

## **Reforming the Medicare physician payment**

ACOFP wants to reform the Medicare physician payment by changing the Sustainable Growth Rate to a payment model that accurately reflects the cost to practice medicine and therefore reimburses at an appropriate rate.

The organization also is working to provide a framework for payment under **Patient Centered Medical Home** (PCMH) model. The PCMH has great potential to revitalize the practice of primary care and family medicine and should be incorporated into the future physician payment model.

Ensuring that existing and new Medicare services are properly reimbursed is another priority for ACOFP. ACOFP is specifically following Health Information Technology, Electronic Prescribing, Chronic Care Management Programs and Equity in reimbursements between Federal and State programs (Medicaid). ACOFP also is working to protect reimbursements for OMT services.

See below for the latest updates on this issue:  
August 2008

## **Senate and House Override President's Veto on Medicare Bill, Cut in Physician Payment Averted**

On Tuesday, President Bush vetoed the "Medicare Improvements for Patients and Providers Act of 2008" (H.R. 6331). Shortly after the President's veto, both the U.S. House of Representatives and U.S. Senate successfully overrode the President's veto. Actions by the House and Senate mean that H.R. 6331 is enacted into law without the President's signature.

The vote brings to a close more than six months of advocacy activity by the osteopathic profession and averts greater than 16 percent of cuts in Medicare payments for osteopathic physicians over the next 18 months. The provisions of H.R. 6331 are effective as of July 1, 2008 and are applicable until December 31, 2009.

ACOFP would like to thank everyone for their support during this campaign.

July 2008

### **Physician Payment Update**

The following is a summary of legislative activity that has taken place since June 12:

Thursday, June 12: U.S. Senate failed to invoke cloture on a motion to proceed to the “Medicare Improvements for Patients and Physicians Act of 2008” (S. 3101), introduced by Senate Finance Committee Chairman Max Baucus (D-MT) and Senators Olympia Snowe (R-ME), John Rockefeller (D-WV), and Gordon Smith (R-OR). The vote on the motion was 54-39.

Nine Republicans voted yes—Sens. Coleman, Collins, Dole, Murkowski, Roberts, Smith, Snowe, Specter, and Stevens. One Democrat voted no—Sen. Reid (procedural move to recall bill at later date). Seven Senators did not vote—Sens. Clinton, Inouye, Kennedy, Landrieu, McCain, Obama, and Sununu.

Monday, June 16: The Centers for Medicare and Medicaid Services (CMS) instructed their fiscal intermediaries to adjust payment systems to reflect the 10.6 percent reduction for services provided on and after July 1, 2008. Once legislation is approved, CMS will issue new directions instructing fiscal intermediaries to restore payments—reflecting enacted law—and to make retroactive payments for services paid at the reduced rate. CMS will not re-open the physician enrollment period as a result of the changes in law.

**Wednesday, June 18:** Senate Minority Leader Mitch McConnell (R-KY) asked for unanimous consent for floor consideration of two Medicare bills. The first pertained to the “Preserve Access to Medicare Act of 2008” (S. 3118); legislation introduced on June 11 by Finance Committee ranking member Charles Grassley (R-IA). The second request was to call up and pass a new bill, the “Medicare and Medicaid Extension Act of 2008” (S. 2499). S. 2499, also authored by Sen. Grassley, would extend for 18-months the “Medicare, Medicaid, and SCHIP Extension Act of 2007” (MMSEA). MMSEA, which was approved and signed into law in December 2007, is the source of the current six-month 0.5 percent update. In addition to extending MMSEA provisions, S. 2499 would provide physicians with a 1.1 percent update for 2009. Senate Majority Whip Richard Durbin (D-IL) objected to both unanimous consent requests on the grounds that neither bill provided sufficient assistance to low-income beneficiaries or included beneficiary improvements sought by Democrats in S. 3101.

Senators Baucus and John Rockefeller (D-WV) held Member-level discussion with House Ways and Means Committee Chairman Charles Rangel (D-NY) and Energy and Commerce Committee Chairman John Dingell (D-MI). Senate Finance Committee staff continued informal discussions, but no agreements were reached.

**Thursday, June 19:** Senator Jon Kyl (R-AZ) asked for unanimous consent for floor consideration of S. 2499. The request was objected to by Senator Durbin on the same grounds outlined above.

Senators Baucus and Rockefeller once again held Member-level discussion with Reps. Rangel and Dingell. They were joined by Energy and Commerce Health Committee Chairman Frank Pallone (D-NJ). During the meeting a new strategy whereby the House would attempt to move legislation similar to S. 3101 was discussed.

**Friday, June 20:** The House Ways and Means Committee Chairman Charles Rangel (D-NY) and Energy and Commerce Committee Chairman John Dingell (D-MI) introduced the “Medicare Improvements for Patients and Providers Act of 2008” (H.R. 6331). This bill is a modified version of legislation, S. 3101, introduced by Senate Finance Committee Chairman Max Baucus (D-MT) earlier this month.

H.R. 6331 prevents implementation of the scheduled 10.6 percent cut scheduled to take effect on July 1 and replaces projected cuts with a continuation of the current 0.5 percent update for the remaining six months of 2008. The bill also provides for a 1.1 percent positive update in 2008. Additionally, the bill extends for 18 months the 1.0 floor on the work GPCI and retains the budget neutrality language associated with changes in the physician fee schedule and the provisions that expand the Patient Centered Medical Home demonstration project. The bill omits the primary care adjustments made to the physician scarcity payments included in the Senate version.

**Tuesday, June 24:** The House of Representatives passed the “Medicare Improvements for Patients and Providers Act of 2008” H.R. 6331 with a 355:59 vote margin far exceeding the necessary 287 votes to gain House passage. 129 Republicans joined 226 Democrats in support of the bill. 59 Republicans voted against the bill and 20 members did not vote.

This was the first and a very important step in the process of halting the 10.6 percent payment cut on July 1 as well as the 5.4 percent cut scheduled for January 1. In addition, the approved bill includes very important primary care provisions including expansion of the Medical Home Demonstration Project as well as improvements to coverage of preventive services.

**Thursday, June 26:** The U.S. Senate, for the second time this month, failed to secure the 60 votes needed to invoke cloture on the “Medicare Improvements for Patients and Providers Act of 2008” (H.R. 6331). The bill was considered under a special unanimous consent agreement that allowed for the bill to be considered approved if the Senate approved the motion to proceed. The final vote was 58-40 with nine Republicans voting yes. Senate Majority Leader Harry Reid once again changed his vote from yes to no, enabling him to recall the bill at a future date. This Senate vote came only days after the House of Representatives approved the same legislation by an overwhelming bipartisan majority of 355-59.

As a result of the Senate vote, the 10.6 percent cut will take effect on July 1.

Republicans voting yes were: Collins, Coleman, Dole, Murkowski, Roberts, Smith, Snowe, Stevens, and Voinovich. Senator Arlen Specter (R-PA) voted for the bill on June 12, but voted against the bill tonight. A complete breakdown of the vote is attached along with a summary of the June 12 vote.

June 2008

### **ACFP Supports Joint Principles of Patient Centered Medical Home**

In February 2007, the Patient Centered Primary Care Collaborative (PCPCC) released its joint principles of the patient centered medical home. After months of work, ACOFP endorsed the joint principles in October 2007. The PCPCC continues to work collaboratively with more than 100 physician, employer,

and insurer groups to advance the medical home concept. The AOA and ACOFP remain at the forefront of this work.

The Patient Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

The AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PCMH.

Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

**Quality and safety** are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
- Evidence-based medicine and clinical decision-support tools guide decision making.
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.

**Enhanced access** to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

**Payment** appropriately recognizes the added value provided to patients who have a patient centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff patient centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement;
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation;
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
- It should recognize case mix differences in the patient population being treated within the practice.
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

March 2008

### **Have You Signed Up?**

All physicians who bill Medicare must sign-up for their National Provider Identifier (NPI). The original deadline to sign-up for the NPI was May 23, 2007. However, all physicians who submit Medicare claims MUST be in full compliance using their NPI by May 23, 2008. All claims submitted without an NPI as of this date will be rejected. If you have not yet received an NPI, there is no cost; however, physicians must sign-up soon in order to avoid costly delays and/or rejection of payment. Once the NPI is obtained, an estimated 120 days is needed to complete the remaining work (internal billing systems, testing with payers, etc.) to use it.

For additional information on the National Provider Identifier and to apply for NPI, visit:  
[cms.hhs.gov/NationalProvidentStand/](http://cms.hhs.gov/NationalProvidentStand/)

### **Physician Quality Reporting Initiative Continues in 2008**

Reporting for the 2008 Physician Quality Reporting Initiative (PQRI) began January 1. The Centers for Medicare and Medicaid Services (CMS) advises that physicians and other eligible professionals, who plan to participate, should begin claims-based reporting as soon as possible.

CMS has expanded the PQRI to cover 119 measures for 2008. The measures fall into seven broad categories, including: 2007 PQRI Quality measures, American Medical Association (AMA) Physician Consortium for Performance Improvement (PCPI) measures, Pennsylvania QIO measures, AQA Starter Set, NQF-endorsed measures, and American Podiatric Medical Association measures.

Bonus payments for successful participation in 2008 PQRI will be paid from Medicare Part B - same as for 2007. Eligible professionals may earn a bonus payment of 1.5 percent of total allowed charges for covered services payable under the Medicare Physician Fee Schedule.

Information on the 119 PQRI measures, such as 2008 PQRI Coding for Quality Handbook, the 2008 Measure Specifications Release Notes and other educational material are available on the CMS web site at [cms.hhs.gov/pqri](http://cms.hhs.gov/pqri). CMS recommends:

- Start reporting early to increase the probability of achieving the 80 percent rate of reporting during the reporting period.
- Report on as many measures as possible to increase the likelihood of achieving successful reporting.
- Ensure that quality codes are reported on the same claim as the diagnosis or CPT-I codes.

Regarding the 2007 PQRI measures, Part B claims for 2007 must have reached National Claims History File by February 29, 2008 for those claims to be included in the calculation for the PQRI bonus to be paid by mid 2008. Analysis of the claims will be performed at the individual NPI level. The bonus will be paid to the holder of the Tax Id Number. Confidential feedback reports will be available around the time of the bonus payment.

January 2008

### **Medical Home Summit**

ACOFP Government Relations staff attended the "Building the Patient Centered Medical Home Policy Conference" on December 6 in Washington, D.C. The day-long event was sponsored by the National Committee for Quality Assurance (NCQA). The event brought health care leaders from throughout the nation together to discuss the need for advancing a Patient Centered Medical Home to coordinate care for patients.

Discussions at the event began with dialogue on the challenges and obstacles facing the medical home as well as how it will be funded and appropriately compensate physicians. The day concluded with experts discussing current functioning medical home models and a roundtable discussion from Capitol Hill staff involved in writing medical home legislation. Much of the dialogue revolved around the impending collapse of primary care and the need to revitalize it.

The patient centered medical home is increasingly viewed as a vehicle to revitalize primary care through an advanced payment structure as an incentive for students to choose primary care over a higher paying specialty. It is also being identified as a more effective and more patient friendly way to deliver health care. ACOFP will continue its involvement with this issue as a member of the Patient Centered Primary Care Collaborative.