GOVERNMENT AFFAIRS WEEKLY

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

July 10, 2015

IN THIS REPORT…

NEXT WEEK IN WASHINGTON…

* On Monday, July 13, the White House Conference on Aging will be held and AAFP President, Robert Wergin will attend.
* On Tuesday, July 14:
  - the Oversight and Investigations Subcommittee of the House Energy and Commerce Committee holds a hearing on strengthening Medicare Part D program integrity.
  - the Health Subcommittee of the House Veterans' Affairs Committee has a hearing on veterans' health care legislation.
  - the Senate Subcommittee on Space, Science and Competitiveness of the Commerce, Science and Transportation Committee will hold a hearing on cures for America's most deadly diseases.
* On Wednesday, July 15, the Senate Special Committee on Aging will hold a hearing titled "Diabetes Research: Improving Lives on the Path to a Cure."

1. CMS RELEASES 2016 PROPOSED MEDICARE PHYSICIAN FEE SCHEDULE

On July 8, the Centers for Medicare & Medicaid Services (CMS) put on display the 2016 proposed Medicare Physician Fee Schedule. Of particular interest to family physicians, this regulation proposes to:

- Specify the 2016 Medicare conversion factor to be $36.1096, which reflects a budget neutrality adjustment and the 0.5 percent update factor set by the law that repealed the Sustainable Growth Rate (SGR) formula
- Establish separate payment for two Advance Care Planning (ACP) services provided to Medicare beneficiaries beginning in 2016
- Improve payment accuracy for primary care and care management services by soliciting comments on how to:
  - Recognize the different resources in cognitive work involved in delivering broad-based, ongoing treatment, beyond those resources already incorporated in the codes that describe E/M services

    - Establish separate payment for collaborative care to address resources involved in collaborations between a specialist and primary care physician or other practitioner in the context of the structure and valuation of current E/M services
    - Appropriately value collaborative care models (primary care teams working in collaboration with a psychiatric consultant) for beneficiaries with common behavioral health conditions
    - Reduce administrative burdens associated with the chronic care management (CCM) and transitional care management (TCM) services
    - Improve the accuracy in payment associated with furnishing services described in the CCM code
- Explore the potential expansion of the Comprehensive Primary Care Initiative, which is a collaboration of currently 38 private and public payers testing better coordinated care through population-based care management fees and shared savings for approximately 480 primary care practice sites in seven markets
- Establish methodology pertaining to the Misvalued Code Target and identify changes that achieve only a 0.25 percent in net reductions; CMS is expected to make further changes for misvalued codes in the final rule to achieve the statutory goal of reductions of at least 1 percent
- Clarify that the billing physician or practitioner for "incident-to" services must also be the supervising physician or practitioner and that auxiliary personnel providing "incident to" services and supplies cannot have been excluded from Medicare, Medicaid, or other federal health care programs by the Office of Inspector General, or have had their enrollment revoked
- Develop further the Value-Based Payment Modifier, which provides for differential payments under the physician fee schedule to physicians, groups of physicians, and other eligible professionals based on the quality and cost of care they furnish to traditional Medical beneficiaries
- Specify policies surrounding the requirement that providers who order advanced diagnostic imaging services must consult with appropriate-use criteria via a clinical decision support mechanism.

The regulation also includes changes to the Physician Quality Reporting System (PQRS), the Medicare Electronic Health Record (EHR) Incentive Program, and the Physician Compare website. It modifies Part B drugs and payments for biosimilar biological products, makes misvalued code changes for radiation therapy, implements the statutory phase-in of significant RVU reductions, makes misvalued code changes for lower GI endoscopy services, updates the physician self-referral policy, changes the Medicare physician and practitioner opt-out policy, and requests input on other changes.

Upon the regulation's release, the AAFP issued a statement noting that this is the first time in more than a decade that the rule did not threaten access to care with mandated Medicare cuts in payment for physician care. The statement also said, "The AAFP strongly recommended that CMS establish advance planning codes that would pay for the medical expertise and physician time in helping patients and families develop care plans."

The regulation will be published permanently in the July 15, 2015 *Federal Register* and CMS will accept comments until September 8, 2015. CMS issued a related press release and fact sheet.

2. ICD-10 TRANSITION PROCESS ANNOUNCED

On July 6, the American Medical Association and CMS jointly announced that for a one year period starting October 1, Medicare claims will not be denied solely on the specificity of the ICD-10 diagnosis codes provided the physician submitted an ICD-10 code from an appropriate family of codes. Medicare claims will not be audited based on the specificity of the diagnosis codes as long as they are from the appropriate family of codes. This policy will be followed by

Medicare Administrative Contractors and Recovery Audit Contractors. To avoid potential problems with mid-year coding changes in CMS quality programs (PQRS, VBM and MU) for the 2015 reporting year, physicians using the appropriate family of diagnosis codes will not be penalized if CMS experiences difficulties in accurately calculating quality scores (i.e., for PQRS, VBM, or Meaningful Use). CMS will continue to monitor implementation and adjust the duration if needed. CMS will establish an ICD-10 Ombudsman to help receive and triage physician and provider problems that need to be resolved during the transition. CMS will authorize advanced payments if Medicare contractors are unable to process claims within established time limits due to problems with ICD-10 implementation.. The AAFP issued a statement praising CMS for its flexibility in implementing this transition, as the AAFP had requested.

3. AAFP EXPRESSES FURTHER CONCERNS WITH MEANINGFUL USE AUDITS

In a July 9 letter to CMS, the AAFP expressed growing concerns with Meaningful Use audits. The AAFP is concerned that auditors are causing undue hardship for family physicians with unreasonable and burdensome documentation requests which result in additional, significant expenses to be a meaningful user.

4. OHIO STATE BUDGET REQUIRES THE STATE TO APPLY TO EXPAND MEDICAID

Earlier this month, Gov. John Kasich signed the Ohio state budget that includes a plan for the state to apply for a Medicaid waiver. The proposed plan would require beneficiaries, except for pregnant women, to participate in a cost-sharing program in which the beneficiaries would be required to pay into a health savings account regardless of income. Beneficiaries could be cut from the program if they do not contribute either 2 percent of their income or $99, whichever is less. The proposal requires approval by the federal government but if it is approved, it is estimated that an additional million Ohio residents would be covered.

5. HOUSE COMMITTEE APPROVES SPENDING BILL WITH TOBACCO PROVISION

The House Appropriations Committee approved the draft agriculture bill for fiscal year 2016 on Wednesday, July 8. The bill, which funds the Agriculture Department, FDA and related agencies, includes a provision to remove the February 2007 date used by the FDA to determine its potential rulemaking authority over various tobacco-related products, including e-cigarettes. The provision effectively would exempt e-cigarettes already on the market from FDA review for safety and advertising restrictions. On July 7, the AAFP joined over 40 groups in a letter to Congress opposing that policy. The senior Democrat on the House Appropriations Committee, Rep. Nita Lowey (D-NY), offered an amendment to strike the provision. Although it was defeated on a vote of 23 to 26, she expects to strike the provision later in the legislative process. White House Office of Management and Budget Director Shaun Donovan sent a July 7 letter which describes as “objectionable” the provision that would erode FDA's ability to regulate certain tobacco products and protect public health.

6. HOUSE APPROVES BIOMEDICAL RESEARCH AND DRUG APPROVAL REFORMS

On July 10, the House of Representatives, by a vote of 344-77, approved the *21st Century Cures Act* (HR 6), a bill to encourage medical innovations through research and to accelerate the approval process for pharmaceuticals. The legislation provides $8.75 billion for the National Institutes of Health (NIH) and $550 million for the Food and Drug Administration (FDA). The bill also includes policy to improve health technology interoperability, exempt continuing medical education from the *Physician Payment Sunshine Act* and a report on how to advance telemedicine.

The White House issued a Statement of Administration Policy for HR 6, praising the legislative effort to accelerate biomedical research to prevent and cure diseases, while expressing some concerns with providing additional funding for NIH and FDA without addressing broader budget caps. The Administration also noted that the level of funding provided for FDA in HR 6 in

inadequate for the agency to "fully implement the programs established in the bill, while maintaining its current performance levels."

The Senate Health, Education, Labor and Pensions Committee is working on a similar initiative titled, the *Innovation for Healthier Americans Act*. While the chairman of the House Energy and Commerce Committee, Rep. Fred Upton (R-MI), the principal sponsor of the bill, expressed his goal of getting a bill to the president's desk this year, it is unlikely that the Senate will have a bill ready for a floor vote before 2016.

7. NEW FamMedPAC REPORT NOW AVAILABLE; PAC SUPPORTS KEY LEGISLATORS
The June/July 2015 FamMedPAC Report, sent today to all 2014 and 2015 PAC donors, gives fundraising and campaign contribution totals, as well as showcasing the PAC's activities at AAFP meetings and events.

The PAC supported the following legislators this week:

- **Rep. Joseph P. Kennedy III (D-MA)**, a new member of the Health Subcommittee of the House Energy and Commerce Committee. FamMedPAC organized and sponsored the event for the physician community.
- **Sen. Harry Reid (D-NV)**, the Minority Leader of the Senate.
- **Rep. C.K. Butterfield (D-NC)**, also a new member of the Health Subcommittee of the House Energy and Commerce Committee.

8. SENATE COMMITTEE EXAMINES SMALL BUSINESS COVERAGE ISSUES
On July 9, the Senate Health Education, Labor, and Pension Committee's Subcommittee on Primary Care and Retirement Security held a hearing to discuss health care coverage issues for small businesses. Under the *Affordable Care Act*, small businesses with fewer than 50 employees receive tax credits to provide coverage within the Small Business Health Options Program. Witnesses spoke about the program's coverage improvements, but many challenges exist including higher insurance premiums, age rating, administrative difficulties and regulatory penalties. The hearing webcast and written testimonies can be accessed online.

9. HOUSE COMMITTEE REVIEWS MEDICAID RECOGNIZING 50-YEAR ANNIVERSARY
On July 8, the House Energy and Commerce's Health Subcommittee held a hearing titled, *Medicaid at 50: Strengthening and Sustaining the Program.* The hearing webcast and written testimonies can be accessed online. During the hearing, Rep. Joe Pitts (R-PA) inquired how the Centers for Medicare and Medicaid Services made its Section 1115 waiver decisions. Rep. Gene Green (D-TX) spoke about the Medicaid's role in increasing access to primary care services, including mental health services. Many hearing participants also spoke about the importance of understanding health care delivery reforms, such as the patient-centered medical home and other innovative care coordination models.

10. REGULATORY BRIEFS

- On June 30, CMS posted the second year of Open Payment data. It includes information on financial transactions between doctors and medical manufacturers totaled $6.49 billion in 2014. The data includes information about 11.4 million financial transactions attributed to over 600,000 physicians and more than 1,100 teaching hospitals.
- On July 1, HHS announced new educational and training resources on multiple chronic conditions for the health care workforce
- Also on July 1, CMS issued the proposed 2016 Hospital Outpatient and Ambulatory Surgical Center rule. It proposes updates to Medicare payment policies and rates for hospital outpatient departments, ASCs, and partial hospitalization services provided by community mental health centers. It also includes important proposed changes to the "Two-Midnight Rule" for 2016 that would continue the long-standing emphasis on the

importance of a physician's medical judgment in meeting the needs of Medicare beneficiaries.

- On July 9, CMS released a final national coverage analysis that the AAFP supported. CMS determined that the evidence is sufficient to add Human Papillomavirus testing once every five years as an additional preventive service benefit under the Medicare program for asymptomatic beneficiaries aged 30 to 65 years in conjunction with the Pap smear test. CMS will cover screening for cervical cancer with the appropriate FDA approved/cleared laboratory tests, used consistent with FDA approved labeling and in compliance with the *Clinical Laboratory Improvement Act* (CLIA) regulations. The AAFP released a statement supporting this step.
- On July 9, CMS announced a proposal for the Comprehensive Care for Joint Replacement payment model. The model proposes to hold hospitals accountable for the quality of care they deliver to Medicare fee-for-service beneficiaries for hip and knee replacements from surgery through recovery.
- Also on July 9, President Obama nominated Andy Slavitt to be the Administrator of the Centers for Medicare & Medicaid Services. The AAFP released a statement supporting this nomination.
- On July 10, the Administration issued final rules that establish an alternative way for eligible organizations that have a religious objection to covering contraceptive services to seek an accommodation from contracting, providing, paying, or referring for such services.
- CMS will host the following free educational calls, registration is required:
    - IQCP for CLIA Laboratory Non-waived Testing: July 15, 1:30pm ET
    - 2016 PFS Proposed Rule: Medicare Quality Reporting Programs, July 16, 1:30pm ET
    - ESRD QIP: Proposed Rule for Payment Year 2019, July 29, 2:00pm ET