulation. This voluntary program will be implemented on January 1, 2012. Medicare ACO applications will be due after the first of the year.

2. CONGRESSIONAL BRIEFING HIGHLIGHTS PHYSICIAN PAYMENT

On October 27, Rep. Allyson Schwartz (D-PA) and Rep. Phil Roe (R-TN) chaired a House Bipartisan Briefing on the Future of the Medicare Physician Payment System. The briefing featured three panelists: Mark McClellan, MD, PhD, (Brookings Institution), Joe Antos, PhD (American Enterprise Institute), and Stuart Guterman (Commonwealth Fund).

Rep. Schwartz identified the goal of permanently fixing (repealing) the SGR and that the Joint Select Committee on Deficit Reduction presents an opportunity that should not be lost. Rep. Roe who is an Ob-Gyn physician, said the SGR is not a partisan issue; as he has never seen a Republican or Democrat heart condition. He noted that in his practice he frequently had to plead with his primary care friends to take a patient.

Dr. McClellan pointed to the meager reimbursement updates received by physicians compared to other providers over the last ten years, let alone the comparison to medical inflation. He described the innovation taking place in the private sector (United Healthcare and others) that embraces care coordination and registries and stressed the need to transition from a purely fee-for-service (FFS) system to a different form of payment.

Dr. Antos said the SGR is irrational policy and it is rational to repeal it. Temporary patches just make the problem worse. And he commended MedPAC for recommending that the burden of repeal be spread across the spectrum including providers and beneficiaries. He pointed out all the flaws of FFS and how it impedes adoption of efficient delivery. He embraced bundled payment and reimbursement based on outcomes. But he cautioned that repealing the SGR without a replacement will unleash increased volume while still not compensating primary care appropriately. He predicts Congress will pass a temporary (1-2 year) patch, but not until the new year.

Mr. Guterman stressed the importance of recognizing that SGR demands short-term and long-term solutions. Volume and intensity drive costs and payments are indifferent to quality (outcomes). He, too, acknowledged that primary care is undervalued and underpaid and the system needs to move to the PCMH, the ACO models, bundled payment and payment for PCPs coordinating and supporting care. But Guterman, like the other panelists, emphasized that the transition from FFS to a new payment model will be difficult and will take time.

3. HOUSE VOTES TO REPEAL TWO HEALTH REFORM PROVISIONS

On Thursday, October 27, the House passed 405-16 a bill (HR 674) that would repeal a requirement that federal, state and local governments withhold 3 percent of some payments to contractors. Earlier the House passed 262-157 a health care bill (HR 2576) that would rewrite an income formula used to calculate subsidies for the purchase of health insurance on state-run exchanges and to determine eligibility for Medicaid.

4. AAFP OPPOSES PROPOSED PRIMARY CARE DEFINITIONS

In a [letter](#) sent October 21 to the Departments of HHS, Labor, and Treasury, the AAFP commented on a proposed regulation that, once finalized, creates a universal Summary of Benefits and Coverage (SBC) [template](#) and a standard glossary of healthcare terms. In the response, the AAFP recognized that these definitions were written to make it as easy as possible for all individuals to understand the terms of their health insurance coverage and compare benefits efficiently and accurately. However the AAFP expressed concern with public and private insurers utilizing inconsistent definitions of primary care. Though the AAFP stands by more robust and accurate definitions, especially as they relate to physician payment policies, the comment letter urged use of the Institutes of Medicine's definition for primary care since it accomplishes the goals of accuracy and accessibility.

5. EXCLUSION OF TOBACCO PRODUCTS IN TRADE AGREEMENT URGED

In a [letter](#) sent September 22 to the U.S. Trade Representative, the AAFP urged exclusion of tobacco products from negotiations on the Trans Pacific Partnership Trade Agreement. The letter urged that US trade negotiators not ask nations to weaken their anti-smoking strategies and supported the WHO Framework Convention on Tobacco Control.

6. FamMedPAC ATTENDS TWO EVENTS THIS WEEK, MEETS WITH CALIFORNIA CHALLENGER

FamMedPAC hosted meetings with two Congressional Representatives this week and met with a candidate from California who is seeking support from the PAC. The major topic of discussion at these events is the need to address the Medicare physician payment formula before the end of the year. This week, Government Relations staff attended meetings with

- **Rep. Jan Schakowsky (D-IL)** is a member of the Health Subcommittee of the House Energy and Commerce Committee and a Chief Deputy Whip for the Democrats in the House. Rep. Schakowsky, a strong supporter of family medicine issues, attended the Family Medicine Congressional Conference two years ago and met several times over the last year with local AAFP members in Illinois.
- **Rep. Pete Stark (D-CA)** is the senior Democratic member of the Health Subcommittee of the House Ways and Means Committee. Rep. Stark is very critical of the way Congress deals with the SGR problem through temporary "fixes" and is pushing for the Deficit Reduction Committee to include a permanent fix in their final proposal.
- **Candidate Ami Bera, MD (D-CA)**. Dr. Bera is a primary care internist and a professor at UC Davis Medical School. He is challenging 9-term Republican incumbent Rep. Dan Lungren. Dr. Bera ran against Rep. Lungren in 2010, and received support from FamMedPAC. The PAC Board will review the race and decide later this year on whether or not to support Dr. Bera's campaign this election cycle.

FamMedPAC Board Chair Dr. Jim King continues to encourage the constituent Chapters to have at least 10 percent of their members contribute to the PAC. If only 10 percent of our members contributed \$100 per year to the PAC, FamMedPAC would have \$2 million each

election cycle to support family medicine-friendly candidates. Below is the current ranking of the Chapters for total amount contributed and percentage of membership contributing.

11-12 Total Donations Ranking:

- (1) Tennessee: \$27,060.00
- (2) Texas: \$20,911.50
- (3) Washington: \$20,115.00
- (4) California: \$19,877.69
- (5) North Carolina: \$14,697.00
- (6) Ohio: \$13,650.00
- (7) Massachusetts: \$12,912.00
- (8) New York: \$12,355.00
- (9) Georgia: \$11,945.00
- (10) Pennsylvania: \$10,919.00

11 – 12 Chapter Percentage Ranking:

- (1) Rhode Island: 7.22%
- (2) South Dakota: 5.70%
- (3) Maine: 5.35% %
- (4) New Hampshire: 4.87%
- (5) District of Columbia: 4.35%
- (6) Massachusetts: 3.66%
- (7) Tennessee: 3.65%
- (8) Montana: 3.61%
- (9) Connecticut: 3.59%
- (10) Hawaii: 3.29%
- (10) Mississippi: 3.29%

7. REGULATORY BRIEFS

- On October 24, the U.S. Department of Health & Human Services [released](#) \$42 million over three years to Federally Qualified Health Centers (FQHCs) in 44 states to improve the coordination and quality of care. As part of this announcement, HHS also stated that 500 FQHCs have been selected for the [Advanced Primary Care Practice](#) demonstration which will be conducted from November 1, 2011 through October 31, 2014. Participating health centers that are Level 3 NCQA PCMH will be paid a monthly fee (\$6) for each eligible person with Medicare that receives primary care services. The CMS Innovation Center and the Health Resources Services Administration (HRSA) will provide technical assistance to help participating community health centers throughout the demonstration.
- On October 25, the White House [announced](#) a new initiative that will help create jobs for veterans. As part of this effort, the Administration will work to connect 8,000 veterans to job openings in Community Health Centers and the Health Resources and Services Administration will give priority when awarding physician assistant training grants to colleges and universities that train veterans as physician assistants.
- On October 27, U.S. Department of Health and Human Services [announced](#) that Medicare Part B premiums for 2012 are lower than projected and the Part B deductible will decrease by \$22. The Medicare Trustees originally predicted monthly premiums would be \$106.60, but premiums will instead be \$99.90.
- November 1 is the deadline to request a hardship exemption in order for physicians and group practices to avoid the 2012 Medicare Electronic Prescribing (eRx) Incentive Program penalty. CMS recently created a related [document](#) and quick reference [guide](#) to help practices determine if they are subject to the 2012 eRx payment penalty.
- On Tuesday, November 8 from 1:30 – 3pm ET, CMS will host a national call on the Physician Quality Reporting System & Electronic Prescribing Incentive Program. [Registration](#) is required.

8. ARIZONA PSYCHOLOGISTS BACK DOWN ON SCOPE EXPANSION

Following letters of opposition from the Arizona AFP and the AAFP, Arizona psychologists this week withdrew their application to the legislature for an expansion of their scope of practice. The original request was to allow psychologists prescriptive authority. The joint interim committee charged with vetting scope expansion requests will meet on Monday, October 31 to hear the remaining prescriptive authority application submitted by chiropractors.