GOVERNMENT AFFAIRS WEEKLY

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

December 4, 2015

IN THIS REPORT…

NEXT WEEK IN WASHINGTON…

* On Tuesday, December 8, the Subcommittee on Oversight and Investigations of the House Energy and Commerce will hold a hearing to examine the ACA's State Insurance Marketplaces.
* Also on December 8, the Senate Health, Education, Labor and Pensions Committee has a hearing on opioid abuse in America.
* On Wednesday, December 9, the Senate Special Aging Committee has a hearing on sudden price spikes in off-patent drugs.
* On the same day, CMS will host a Physicians Open Door Forum: 1-800-837-1935 & ID 8295254 at 2 pm ET.

1. SENATE BUDGET BILL TO REPEAL HEALTH CARE REFORM IS APPROVED

On Thursday, December 3, by a largely partisan vote of 52 to 47, the Senate passed the *Restoring Americans' Healthcare Freedom Reconciliation Act* (HR 3762). The House must approve the changes and send the bill to the President. However, the White House has promised to veto the Senate-passed bill which would repeal key provisions of the *Affordable Care Act* and deny federal funding to Planned Parenthood clinics.

During its debate on HR 3762, the Senate voted down four amendments to the bill that were designed to address firearm safety issues. Senator Dianne Feinstein (D-CA) offered an amendment to prohibit those who are on the terror watch list to purchase firearms. The amendment failed by a vote of 45-54. Sen. Joe Manchin (D-WV) offered an amendment to expand background checks for gun purchases, which failed by a 48-50 vote. Sen. John Cornyn (R-TX) offered alternative amendments focused on restoring gun rights for those listed on the anti-terror watch list and Sen. Charles Grassley (R-IA) offered an amendment to persecute felons and others who try to purchase weapons illegally. These amendments failed by 55-44 and 53-46 respectively. Each amendment needed 60 votes to win approval.

2. AAFP URGES PAUSE AND REFOCUSED MEANINGFUL USE REQUIREMENTS

In a letter sent December 2 to HHS, the AAFP responded to the rule titled "Electronic Health Record Incentive Program—Stage 3 and Modifications to Meaningful Use in 2015 through 2017." The letter expressed significant concern that Center for Medicare and Medicaid Services (CMS) does not allow for continued successful practice transformation, but rather places further obstacles in the path to this goal. The AAFP cited a 27-percent decrease among its members in their satisfaction with electronic health records and a decrease in their participation in the Meaningful Use program.

The AAFP noted that these statistics and the palpable frustration in the physician community point to a program in crisis and that Meaningful Use Stage 3 will only exacerbate it. Furthermore, the letter expressed deep concerns that insufficient progress will be made by 2018 to allow providers to be successful in the value-based environment envisioned by the *Medicare Access and CHIP Reauthorization Act (MACRA)*.

The AAFP called on HHS to:

- Pause the Meaningful Use program to:
    - Allow the health care industry to focus on interoperability
    - Allow vendors and providers to focus on functionality and workflows
    - Align Meaningful Use regulations with pending MACRA regulations to reduce administrative and change burdens on practices.
- Refocus and streamline Meaningful Use on interoperability and support capabilities needed for value-based payment.

3. AAFP CALLS ON CONGRESS TO FUND KEY HEALTH PROGRAMS

Congressional negotiations are expected to continue through the weekend in the face of the expiration of the current stopgap spending law on Friday, December 11. On November 16, the AAFP joined 145 other organizations in signing a letter to ask Congress to provide the highest possible funding level for the Health Resources and Services Administration (HRSA) in the FY 2016 spending bill. The letter asked Congressional leaders to reject policy riders "that would undermine HRSA's efforts to improve the health of individuals and communities."

4. PACE OF ENROLLMENT IN HEALTH PLANS SLOWS

On Friday, December 4, CMS announced that nearly 395,000 people chose health plans through HealthCare.gov in the fourth week of open enrollment during the week of November 22. Since enrollment began Nov. 1, more than 2 million have selected a plan through the federal enrollment website, and nearly two-thirds are customers renewing existing coverage. The figures cover just the 38 states using HealthCare.gov for enrollment. CMS also released state-specific figures. Florida had the highest enrollment, with nearly 445,000 people picking plans since Nov. 1, while Texas came in second, with nearly 225,000 people choosing a plan.

5. SENATE COMMITTEE HOLDS A HEARING ON NON-VA CARE PROGRAMS

On December 2, the Senate Committee on Veterans' Affairs held a hearing titled "Consolidating Non-VA Care Programs." During the hearing, Senators and veterans' groups discussed the ability of the Department of Veterans Affairs' (VA) to implement an effective plan for community care programs. The hearing relates to the scandal at VA over lengthy wait times for veterans at medical centers and clinics as well as a VA regulation that expands access to care at Non-VA medical facilities and physician offices. The VA's Deputy Secretary, Sloan Gibson, and the Undersecretary for Health, Dr. David Shulkin, argued on behalf of the new program yet faced tough questions from senators on whether they can follow through with the plan.

6. AAFP ASKS FOR REVISION TO TOBACCO CESSATION INSURANCE GUIDANCE

In a November 12 coalition letter, the AAFP and other organizations requested that the U.S. Departments of Health and Human Services (HHS), of Labor, and of Treasury update guidance on insurance coverage of tobacco cessation as a preventive service. This follows the U.S. Preventive Services Task Force's updated recommendation for tobacco cessation treatment. The letter asks for an updated Frequently Asked Questions (FAQ) document that makes it clear plans must cover a comprehensive tobacco cessation benefit with no cost-sharing.

7. AAFP AND CHAPTERS OPPOSE CHANGES TO FDA TOBACCO AUTHORITY

On December 2, the AAFP organized a chapter sign-on letter to Congress urging legislators to oppose the *FDA Deeming Authority Clarification Act* (HR 2058). There were 49 states, the District of Columbia, and Puerto Rico that signed on with the AAFP to oppose this legislation. It seeks to exempt e-cigarettes and cigars from pre-market review by the FDA and could impact the states' ability to regulate those products as well.

8. STATE SPENDING IS GROWING, ESPECIALLY FOR MEDICAID

On November 19, the National Association of State Budget Officers (NASBO) released its State Expenditure Report, which showed that states increased their spending in fiscal year 2015 by the biggest margin in more than 20 years. Most of the increase was due to Medicaid spending under the first full year of the *Affordable Care Act*. With a 7.8-percent increase in spending last fiscal year, it is the biggest spending increase since 1992. There was a 15-percent increase in Medicaid spending, much of which was paid for by the federal Medicaid funds. NASBO reported that Illinois, Michigan, Kentucky, Nevada and Oregon saw increases in federal funding of more than 30 percent because they chose to expand Medicaid.

9. REGULATORY BRIEFS

- On November 16, CMS announced revised 2014 Annual Quality and Resource Use Reports (QRURs) that were originally released on September 8, 2015. The 2014 Annual QRURs are available through the CMS Enterprise Portal and show how groups and solo practitioners performed in 2014 on the quality and cost measures used to calculate the 2016 Value Modifier. For groups with 10 or more eligible professionals (EPs) that are subject to the 2016 Value Modifier, the QRUR shows how the Value Modifier will apply to physician payments under the Medicare Physician Fee Schedule (MPFS) for physicians who bill under the group in 2016. For all other groups and solo practitioners, the QRUR is for informational purposes only and will not affect their payments this year.
- On November 16 CMS announced $32 million to help get eligible children enrolled in health coverage.
- On November 19, CMS released a new report showing that consumers have received more than $2.4 billion premium rebates since 2011 because the *Affordable Care Act* requires that health insurance companies spend at least 80 percent of premium dollars on health care. For 2014 alone, over 5.5 million consumers received nearly $470 million in rebates, for an average of $129 per family.
- On November 20 CMS issued the proposed annual Notice of Benefit and Payment Parameters for 2017, governing participation in the Health Insurance Marketplaces. The proposed rule seeks comment on proposals that will provide continued choice and competition for consumers, and a vibrant and growing market for affordable, quality health plans.
- On November 23 CMS released a new program statistics website. The website features web tools for users to explore CMS data, including viewing maps and examining enrollment information, through an interactive dashboard.
- On November 25 HHS published the federal financial participation in state assistance expenditures and federal matching shares for Medicaid and for the Children's Health

Insurance Program. These percentages will be effective from October 1, 2016 through September 30, 2017.

- On November 25 CMS issued the updated 2016 CMS Quality Strategy. The main purposes of the CMS Quality Strategy update are to achieve the broad aims of the National Quality Strategy (NQS) and to apply the Administration's strategy for shifting Medicare payments from volume to value. CMS also released a related blog by Patrick Conway, M.C., MSc., Acting Deputy Administrator and Chief Medical Officer of CMS.
- On November 30 HHS released the Semiannual Report to Congress.
- On November 30 CMS posted the monthly Medicaid and Children's Health Insurance Program (CHIP) enrollment report for September 2015.
- On December 1, the Department of Veterans Affairs announced a number of changes to the Veterans Choice Program and is accepting comments until March 30, 2016.
- On December 1, HHS released a report on preliminary results from patient safety efforts undertaken by HHS and its partners in the hospital setting. An estimated 87,000 fewer patients died in hospitals and nearly $20 billion in health care costs were saved as a result of a reduction in hospital-acquired conditions from 2010 to 2014. Preliminary estimates show that in total, hospital patients experienced 2.1 million fewer hospital-acquired conditions from 2010 to 2014, a 17 percent decline over that period.
- On December 2, CMS released its 2014 National Health Expenditures report. In 2014, per-capita health care spending grew by 4.5 percent and overall health spending grew by 5.3 percent. Those rates are below most years prior to passage of the Affordable Care Act. In addition, consumer out-of-pocket spending grew by only 1.3 percent in 2014, as compared to 2.4 percent growth in 2013, reflecting the increased number of individuals with health coverage.
- On December 3 CMS issued a final rule that extends access to enhanced federal financial participation for Medicaid eligibility and enrollment systems on an ongoing basis. Specifically, the final rule continues the increase in the level of federal support from 50 percent to 90 percent for new eligibility and enrollment systems builds and the increase in the federal matching rate for maintenance and operations of such systems from 50 percent to 75 percent if the systems meet certain critical success factors.
- On December 4 CMS issued revised materials on the EHR Incentive Program website.
- CMS will host the following free educational calls, registration is required:
    - 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
    - ESRD QIP: Payment Year 2019 Final Rule Call, January 19, 2:00pm