

September 30, 2011

## IN THIS SPECIAL FEDERAL REGULATORY REPORT...

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### NEXT WEEK IN WASHINGTON...

\* Congress will return from a recess in honor of the Jewish New Year and will begin debate of discretionary funding for the next fiscal year.

## 1. CMS LAUNCHES COMPREHENSIVE PRIMARY CARE INITIATIVE

On September 28, the Centers for Medicare & Medicaid Services [announced](#) the [Comprehensive Primary Care Initiative](#) (CPCI). This important effort, initiated by the CMS Innovation Center and [supported](#) by the AAFP, is designed to help primary care practices deliver higher quality, better coordinated, and more patient-centered care. Under the CPCI, Medicare, commercial, and state insurance plans will offer bonus payments to primary care doctors who better coordinate care for their patients.

The initiative will combine fee-for-service payments with a per-patient, per-month (PBPM) coordination fee that will range from \$8 to \$40 and will be risk-adjusted based on a one-time retrospective look at the three years of prior claims data and hierarchical condition category (HCC) scores. CMS will identify five to seven regional markets to participate and will then recruit 75 primary care practices, recognized as medical homes and whose physicians are board certified, to participate. Those primary care physicians will earn the monthly per-patient fee for both Medicare and Medicaid patients as well as for their patients who are enrolled in participating private sector plans. The cost savings resulting from this reform will be shared with the physicians as an incentive to keep health care affordable. After a few years, the coordination fee would be adjusted down as regional savings are shared with providers. CMS has the authority to expand the initiative across the country for Medicare and Medicaid if it is shown to improve quality and lower costs.

Public and private health care payers interested in applying to participate must submit a non-binding letter of Intent by November 15, 2011. Interested primary care practices will then apply to participate in the spring of 2012. The intent is for the CPCI to be operational in the summer of 2012.

For practices to be eligible for the CPCI, they must meet the following criteria:

- A practice must be a primary care practice and as such:
  - Provide the first point of contact for patients and ongoing care.
  - Be led by a board-certified general practitioner, internist, family physician, geriatrician or advanced practice nurse (as allowed by state law).
  - Composed of predominantly, but not necessarily exclusively, primary care providers, defined as one of the following: a physician who has a primary specialty designation of family medicine, internal medicine, or geriatric medicine; a nurse practitioner, clinical nurse specialist, or physician assistant for whom primary care services accounted for at least 60% of allowed charges under the Physician Fee Schedule.
  - Provide predominantly, but not necessarily exclusively, primary care services. These services may include those denoted by the following codes: 99201-99215; 99304-99318; 99324-99340; 99341-99350; GO402, G0438, and G0439; 99241-99245; 99354-99355; 99358-99359; 99381-88387; 99391-99387; 99401-99404; 99406-99409; 9941-99412; 99420; 99429; 99374-99380; and G0008-G0010.
  - May have multiple sites as long as these sites function as an integrated entity with centralized decision making, shared office space, facilities, clinical records, equipment, and personnel.
- Have National Provider Identifiers (NPIs) and Tax Identification Numbers (TINs).
- Be geographically located in a selected market.
- Have at least 60 percent of revenues generated by payers participating in this initiative.
- Have a minimum of 200 eligible non-institutionalized Medicare beneficiaries, who are eligible for Part A and enrolled in Part B, but who are not enrolled in a Part C plan, Medicare Cost Plan, Demonstrations Plan, or PACE Plan, and who do not have end-stage renal disease (ESRD). Medicare must be the primary insurer for these beneficiaries.
- Use an electronic health record (EHR) system or electronic registry.

The AAFP continues to analyze this exciting new initiative, though there are already a few areas of concern in which the AAFP will continue working with CMS to improve:

- The definition of primary care providers for eligibility purposes, which if not properly constructed could prevent about 40 percent of family physicians from participating and an even higher percentage of general internal medicine physicians.
- CMS announced few details regarding how and when CMS can lower the PBPM fee. If the PBPM fee is designed to pay for coordination of care, why would it fluctuate with the level of savings?
- CMS must perform the risk adjustments needed for the PBPM fee. In the past, CMS's ability to properly risk adjust has been questionable and the AAFP will work with the agency to ensure appropriate risk adjustment for the Medicare and Medicaid populations.
- Though the AAFP understands that CMS, in order to properly study and evaluate their payment initiatives, must prevent physician participation in the CPCI if the physician is already participating in a separate initiative, the AAFP is concerned that family physicians must choose between the CPCI and other innovative payment efforts. To participate in the CPCI, practices will not be allowed to also participate in the:
  - Medicare Shared Savings Program (Medicare ACO) or the Pioneer ACO program;
  - Federally Qualified Health Center (FQHC);
  - Advanced Primary Care Practice Demonstration;
  - Independence at Home Demonstration;
  - Medicare High Cost Demonstration;

- Multi-payer Advanced Primary Care Practice Demonstration; or the
- Physician Group Practice Demonstration.
- The Innovation Center will enter into an agreement with selected practices that include terms and conditions of participation. Practices will be monitored continuously, and the Innovation Center reserves the right to terminate its participation with practices that are not performing according to the requirements established at the outset of the initiative. Payers and practices will enter into agreements of their own.

This AAFP prepared summary is also available [online](#). For more information from CMS, visit the Comprehensive Primary Care initiative [web site](#), review the more detailed [Solicitation for the Comprehensive Primary Care Initiative](#), or ask specific questions to CMS by e-mailing [CPCi@cms.hhs.gov](mailto:CPCi@cms.hhs.gov).

## 2. AAFP RESPONDS TO PROPOSED EXCHANGES REGULATION

In a comment [letter](#) sent to CMS on September 28, the AAFP responded to the [proposed](#) regulation entitled, *Establishment of Exchanges and Qualified Health Plans*. The AAFP response, based on the [Family Medicine Principles for State Health Insurance Exchanges](#), expressed support overall for the exchanges as a way to improve patient access to affordable insurance. In the response, the AAFP committed to reviewing and commenting on the HHS draft template that will, once released, outline the required components of an exchange. The AAFP urged inclusion of primary care physicians and discussed the role of the patient-centered medical home model as one that improves quality while helping to restrain costs. The AAFP also recommended that CMS require that exchange governing boards include consumers and primary care physicians.

The AAFP called for alignment of quality measures used in exchanges with measures used in other quality improvement efforts, urged inclusion of standard physician contracts, and suggested including primary care medical spending targets. From the patient's perspective, the AAFP suggested a streamlined enrollment process for applicants, expressed concern over network adequacy and noted the need to specify network adequacy standards, and urged HHS to adopt PCMH standards for the "qualified direct primary care medical home plan" that can be offered through the exchange.

## 3. QUALIFIED SUPPORT SENT FOR INTENSIVE BEHAVIORAL THERAPY FOR OBESITY

The AAFP sent a response [letter](#) to CMS on September 28 supporting a CMS proposal to cover intensive behavioral therapy for obesity, defined as a body mass index (BMI)  $\geq 30$  kg/m<sup>2</sup>. For Medicare beneficiaries with obesity, who are competent and alert at the time that counseling is provided and whose counseling is furnished by a qualified primary care physician or other primary care practitioner and in a primary care setting, CMS proposes to cover:

- One face to face visit every week for the first month;
- One face to face visit every other week for months 2-6; and
- One face to face visit every month for months 7-12.

At the six month visit, a reassessment of obesity and a determination of the amount of weight loss would be performed. To be eligible for additional face to face visits occurring once a month for an additional six months, Medicare beneficiaries must have achieved a reduction in weight of at least 3kg over the course of the first six months of intensive therapy.

Since obesity is a complex condition usually involving comorbidity, the AAFP response letter expressed hesitation over the arbitrary weight loss requirement of 3kg. Several factors can influence weight loss, such as medications, smoking cessation, relapse or other medical

conditions. This determination must be documented in the physician office records for applicable beneficiaries consistent with usual practice.

#### **4. GROUP THANKS CMS FOR MEDICAID TOBACCO CESSATION POLICY**

In June 2010, the AAFP participated with several other organizations in a letter to the CMS Director of Medicaid and Children's Health Insurance Program regarding the coalition's support for permitting states to obtain federal Medicaid funds for tobacco cessation quit-lines. Recently CMS changed Medicaid policy by making tobacco cessation quit-line services for Medicaid beneficiaries an allowable Medicaid administrative cost expenditure and for expanding tobacco cessation services for pregnant women on Medicaid. In another coalition [letter](#) sent September 27, the AAFP and other organizations expressed support and appreciation for that decision.

#### **5. Regulatory Briefs**

- On September 27, HHS [announced](#) grants to 61 states and communities with over 120 million residents to fight chronic disease. Created by the *Affordable Care Act*, Community Transformation Grants help states and communities to use these funds, which total more than \$103 million, to improve the health of their communities.
- Recently the Patient-Centered Outcomes Research Institute [announced](#) that \$26 million in grants are available to up to 40 organizations that apply through December 1 for pilot projects to advance patient-centered outcomes research. Letters of intent for grants are due by November 1.
- On September 29, the Health Resources and Services Administration (HRSA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) [announced](#) \$47 million in grants to assist over 900 community health centers to provide assistance to health centers as they attempt recognition as a patient-centered medical home. A listing of grantees for the Health Center Quality Improvement and Patient Centered Medical Home Supplemental Funding is available on the HRSA [website](#) and a listing of grantees for the Primary and Behavioral Health Integration awards is available on the SAMHSA [website](#).
- Also on September 29, the Centers for Disease Control and Prevention (CDC) announced \$25 million in funds for the [Childhood Obesity Demonstration Project](#). It is designed to use successful elements of primary care and public health to combat childhood obesity in the Children's Health Insurance Program (CHIP). The project grantees include three research facilities (University of Texas Health Science Center at Houston, San Diego State University, Massachusetts State Department of Public Health) that will receive approximately \$6.2 million over four years to identify effective childhood obesity prevention strategies. The evaluation center (University of Houston) will receive about \$4.2 million over four years and will determine successful strategies and share lessons and successes.
- On October 18 from 1:30pm- 3pm ET, CMS will hold a free national conference call on the Physician Quality Reporting System & Electronic Prescribing Incentive Program. Registration information will be made available soon.
- CMS recently announced that registration is now open for the third and final ACO Accelerated Development Learning Session (ADLS), which will be held in Baltimore, MD on November 17-18. The first session was held in June in Minneapolis, MN and the second was held in September in San Francisco, CA. The content at each ADLS is repetitive and is not part of an ongoing series. Registration is free and open for teams of between two and four senior leaders from health care delivery organizations interested in forming an ACO or from an existing ACO. Some of the content will also be live webcast. More information is available on the ADLS [website](#).
- The CMS Innovation Center will co-host with the HHS Office of the National Coordinator the first [Care Innovations Summit](#) on January 26, 2012 in Washington, DC. The summit

will showcase at least 40 care innovation projects across the country that are enabling achievement of the three-part aim of better care and better health at lower cost through continuous improvement. The event is free of charge though space is limited to 1,000 attendees.