AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

WASHINGTON UPDATE

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On the Horizon …

* A proposed rule by CMS on the 2018 Quality Payment Program is anticipated to be released in June.
* June 13, Senate Health, Education, Labor, and Pensions Committee hearing, Cost of Prescription Drugs: How the Drug Delivery System Affects What Patients Pay
* June 14, House Energy and Commerce, Health Subcommittee hearing on safety net health programs

TAKE ACTION

1. Tell Your US Representative That the Time for Medical Liability Reform is Now!

The current medical liability system fails both patients and health care providers, so Rep. Steve King (R-IA-4) has introduced the Protecting Access to Care Act of 2017. This bill, being voted on in the House next week, will help reduce liability insurance premiums and the cost of defensive medicine by enacting important reforms. Use this tool to send a message directly to your Representative asking them to vote yes on these common sense reforms.

2. Help Protect the Successful Teaching Health Center GME Program

The Teaching Health Center Graduate Medical Education (THCGME) program helps address the shortage of primary care physicians by training residents in community-based settings. A proven success, the THCGME program improves on three major concerns regarding the physician workforce: the serious shortage of primary care physicians in general, their geographic maldistribution, and the growing need for physicians who serve underserved communities. However, if we do not take action this important program expires September 30! Use this tool to tell your legislators to reauthorize and adequately fund the Teaching Health Center GME program.

U.S. CONGRESS

1. House Energy and Commerce Committee Approves the FDA Reauthorization Act

On June 7, the House Energy and Commerce Committee approved HR 2430, the FDA Reauthorization Act of 2017 by a 54-0 vote. The bill updates the U.S. Food and Drug Administration user fees that generate revenue to expedite the agency's product review processes. The current user fee authority ends September 30, 2017. The committee approved six amendments addressing medical device policies. It also supported Rep. Jan Schakowsky's (D-IL) nonbinding "sense of Congress" amendment urging the U.S. Department of Health and Human Services and Congress to take administrative and legislative action to lower drug prices. Overall, policy makers avoided substantive drug pricing reforms and rejected the following pharmaceutical amendments.

- Rep. Peter Welch (D-VT) offered an unsuccessful amendment to lower prescription drug costs by allowing U.S. products that are manufactured for overseas markets to be sold to American consumers.

- Reps. Davis McKinley (R-WV) and Peter Welch (D-VT) introduced an amendment to prevent pharmaceutical manufacturers from using its Risk Evaluation and Mitigation program (REMS) to delay or deny generic drug companies from creating new products.
- Reps. Morgan Griffith (R-VA) and Brett Guthrie (R-KY) submitted amendments to allow companies to market drugs and devices for unapproved uses. Over a dozen consumer groups submitted a letter vigorously opposing this policy on the amendment based on patient health and safety concerns.

The Senate approved its FDA user fee bill (S. 934) on May 18. Both chambers are expected to approve their respective measures before July.

2. Senate Finance Committee Examines President's FY 2018 Budget Request
On Thursday, June 8, the Senate Finance Committee held a hearing entitled "The President's Fiscal Year 2018 Budget." The sole witness was Tom Price, M.D., Secretary of the U.S. Department of Health and Human Services. The AAFP filed a statement for the record in advance of the hearing. In his opening statement, Chairman Orrin Hatch (R-UT) primarily criticized the Affordable Care Act as a failing program, pointing to recent announcements from health plans to exit certain markets, and raise premiums in other markets. Ranking Democrat Ron Wyden (D-OR) in his opening statement criticized the President's budget proposal for sharply reducing commitments to health spending, and to Medicaid in particular.

Of relevance to family medicine, Sen. Bill Cassidy (R-LA) engaged Secretary Price about the Administration's announcement to incentivize the use of Direct Primary Care (DPC) in Medicaid. He asked Secretary Price to elaborate on the specifics of HHS's plan to accelerate the growth of the model. Secretary Price did not answer the question directly but did refer to DPC as an "incredible program that gets the dynamism in healthcare." He added: "The opportunity to have a personal primary care physician in all settings across our health system would be absolutely beneficial to the ability of that patient to get the kind of care that he or she needs. Right now you can't do that, so what we want to do is move toward a system that allows for more personalized care and the DPC model is one that I think holds great promise."

The Democrats on the Committee used their time mostly to defend Medicaid, the ACA, and call for improvements and fixes to existing programs rather than reductions. Sen. Tom Carper (D-DE) pointed out that Secretary Price had formerly supported elements of the ACA such as an individual mandate, insurance-market protections, and health-insurance exchanges. Sen. Claire McCaskill (D-MO) bemoaned the departure from "regular order" in the Senate (referring to the open process of legislating through committee hearings and other public proceedings) on the ACA repeal-and-replace bill. She asked Chairman Hatch whether he would hold a hearing on the repeal-and-replace bill, which he would not commit to doing. In response to the Administration's proposal to establish a new grant program to combat opioid abuse, Sen. Sherrod Brown (D-OH) expressed incredulity that a grant program could ever substitute for the loss of Medicaid expansion coverage for the millions suffering from addiction. Notably, Sen. Johnny Isakson (R-GA) also appeared to express concern about the proposed Medicaid reductions. He reminded Price (also from Georgia) that Medicaid covers some 1.9 million Georgians, including 1.3 million children.

3. House Ways and Means Committee Examines President's FY 2018 Budget Request
The House Ways and Means Committee held a parallel hearing on the President's Budget on Thursday (entitled "Hearing on the Department of Health and Human Services' Fiscal Year 2018 Budget Request"), where Secretary Price (a former member of the Committee until this year) also appeared as the lone witness. The AAFP filed a statement for the record in advance of the hearing.

In his opening statement, Chairman Kevin Brady (R-TX) touted the House's passage of the *American Health Care Act*, but also the importance of stabilizing the troubled individual insurance market. Chairman Brady admitted that uncertainty surrounding the *Affordable Care Act* cost-sharing reduction payments to health plans is contributing to spiking premiums, and called on Congress to appropriate the necessary funds to ease the uncertainty. Ranking Democrat Richard Neal (D-MA) agreed that the payments must be made, but called for the Administration to commit to making them, in 2017 and beyond. Rep. Neal also sharply criticized the budget for its proposed cuts to Medicaid and other social service programs (for example the Social Services Block Grant and Temporary Assistance to Needy Families). In his own opening statement, Secretary Price suggested that a budget should be evaluated not in terms of raw spending levels, but rather in terms of whether programs are effective and successful. He repeatedly pointed out that the Administration views many programs as underperforming, even with their current level of resources.

Of interest to the AAFP, Rep. Lloyd Doggett asked why President Trump's positions on drug prices (e.g. his campaign promise to give Medicare and other federal programs the authority to negotiate prices) were not included in the budget request. He asked Secretary Price for a written response. At least three members (Reps. Neal, Pat Tiberi (R-OH), and Jim Renacci (R-OH)) used their time to raise concerns about the opioid-addiction crisis and call upon the Administration to take urgent action. Rep. Tom Rice (R-SC) used his time to discuss the importance of using telehealth to lower health-care costs and improve quality of care. Rep. Pat Meehan (R-PA) discussed the promise of alternative payment models and "collaborations on preventive care" that are impeded by the Stark Law and Anti-Kickback Statute. The Democrats on the committee primarily laid into Secretary Price for the cuts proposed in the budget to Medicaid and other public-assistance programs.

4. House Panel Explores Payment Reforms in Medicare Advantage

On Wednesday, June 7, the House Ways and Means Health Subcommittee held a hearing entitled "Medicare Advantage Hearing on Promoting Integrated and Coordinated Care for Medicare Beneficiaries." The hearing, which was relatively bipartisan, and technical in nature, provided a platform for subcommittee members to learn about specialized models within Medicare Advantage that provide coordinated care for the neediest Medicare patients, including those with multiple chronic conditions. Subcommittee Chairman Pat Tiberi (R-OH) in his opening statement said that the goal of the hearing was "to look at some of the lessons learned from smaller programs that offer targeted, coordinated care to some of the frailest and sickest beneficiaries in the Medicare program." In particular Chairman Tiberi invited members to explore the Program for All-Inclusive Care for the Elderly (PACE)—which provides home-based care to 42,000 individuals—and Medicare Advantage Special Needs Plans (SNPs)—covering 2.3 million Medicare enrollees including many who are also eligible for Medicaid (dual eligibles). Ranking Member Sandy Levin (D-MI) added in his opening statement that the hearing would cover value-based insurance design (V-BID), which he said was a model "in its infancy in Medicare."

The four witnesses were non-partisan health-policy and economic experts on Medicare Advantage. Gretchen A. Jacobson, Ph. D., of the Kaiser Family Foundation provided high-level general background on the dually-eligible population, and technical expertise on all three of the MA models being discussed. Cheryl Wilson, RN, MA, LNHA, CEO of St. Paul's Senior Services in San Diego, explained the PACE program. David Grabowski, Ph. D., of Harvard Medical School, provided academic perspective on SNPs, particularly the so-called "D-SNPs" for dual eligibles. He pointed out that the dually eligible "have three health insurance cards (Medicare, Part D, and Medicaid) with three sets of benefits. Given this bifurcated coverage under Medicare and Medicaid, each program has the narrow interest in limiting its share of costs, and neither program has an incentive to take responsibility for care management or quality of care." Prof. Mark Fendrick, M.D. of the University of Michigan provided expertise on V-BID.

5. Senate Committee Examines Veterans Choice Program

The Department of Veterans Affairs is seeking Congress' help to overhaul an Obama-era initiative that allows military veterans to seek care from private doctors if Veterans Affairs facilities have excessive wait times. During a hearing on Wednesday before the Senate Committee on Veterans' Affairs, VA Secretary Dr. David Shulkin outlined his vision of a revamped Veterans Choice program, which would be renamed The Veterans Affairs Community Care Program. Under the current Veterans Choice program, veterans who have waited at least 30 days for an appointment at a VA facility or have to travel more than 40 miles for VA care can receive federally funded treatment from local, non-VA doctors. Over 1 million veterans have received care under the initiative, according to VA data. The new program would jettison the day and mile requirements. Instead, a VA clinician would perform a health risk assessment on a veteran and determine if the VA or a private provider would be the best place for the patient to receive care and work together on the next steps for treatment. In April, President Donald Trump signed legislation extending the sunset date of the Veterans' Choice Program and addressing the provider payment issue. The VA had been relying on a third-party vendor to oversee payments. Starting this summer, the VA will pay claims directly.

CENTERING ON THE STATES

1. Bills of Interest

Following are bills of interest:

- **Direct Primary Care** – Pennsylvania House Health Committee Chairman Matt Baker issued a co-sponsorship memoranda asking House members to co-sponsor his legislation on direct primary care. The bill will be introduced later this month and is a Pennsylvania Academy of Family Physicians priority.
- **Medicaid**—Nevada has passed legislation requiring the Department of Health and Human Services to establish a health care plan within Medicaid for purchase by persons who are not otherwise eligible for Medicaid. This measure awaits decision by Gov. Brian Sandoval (R).
- **Prescription Drug Pricing** –Gov. Larry Hogan (R) announced he would allow HB 631 to become law without his signature. The bill prohibits a manufacturer or wholesale distributor from engaging in price gouging in the sale of an essential off-patent or generic drug. Several states introduced bills this session aimed at addressing prescription drugs' rising costs. The California Senate has passed legislation requiring drug manufacturers to provide a 90-day advanced notice to health plans and State purchasers of increases in wholesale cost of drugs.
- **Single Payer**—The California Senate has passed legislation which would create a public single payer healthcare system. The bill is estimated to cost $330 billion to $400 billion annually. Currently the legislation does not include how this measure will be funded.

2. States Struggle with Marketplace Rate Filing Processes

Arkansas and New Mexico are the most recent states to allow insurers to submit multiple sets of rate requests for their plans in 2018. California was the first state to authorize these procedures in the wake of uncertainty over federal cost-sharing reduction payments. Connecticut has also pushed the deadline for insurers to submit 2018 rates from July to September.

3. Indiana Adds Work Requirement Amendment to Waiver Application

On May 24, Indiana released an amendment to its pending Medicaid expansion waiver application, Healthy Indiana 2.0. The original waiver is a three year 1115 waiver application which was submitted in February and is still pending approval. The amendment would require all able-bodied beneficiaries to work at least 20 hours per week, be enrolled in full- or part-time education, or participate in a job search and training program. Specific individuals like medically

frail individuals would be exempt from the work requirement. The amendment is open for public comment until June 23.

EXECUTIVE BRANCH

1. Regulatory Briefs

- On May 30, CMS announced plans to use new Medicare Beneficiary Identifiers that will be accessible through secure look-up tools for health care providers and beneficiaries. CMS is required to remove Social Security numbers from all Medicare cards by April 2019 to help prevent identity theft.
- On June 1, the AAFP nominated Dr. Amy Mullins to the Quality Measure Development technical advisory panel.
- On June 5, the VA announced that the agency will use the same EHR system as the DoD.
- On June 5, CMS released proposed revisions to arbitration agreement requirements for long-term care facilities.
- On June 6, the VA launched the Physician Ambassador Program, which is an effort to recruit volunteer medical providers. The Physician Ambassador Program is a compensation program that provides civilian physicians and clinicians an opportunity to give back to the Veteran community.
- On June 8, CMS released a request for information to create a more flexible, streamlined approach to the regulatory structure of the individual and small group markets.