GOVERNMENT AFFAIRS WEEKLY

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IN THIS REPORT…

NEXT WEEK IN WASHINGTON…

On Thursday, April 23--

* the Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education will hold a hearing to examine proposed budget estimates and justification for FY 2016 for HHS.
* the Subcommittee on Health in the Senate Finance Committee will hold a hearing on the impact of the Medical Device Tax included in the *Affordable Care Act*.
* the Oversight and Investigations Subcommittee of the House Energy and Commerce Committee has scheduled a hearing on combatting opioid abuse.

1. CONGRESS REPEALS THE MEDICARE SGR PHYSICIAN PAYMENT FORMULA

Late on Tuesday, April 14, by a vote of 92-8, the Senate approved the Medicare Access and CHIP Reauthorization Act of 2015 (HR 2) and the President signed it a day later. This landmark legislation, which the House of Representatives had approved on March 26, repeals the Sustainable Growth Rate (SGR) methodology of determining annual updates of the Medicare Physician Fee Schedule. This is the cost-containment provision of the fee schedule that produced annual reductions in payment rates that Congress overruled some 17 times in the past decade. This year, the pending reduction would have been 21.2 percent, for example.

AAFP Grassroots efforts produced 4,332 letters to Congress from 1,357 AAFP members and a total of 646 phone calls to Congressional offices.

The legislation establishes a five-year transition period with mandated annual updates of 0.5 percent each year. Then, payments would be based on one of two systems:

- A new Merit-based Incentive Payment System that uses performance measures to affect fee-for-service payments

- Alternative Payment Models that would deviate from fee-for-service to pay for health care management approaches, like a Patient Centered Medical Home.

2. CHILDREN'S HEALTH INSURANCE, TEACHING HEALTH CENTERS EXTENDED
The legislation that repealed the SGR (HR 2) also extended funding for two years for Community Health Centers, the National Health Service Corps and Teaching Health Centers. The funding levels for CHCs and NHSC are the same as the current year, while THCs, which are community-based outpatient facilities that train medical students, are funded at $60 million for 2 years.

3. AAFP URGES TAX RELIEF FOR INDIAN HEALTH SERVICE LOAN PAYMENTS
On April 16, Rep. David Valadao (R-CA) introduced the *Indian Health Service Health Professions Tax Fairness Act* (HR 1842), to amend the tax code excluding from gross income payments under the Indian Health Service Loan Repayment and certain Indian Health scholarship payments. The AAFP and 22 other groups sent a letter on March 24 urging Representatives to cosponsor the bill which was introduced with 35 bipartisan cosponsors. The House bill mirrors S 536, which Sen. Tom Udall (D-NM) introduced last month. The Senate measure also extends to those IHS payments the same tax free status enjoyed by the NHSC.

4. FamMedPAC CELEBRATES SGR SUCCESS WITH KEY LEGISLATORS
As the Senate took up and passed the SGR-repeal legislation this week, FamMedPAC joined other physician specialty groups in supporting several House champions of the legislation. AAFP was also a co-host for a reception for newly elected Republican Members of the House. The PAC supported the following candidates and events this week:

- **Rep. Phil Roe (R-TN)**, a physician and member of the House Doctor's Caucus, was instrumental in helping secure the support of his fellow Republicans for last month's House SGR vote.
- **Rep. Marsha Blackburn (R-TN)** is Vice-Chair of the House Energy and Commerce Committee and a member of the Energy and Commerce Health Subcommittee.
- **Rep. Charlie Dent (R-PA)** is a member of the Health Subcommittee of the House Appropriations Committee.
- **House Freshmen Reception:** FamMedPAC was a co-sponsor of a reception for newly elected Republican Members of the House. The reception gave the physician community a chance to introduce our issues to these new Members and to thank members of the Doctor's Caucus, who also attended. **Rep. Michael Burgess (R-TX)** and **Rep. Joe Heck (R-NV)** attended and introduced the new Members.

5. AAFP JOINS STATEMENT TO PROTECT THE PATIENT-PHYSICIAN RELATIONSHIP
Last week, the AAFP signed onto a coalition statement by the Coalition to Protect the Patient Physician Relationship on legislative interference. The statement reiterates Coalition principles and addresses a recent law in Arizona that mandates health care professionals to provide unsubstantiated medical information. The Coalition was created in 2014 to address legislative infringements on the patient-provider relationship and is comprised of physician organizations (AMA, ACP, AAP, AOA, ACOG), patient advocate organizations and issue-specific non-profits.

6. STATE LEGISLATURES ALREADY ADJOURNING THEIR 2015 SESSIONS
In the past several weeks, many state legislatures have adjourned their 2015 regular legislative sessions. This year, all 50 state legislatures and the District of Columbia convened. The AAFP is tracking a number of state legislative issues including scope of practice, prescription drug abuse, medical liability reform, direct primary care, Medicaid expansion, and insurance marketplaces, among others.

7. AAFP COMPARES PBPM OF NEW ONCOLOGY MODEL AND CPC INITIATIVE
In an April 2 letter to CMS, the AAFP responded to the agency's "Oncology Care Model (OCM): Request for Applications." After expressing hope that the agency and the physician practices selected for participation in this model will be able to reduce Medicare expenditures while improving cancer care for approximately 175,000 cancer care episodes for Medicare fee-for-service beneficiaries over this course of this 5-year model, the letter then compared the monthly per beneficiary per month (PBPM) payments between this new OCM and the existing Comprehensive Primary Care (CPC) initiative. The OCM PBPM will be $160 per OCM beneficiary per month for the duration of each 6-month episode, and will remain constant for the 5-year model. The letter reminded CMS that the CPC initiative also requires participating practices to provide enhanced services driven by the practice requirements, aimed at transforming practices towards a comprehensive, person-centered, and coordinated care. However, while the OCM model PBPM will be $160, the CPC initiative provides an $8-$40 (average $20) PBPM to primary care practices during the first two years of the demonstration. And whereas the OCM PBPM will remain constant for the duration of the 5-year model, the PBPM to primary care practices will decrease to an average of $15 in years 3 and 4 of that initiative. The significant, glaring discrepancy between the two program's PBPM payments is of great concern to the AAFP.

8. COALITION LETTER TO HUD URGES SMOKELESS GOVERNMENT HOUSING
On March 27, the AAFP and other public health organizations sent a letter to the U.S. Department of Housing and Urban Development (HUD) to express strong support for the requirement that all government subsidized housing be made smoke-free. The letter stated that such a step would be historic in protecting public health since exposure to the toxins in secondhand smoke poses health risks, particularly for children and pregnant women.

9. AAFP EXPRESSES CONCERNS ABOUT MEANINGFUL USE AUDITS
The AAFP sent CMS a letter on April 6 that expressed increasing concerns with Meaningful Use audits. The letter argued that family physicians have a reasonable expectation that the Meaningful Use financial subsidy would help offset the implementation costs and associated initial decrease in practice productivity. However, auditors are causing undue hardship for family physicians with unreasonable and burdensome documentation requests. The letter urged CMS to take these issues into account and provide immediate and increased relief to those who have acted responsibly and legally and had no intent to defraud or deceive by participating in the Meaningful Use program. The AAFP called the current zero-tolerance policy in auditing to be overly burdensome and undermines the purpose of the Meaningful Use requirements.

10. AAFP RESPONDS TO INTEROPERABILITY ROADMAP
In an April 1 letter to the Department of Health and Human Services, the AAFP responded to the "Connecting Health and Care for the National, A Shared Nationwide Interoperability Roadmap" released by the department. The letter expressed appreciation for the creation of an interoperability roadmap and noted that the lack of interoperability is a key issue for family physicians. The absence of real interoperability creates a barrier to improving health outcomes, improving health care quality, and lowering health care costs. The AAFP discussed concern about the lack of specificity of the roadmap, especially within the next few years and urged HHS to provide more details around a path forward to continue the adoption of Direct Exchange and the need to refine and further define the clinical content standards.

11. AAFP RESPONDS TO CHILD AND ADULT CARE FOOD PROGRAM
In an April 15 letter to the Food and Nutrition Service within the U.S. Department of Agriculture, the AAFP responded the Child and Adult Care Food Program: Meal Revisions Related to the Healthy, Hunger-Free Kids Act. In it the AAFP commended the USDA for updating the meal pattern and nutrition standards for the Child and Adult Care Food Program (CACFP), as well as

for school meal programs serving school-based Pre-K and afterschool programs. The AAFP agreed with USDA that the goal of improving good nutrition for low-income children in child care and afterschool programs is best served by a balanced approach that improves nutrition while allowing providers to continue to afford participation in CACFP.

12. REGULATORY BRIEFS

- On March 27, the White House released a plan that identifies actions to be taken to combat the rise of antibiotic-resistant bacteria. To provide advice regarding programs and policies intended to support this effort, the Secretary of Health and Human Services established the Presidential Advisory Council on Combating Antibiotic-Resistant Bacteria and is seeking nominations of individuals who are interested in being considered for appointment to the council.
- On March 27 the FTC released reports on 2012 cigarette and smokeless tobacco sales and marketing expenditures. Cigarette sales declined, smokeless tobacco sales increased from 2011 levels and the number of cigarettes sold to wholesalers and retailers in the United States declined from 273.6 billion in 2011 to 267.7 billion in 2012. The amount spent on cigarette advertising and promotion by the largest cigarette companies in the United States rose from $8.37 billion in 2011 to $9.17 billion in 2012.
- On March 31 HHS awarded approximately $12 million today to BioCryst Pharmaceuticals of Durham, North Carolina, for the advanced development of a experimental drug for Ebola.
- On April 2, ONC announced the availability of online tools and resources designed to help states participating in the State Innovation Models initiative improve health care quality and lower costs. With the support of $665 million in awards, over half of states (34 states and 3 territories, and the District of Columbia), representing nearly two-thirds of the population are participating in the initiative.
- On April 6, CMS announced a proposed rule to align mental health and substance use disorder benefits for low-income Americans with benefits required of private health plans and insurance. The proposal applies certain provisions of the *Mental Health Parity and Addiction Equity Act of 2008* to Medicaid and Children's Health Insurance Program (CHIP). The Act ensures that mental health and substance use disorder benefits are no more restrictive than medical and surgical services.
- On April 6, CMS released final Medicare Advantage (MA) and Part D Prescription Drug program changes for 2016. The MA and Part D prescription drug programs' enrollments and quality continue to grow and improve since the Affordable Care Act became law. The announcement finalizes changes in payments that will affect plans differently depending on the characteristics of those plans. On average, the expected revenue change is 1.25 percent.
- On April 10, CMS issued a proposed rule for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs to align Stage 1 and Stage 2 objectives and measures with the long-term proposals for Stage 3, to reduce complexity, and to simplify providers' reporting. The proposal, if finalized, would make several AAFP recommended changes by:
    - Reducing the overall number of objectives to focus on advanced use of EHRs;
    - Removing measures that have become redundant, duplicative or have reached wide-spread adoption;
    - Realigning the reporting period beginning in 2015, so hospitals would participate on the calendar year instead of the fiscal year; and
    - Allowing a 90 day reporting period in 2015 to accommodate the implementation of these proposed changes in 2015.

  As of March 1, 2015, more than 525,000 providers have registered to participate in the Medicare and Medicaid EHR Incentive Programs. In addition, more than 438, 000

eligible professionals, eligible hospitals, and CAHs have received an EHR incentive payment. As of the end of 2014, 95 percent of eligible hospitals and CAHs, and more than 62 percent of eligible professionals have successfully demonstrated meaningful use of certified EHR technology.

- On April 13, CMS finalized policy on the screening for HIV infection. CMS determined that the evidence is adequate to conclude that screening for HIV infection for all individuals between the ages of 15 and 65 years, as is recommended with a grade of A by the United States Preventive Services Task Force (USPSTF), is reasonable and necessary for the early detection of HIV and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B. The AAFP supported this in a February 18 letter to the agency.
- On April 10, ONC posted a report discussing strategies to address blocking of electronic health information since it interferes with the exchange of electronic health information.
- On April 15, CMS releases the proposed 2016 Skilled Nursing Facility rule. It would increase aggregate payments by 1.4 percent, or $500 million, in 2016 compared to FY15.
- On April 15, CMS announced $201 million in grants to support marketplace navigators. Interested entities may apply until June 15 for a portion of $201 million in grants to support navigators in federally-facilitated and state partnership marketplaces over three years. Letters of intent to apply are due June 3. According to CMS, the grants will be awarded in 12-month increments, with at least $600,000 available for the first 12-month period in each state with a federally facilitated or state partnership marketplace.
- On April 14, CMS issued a proposed rule that would extend access to enhanced federal financial participation for Medicaid eligibility and enrollment systems on an ongoing basis. This additional time and funding will allow states to complete current work on fully modernized Medicaid eligibility and enrollment systems, and will support Medicaid eligibility and enrollment and delivery system needs.
- On April, 16, CMS introduced star ratings on Hospital Compare in order to make it easier for consumers to choose a hospital and understand the quality of care they deliver.
- On April 17, CMS and the FDA announced an interagency task force that will continue and expand on collaboration related to the oversight of laboratory developed tests (LDTs), which are tests intended for clinical use and designed, manufactured, and used within a single lab.
- CMS will host the following free educational calls, registration is required:
    - Medicare Shared Savings Program ACO: Application Process, April 21, 1:30pm ET