



# Government Relations Report

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AAFP Division of Government Relations – 2021 Massachusetts Avenue, NW – Washington, DC 20036

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December 2007

## GRASSROOTS ADVOCACY

From November 6 to 8, AAFP members participated in a Virtual Rally on Capitol Hill in coordination with the other physician groups. A President's letter was sent to all active AAFP members, asking them to call their Senators' offices in anticipation of the Congressional recess for Thanksgiving. Using the AMA toll-free grassroots hotline, members contacted their Senators urging them to provide a multi-year positive update to Medicare payments to physicians. The AMA reports that over 12,000 calls were made to Congressional offices on its hotline during this period, and credits the AAFP and other physician groups with successfully promoting this effort.

Since October 1, 2007 more than 1425 messages were sent to legislators from AAFP members using Speak Out.

Issue	# of Messages (as of 11/28/07)
SCHIP	1,000
Medicare Physician Payment	150
Other / Compose your own message	275

As of November 28, 2007, AAFP has identified Key Contacts for 426 of the 536 Congressional legislators.

Chamber	Key Contacts	Target (# of legislators)
Senate	96 (96%)	100
Senate Leadership & Key Committees	63 (95%)	66
House	330(75%)	436 (including DC)
House Leadership & Key Committees	140 (79%)	174

## FEDERAL GOVERNMENT ADVOCACY

### Medicare Physician Payment

The Senate Finance Committee has scheduled debate on a yet-to-be-introduced Medicare bill that would address the pending 10.1-percent reduction in Medicare payments to physicians. Negotiations continue on whether to make it a single year freeze or a two-year update. If committee members can agree on where to find offsetting reductions in the budget to pay for the physician fee update, then the debate will take place on December 5. If they cannot agree, that schedule is likely to slip.

The Finance Committee has expressed an interest in adding a provision in the Medicare bill that would expand the currently authorized Medicare medical home demonstration grant program to include a national sample of at least 500 medical homes. It might include a component that would evaluate the implementation of the medical home in underserved areas of the nation and a separate component that would include the use of advanced healthcare information technology in the medical home practices.

On November 8, AAFP Board member Bradley Fedderly, M.D., of Milwaukee urged Congress to replace the flawed sustainable growth rate (SGR) formula during testimony before the House Small Business Subcommittee on Regulations, Healthcare and Trade. "Medicare beneficiaries comprise about a quarter of the typical family medicine practice," said Dr. Fedderly. "Therefore, an accurate and more contemporary physician payment method is key. Congress needs to restructure the Medicare payment system to recognize and reward care coordination and quality and to prevent expensive and duplicative tests and procedures," he testified.

The subcommittee's hearing on the impact of scheduled Medicare cuts on solo and small group practices underscored the inadequacies of the SGR formula, which determines physician payment rates under Medicare. Dr. Fedderly, who was joined on a panel by representatives from several other physician organizations, assailed the SGR formula as "inaccurate and outdated." He urged Congress to replace it with a new payment formula that "considers and reflects the change in the cost for small business medical practices to provide care."

Dr. Fedderly's message was three-fold:

- Enact a two-year positive update for payment rates and use the time to develop a replacement for the dysfunctional SGR formula.
- Adopt the patient-centered medical home as a central part of the Medicare program and incorporate a fee for physicians who coordinate the care of Medicare patients. "This should be a blended model that combines fee for service with a monthly coordination payment," he said.
- Provide Health Information Technology grants and low-interest loans to solo and small group medical practices that provide a patient-centered medical home to Medicare beneficiaries.

Rep. Michael Burgess (R-TX), an OB-Gyn, also testified before the committee and said the "SGR must be eliminated" and replaced with a Medicare payment system that adjusts for growth in services and that is agile enough to determine what constitutes appropriate growth in service volume. The SGR formula is "fantasy, it is fiction and it is made up," from the perspective of physicians, Rep. Burgess said. He called on Congress to replace the SGR with a formula that is based on the Medicare Economic Index.

Rep. Charles Gonzalez (D-TX), chair of the subcommittee, decried the cuts called for under the SGR formula, saying that the "potential impact of these cuts must be considered in light of the fact that these medical practices function like any other small business and face low profit margins."

### **Appropriations**

Just before recessing for Thanksgiving, Congress failed to override the president's veto of the Labor-HHS-Education appropriations bill for the fiscal year that began on October 1. AAFP joined the Coalition for Health Funding and the Committee on Education Funding to support the nearly successful effort to enact the FY 2008 spending bill that would have funded primary care training at the FY07 level of \$48.9 million and the Agency for Healthcare Research and Quality at \$334.6 million, nearly \$15 million more than FY07. The 277-141 vote in the House of Representatives on November 15 was just two votes short of the two-thirds needed to enact the bill in spite of the veto. The government is currently operating under a stopgap "continuing resolution" which will provide funding through December 14.

The White House continues to insist that the president will not sign appropriations bills which exceed his budget request and criticizes the bill for funding "programs that are duplicative or ineffective." The vetoed bill sought to fund Title VII Health Professions Primary Care Training Grant program despite the Administration's request that it be eliminated.

Senate Majority Leader Sen. Harry Reid (D-NV) proposed a catch-all or "omnibus" appropriations bill that would split the difference between what Congress and the White House have proposed as discretionary spending totals for several domestic appropriations bills. The president's budget request falls \$9.6 billion short of the House- and Senate-passed HHS appropriations package.

The AAFP Government Relations staff continues to remind Congressional appropriators of the importance of funding the Title VII program and to urge them to resist across-the-board cuts which will disproportionately harm those programs, like Title VII, which were funded at the FY 2007 level.

### **Health Information Technology**

On September 26, the House Science and Technology Committee held a hearing entitled, "Meeting the Need for Standards and Interoperability in Healthcare IT." Witnesses included representatives from the American Health Information Management Association, the Alliance of Specialty Medicine, General Electric, the Hospital Corporation of America and Greenway Technologies. The hearing was in response to a bill that Representative Bart Gordon (D-TN) introduced. The measure (HR 2406) would authorize the National Institutes of Standards and Technology (NIST) to create or adopt existing technology-neutral guidelines and standards for federal agencies to use in health information technology (HIT). While all witnesses acknowledged the need for HIT interoperability, there was disagreement about whether or not NIST was the appropriate entity to create standards. During his opening statement, Rep. Gordon emphasized the fact that most health care takes place in practices with fewer than 5 physicians, that doctors find HIT unaffordable and that the 10-percent Medicare payment cut must be stopped.

The AAFP sent a statement for the record that indicated that AAFP did not believe that NIST should take on a new role in the selection or development of standards for portability and interoperability of

health information. Specifically, the statement argued that the private sector has created an abundance of standards, and that the institute's real value is in testing and validating the utility and affordability of these many standards.

On November 1, the House Oversight and Government Reform Subcommittee on Government Management, Organization and Procurement held a hearing entitled, "Too Many Cooks? Coordinating Federal and State Health IT." Rep. Ed Towns (D-NY), who is drafting a bill to help underserved areas take advantage of health information technology, chaired the hearing.

Witnesses included Robert M. Kolodner, MD, National Coordinator for Health Information Technology, HHS; Cheryl Austein Casnoff, Associate Administrator, Office of Health Information Technology, HRSA; Carolyn Clancy, MD, Director, AHRQ and AAFP member Neil Calman, MD, President of The Institute for Urban Family Health. All witnesses agreed on the need to ensure the delivery of HIT to underserved areas and highlighted efforts in that area. The AAFP sent a statement for the record commenting on the draft proposal as a follow up to a meeting with Congressional staff on the issue. The AAFP statement supported Rep. Towns' desire to target federal resources to reduce health disparities using health information technology.

Finally, Government Relations staff have met several times with staff from the sponsors of the *Wired for Healthcare Act* (S 1693). Authors include Senators Edward Kennedy, (D-MA); Hillary Clinton (D-NY), Michael Enzi (R-WY) and Judd Gregg (R-NH). Recent meetings have involved representatives from approximately 20 medical groups and concerns have centered on new sections on quality reporting that were added to an earlier version of the bill.

In addition to sending our own letter in June that emphasized the burdensome nature of the grant program for physicians and the need for system-wide interoperability, in early November, the AAFP signed onto a coalition letter sponsored by the AMA that focused primarily on the new quality provisions, as well as the need for accurate public reports and substantial physician input into the process. On November 27, numerous medical groups met with the same staffers to discuss their changes to the quality reporting section. The latest iteration of the bill may address the concerns of the physician community.

### **E-Prescribing**

AAFP staff continues to work with Senator John Kerry (D-MA) and the staff for the House Ways and Means Health Subcommittee on e-prescribing provisions that possibly would be contained within in a Medicare bill. The Kerry draft proposal would provide bonuses to physicians who begin e-prescribing. On the House side, staff is just beginning to draft legislation but is considering a process that would provide incentives for physicians to purchase these systems.

### **Medicare Part D Prescription Drug Program**

On November 9, the Medicare Payment Advisory Commission (MedPAC) held three sessions on the Part D Prescription Drug Program. Of most interest to family physicians were the panels on formularies and the benefit design. In the former panel, Jack Hoadley, a researcher from Georgetown University, found that while most plans use a three-tier formulary, those allowing beneficiaries a greater choice of drugs include greater restrictions. Additionally, Hoadley found that plans dropped less than one percent of drugs from their formularies. Of greatest concern to

commissioners, however, was whether this broad analysis determined if beneficiaries were getting the drugs they needed. Hoadley stated that physician focus groups revealed many would switch a patient's drug to avoid going through the exceptions process.

The second panel focused on MedPAC research indicating that the percentage of beneficiaries with drug coverage had increased from 75 percent to 90 percent with the inception of the Part D program and that enrollment is concentrated in a few drug plan sponsors. Additionally, beneficiaries largely choose Medicare Advantage enhanced plans that cover drugs in the gap (generally generic) or require no deductible. Of concern to the commissioners was the fact that 2.6 million low-income individuals will need to change plans this year due to premium prices. Commissioners stated that this group needs greater stability and noted that plan switching must be increasing administrative costs. Finally, commissioners were surprised by the \$4.3 billion amount owed to CMS by the plans due to the fact that the latter overestimated their prospective costs.

### **AAFP Member Serving on MedPAC**

Dr. Tom Dean of Wessington Springs, SD was appointed to the Medicare Payment Advisory Commission (MedPAC) and has attended his first two meetings of the 17-member independent federal body established to advise Congress on issues affecting the Medicare program. Government Relations staff have met with Dr. Dean and provided him with background materials on relevant issues.

Dr. Dean is a former president of the National Rural Healthcare Association and currently serves as chief of staff at Avera Wesskota Memorial Medical Center in Wessington Springs. He is on the board of Avera Health Plan, the Bush Foundation Medical Fellowship, and the South Dakota Academy of Family Physicians. In 1994, Dr. Dean received the Dr. Robert Hayes Memorial Award for outstanding rural health provider. He has served the Wessington Springs community for the past 28 years.

It is particularly valuable to have a family physician's perspective among the MedPAC commissioners because the Commission has been interested in the valuation of medical services, including primary care. MedPAC has recommended that CMS reduce its reliance on physician specialty societies for valuing medical services and procedures by establishing a standing panel that would provide expertise in addition to that provided by the AMA Relative Value Scale Update Committee (RUC). This new panel would help CMS identify misvalued (especially overvalued) services and collect data to establish supporting evidence for the RUC to consider.

Accurate valuation of medical services is important but takes on enhanced meaning to family physicians as CMS implements the medical home demonstration program, which calls for a care coordination fee determined by means of the RUC process. MedPAC has long supported the concept of care coordination especially in the Medicare population that has multiple chronic conditions.

### **State Children's Health Insurance Program (SCHIP)**

After intense negotiations between a partisan group of Finance Committee senators and Republican House members, Congress recessed for the Thanksgiving holidays without reaching an agreement on the reauthorization of the State Children's Health Insurance Program. The White House and the House GOP members want the reauthorization to limit eligibility to those children whose families earn

less than 200 percent of the federal poverty level (around \$40,000 for a family of four). Legislators agreed to allow the ceiling to expand to 250 percent of poverty if a state could show that it has covered a certain percentage of its resident children who live in families at the 200 percent level or below. However, they could not agree on what would be the appropriate percentage of coverage for the poorer families. Other issues of disagreement included how to prove citizenship, whether the poverty requirements should apply to Medicaid as well as SCHIP, and how much time the states should have to come into compliance with the stricter poverty standards.

If the negotiations are not successful by the time Congress returns from its recess on December 3, the legislators may try to include an extension of the current program until September 30, 2008 forcing a politically difficult vote just before elections. However, a recent study by the Congressional Research Service suggests that this approach creates some coverage problems for some states. According to the CRS, 21 states are projected to exhaust their available federal SCHIP funding during FY 2008 under current law.

### **Behind-the-Counter Drugs**

On November 28, the AAFP submitted comments to the Food and Drug Administration opposing their proposal to allow some prescription drugs to be dispensed by pharmacists without consultation with a physician. In general, AAFP comments focused on the fact that the proposed solution does not address the complexities involved in today's pharmaceutical world. More importantly, with its narrow focus on the role of the pharmacist, the plan ignores the larger health care system, and, in particular, the crucial role that is played by a physician whose goal is to coordinate patient care.

### **Consolidation of Health Plans**

On October 25, AAFP President, Dr. Jim King testified before the House Small Business Committee. The topic was "Health Insurer Consolidation – The Impact on Small Business." The hearing examined the effects of consolidation on the cost of health insurance and the impact on physicians and other health care providers.

Dr. King joined Dr. William G. Plested III, Immediate Past President of the AMA, Robert Hughes, President of the National Association for the Self-Employed, James R. Office, General Counsel for Victory Wholesale Grocers Springboro, Ohio, and Greg Scandlen, President, Consumers for Health Care Choices in providing testimony and responding to questions.

The hearing was predicated upon concerns among physicians, small businesses and consumers regarding increasing consolidation in the health insurance industry and the lack of enforcement of antitrust laws by the Federal Trade Commission and the Department of Justice. In January 2007, the *Wall Street Journal* reported that "the federal government has nearly stepped out of the antitrust enforcement business, leaving companies to mate as they wish."

Committee Chairwoman Rep. Nydia Velazquez (D-NY) expressed concern that doctors are being offered "take it or leave it" contracts and that while insurance plan consolidation has increased, competition has decreased and premiums have risen.

Rep. Steve Chabot (R-OH), the senior Republican on the committee, quoted a U.S. Supreme Court ruling that stated: "Unrestrained interaction of competitive forces yields the best resources..."

Antitrust is supposed to help foster fair competition but as the number of health plans has decreased, health insurance premiums have risen. He pushed for reintroduction of the Association Health Plan legislation passed by the House in the 109th Congress because this consolidation should teach us that “the worst possible thing could be a single payer.”

Dr. King pointed out that between 1992 and 2006, the number of health insurance companies dropped from 95 to only 7. He provided examples of how consolidation of health insurance plans has affected the ability of family physicians to negotiate contracts. Among the examples was a solo family physician in Colorado whose practice has nearly two-thirds of its patients insured by one commercial payer, and was told by the insurer, “As a solo physician, you are the weakest economic unit and must take what we decide to give.”

Dr. King also described the exceptional value of a “patient-centered medical home,” and emphasized that the success of the medical home depends on a long-term relationship between the physician and the patient. This relationship can be threatened and even destroyed if insurance companies dictate the terms of medical practice and limit the patient’s freedom of choice.

Dr. King criticized the current antitrust statutes which, he said, were established years ago during a very different competitive environment. Under these outmoded laws, physicians are barred from discussing the financial aspects of their practice with any unrelated entity, while insurance companies use market share and sheer economic strength to carry out near-monopolistic behaviors. He recommended changing anti-trust laws so that physicians can be true market participants.

### **FamMedPAC**

Contributions to the PAC from January 1, 2007 to November 29, 2007, total \$339,305. 1297 AAFP members made a contribution to FamMedPAC since January 1, 2007. The average contribution amount is \$262. If the current pace holds, FamMedPAC will raise more in 2007 than in the entire 2005-2006 election cycle.

The PAC had a booth at the Congress of Delegates meeting and in the exhibit hall for the Scientific Assembly in Chicago. Some 164 AAFP members donated more than \$38,000 during the week. FamMedPAC also sponsored two receptions during the week to thank donors for their support.

The PAC is conducting joint fundraising activities with the Florida, Michigan, North Carolina and Louisiana chapter PACs. The effort involved a joint letter on behalf of both the state and national PACs, and included separate return envelopes for members to send contributions to each. The cost of the mailing and printing was split between FamMedPAC and the state chapter.

Below is a list of the top chapter contributors to FamMedPAC.

#### 2008 Election Cycle Total Contributed

<u>Chapter</u>	<u>Contributors</u>	<u>Amount</u>
1) Tennessee	108	\$32,514
2) Ohio	48	\$19,766
3) Kansas	48	\$15,762

4) California	67	\$14,070
5) Pennsylvania	49	\$12,955
6) Texas	42	\$12,690
7) Minnesota	57	\$11,505
8) N. Carolina	47	\$10,945
9) Florida	29	\$10,030
10) Iowa	21	\$9,575

2008 Election Cycle Percentage of Members Contributing

<u>Chapter</u>	<u>Contributors</u>	<u>Percentage</u>
1) Tennessee	108	8.18
2) Rhode Island	12	6.86
3) Kansas	48	5.21
4) South Dakota	13	4.53
5) Montana	13	3.88
6) Maine	18	3.61
7) Alaska	10	3.52
8) Nebraska	23	3.50
9) Oregon	34	3.45
10) N. Carolina	70	3.43

As of November 29, 2007, FamMedPAC has contributed a total of \$266,000 to candidates and committees in this election cycle. Campaign contributions are listed below.

<b>Candidate</b>	<b>Party</b>	<b>State</b>	<b>Amount</b>
Rep. Thomas H. Allen	D	ME	\$2,500
Rep. Jason Altmire	D	PA	\$2,500
Rep. Michael Arcuri	D	NY	\$3,500
Sen. Max Baucus	D	MT	\$7,500
Rep. Melissa L. Bean	D	IL	\$2,500
Rep. Xavier Becerra	D	CA	\$1,000
Rep. Shelley Berkley	D	NV	\$1,000
The Blue Dog PAC	D		\$5,000
Rep. F. Allen Boyd Jr.	D	FL	\$1,500
Sen. Sherrod Brown	D	OH	\$5,000
Rep. Lois Capps	D	CA	\$2,500
Del. Donna M. Christensen	D	VI	\$3,500
Rep. James Clyburn	D	SC	\$2,500
Democratic Congressional Campaign Committee			\$15,000
Rep. Diana L. DeGette	D	CO	\$2,500
Rep. John D. Dingell	D	MI	\$5,000
Rep. Lloyd Doggett	D	TX	\$2,500
Democratic Senatorial Campaign Committee			\$15,000
Rep. Rahm Emanuel	D	IL	\$2,500
Rep. Eliot Engel	D	NY	\$2,000
Rep. Anna Eshoo	D	CA	\$2,500
Rep. Gabrielle Giffords	D	AZ	\$2,500
Rep. Kirsten Gillibrand	D	NY	\$2,500
Rep. Charles A. Gonzalez	D	TX	\$3,000
Rep. Bart Gordon	D	TN	\$2,500

Rep. Gene Green	D	TX	\$2,500
Rep. John Hall	D	NY	\$2,500
Sen. Tom Harkin	D	IA	\$5,000
Rep. Stephanie Herseth	D	SD	\$1,000
Rep. Michael M. Honda	D	CA	\$1,000
Rep. Darlene Hooley	D	OR	\$2,500
Rep. Steny H. Hoyer	D	MD	\$5,000
Rep. Jesse Jackson Jr.	D	IL	\$2,500
Sen. Tim Johnson	D	SD	\$2,500
Rep. Steve Kagen	D	WI	\$2,500
Sen. Ted Kennedy	D	MA	\$5,000
Rep. Patrick J. Kennedy	D	RI	\$2,000
Sen. John F. Kerry	D	MA	\$2,500
Sen. Mary Landrieu	D	LA	\$2,500
Rep. John Lewis	D	GA	\$2,500
Sen. Blanche L. Lincoln	D	AR	\$2,500
Rep. Jim McDermott	D	WA	\$2,500
Rep. Harry E. Mitchell	D	AZ	\$2,500
Rep. Dennis Moore	D	KS	\$1,000
Rep. Frank Pallone Jr.	D	NJ	\$2,500
Rep. Earl Pomeroy	D	ND	\$5,000
Rep. Charles B. Rangel	D	NY	\$5,000
Sen. Jack Reed	D	RI	\$2,500
Sen. Harry Reid	D	NV	\$2,000
Sen. John D. Rockefeller IV	D	WV	\$2,500
Rep. Ciro D. Rodriguez	D	TX	\$2,500
Rep. Tim Ryan	D	OH	\$1,000
Rep. Zack Space	D	OH	\$2,500
Rep. Fortney H. Stark	D	CA	\$5,000
Rep. John S. Tanner	D	TN	\$2,000
Rep. Chris Van Hollen Jr.	D	MD	\$2,000
Rep. Joe Barton	R	TX	\$1,500
Rep. Marsha Blackburn	R	TN	\$2,000
Rep. Roy Blunt	R	MO	\$2,500
Rep. John Boehner	R	OH	\$5,000
Rep. Charles W. Boustany Jr.	R	LA	\$1,000
Rep. Michael C. Burgess	R	TX	\$1,000
Rep. Steve Buyer	R	IN	\$2,500
Rep. Dave Camp	R	MI	\$2,500
Sen. Thad Cochran	R	MS	\$1,000
Sen. Mike Crapo	R	ID	\$2,000
Rep. Barbara Cubin	R	WY	\$2,500
Rep. Nathan Deal	R	GA	\$2,000
Rep. Phil English	R	PA	\$1,000
Sen. Michael B. Enzi	R	WY	\$2,500
Rep. Phil Gingrey	R	GA	\$1,000
Sen. Charles E. Grassley	R	IA	\$2,500
Sen. Jon Kyl	R	AZ	\$2,000
The Republican Mainstreet Partnership PAC			\$5,000
Sen. Mitch McConnell	R	KY	\$2,500
Rep. Timothy F. Murphy	R	PA	\$2,500
National Republican Congressional Committee			\$15,000
National Republican Senatorial Committee			\$5,000
Rep. John E. Peterson	R	PA	\$1,000
Rep. Joseph R. Pitts	R	PA	\$2,500
Rep. Tom Price	R	GA	\$1,000

Rep. Jim Ramstad	R	MN	\$2,500
Rep. Dennis Rehberg	R	MT	\$1,000
Rep. Michael J. Rogers	R	MI	\$2,500
Rep. John M. Shimkus	R	IL	\$1,000
Sen. Arlen Specter	R	PA	\$1,000
Rep. John Sullivan	R	OK	\$1,000
Rep. Patrick J. Tiberi	R	OH	\$3,000
Rep. James T. Walsh	R	NY	\$1,000
Rep. Dave Weldon	R	FL	\$1,500

Several AAFP members met with their Senators and Representatives back in their home state and delivered FamMedPAC contributions. By delivering the contribution in person, these AAFP members are establishing personal relationships with their legislator and emphasizing the importance of family medicine in the local community.

- FamMedPAC Board member Dr. Jun David and New York Chapter Executive Vito Grasso are delivering contributions to three New York Representatives: Rep. Mike Arcuri, Rep. John Hall, and Rep. Kirsten Gillibrand.
- Dr. Catherine Bishop is delivering a PAC contribution to her Representative, Rep. Zack Space of Ohio.
- AAFP Board member Dr. Jim Dearing and Arizona Chapter Executive, Laura Hahn, are delivering PAC contributions to Rep. Harry Mitchell and Sen. John Kyl of Arizona.
- Rep. Marsha Blackburn of Tennessee met with Dr. Jim King, who presented her with a PAC contribution.

### **2008 Presidential Campaign**

Sen. Barack Obama (D-IL) was the most recent 2008 Presidential candidate to return the AAFP candidate survey and his answers are posted on the Academy website. In addition, a grid has been created that includes all Presidential candidates and their positions on issues of interest to the AAFP, including Medicare payments to physicians; the implementation of the patient centered medical home; elimination of health care disparities; improved access to health care; medical liability reform; and assistance for students and residents of family medicine. This document also has been posted on [aafp.org](http://aafp.org).

## **STATE GOVERNMENT ADVOCACY**

### **Medical Home**

Steven Crawford, MD, chair of the Commission on Governmental Advocacy, attended the Council of State Governments Annual Meeting in early November. With the groundwork laid at the CSG leadership meeting in June, Oklahoma Senator Connie Johnson spoke eloquently to the Patient-Centered Medical Home resolution considered at the Health Policy Task Force.

The measure recommends that states use the Joint Principles of the Patient-Centered Medical Home as a guideline to developing health care proposals and calls for states to fund pilot programs. CSG will be sending this resolution to all governors and to the legislative leadership in the fifty states, territories and District of Columbia. Additionally, Sen. Johnson will be taking the resolution and opening a dialog with the National Black Caucus of State Legislators on the value of a medical home in addressing health disparities.

Staff is working on a package of information for chapters that will include the resolution and other tools addressing the medical home that they can use in seeking appropriate state legislative action.

### **State Legislative Conference**

The State Legislative Conference was held November 16-17, 2007, in Memphis, Tennessee. The patient-centered medical home was the focus of the meeting. There were 100 participants representing thirty-two states. Additionally, there were three awards presented to the Colorado, Kansas and Texas chapters in recognition of their advocacy efforts.

### **Suggested State Legislation**

The first volume of Suggested State Legislation (SSL) was released to constituent chapters on November 29, 2007. The publication contained 11 pieces of legislation covering six policy areas. The legislation was reviewed by the CGA subcommittee on State Government Advocacy and included based on meeting specific criteria. The SSL was developed in direct response to chapter and member requests for model legislation. This first volume includes the Colorado Insurance Contracting bill and legislation addressing workforce, scope of practice, medical liability, public health and medical home.

### **Tamper Resistant Prescription Pads**

Implementation of the requirement to use tamper resistant prescription pads for all written prescriptions for Medicaid patients was delayed six months. The requirement now becomes effective April 1, 2008. This provides states with time needed for the regulatory process. Several states have announced the regulatory changes and opened the comment period. Washington, Oklahoma, Virginia, Oregon, Delaware, Alaska and New Jersey are in the process of promulgating rules on the new requirement. The National Association of Chain Drug Stores is working on consensus correspondence and will ask the AAFP to sign on to a letter that will go to state Medicaid directors on this issue.

### **State Legislative Priorities for 2008**

Chapters have begun providing their 2008 state legislative priorities. To date, much of the activity is focused in areas of public health (tobacco tax increases, appropriate allocation of tobacco settlement funds, public smoking bans, vaccine issues), workforce, and medical home. The College of Pathology will again push for legislation that would restrict the billing of CPT codes. AAFP chapters continue to respond that restrictive billing is outside the purview of the legislature. Expansions of non-physician providers' scope of practice remain a challenge to many chapters. This becomes particularly sensitive at a time when medicine will be lobbying on Medicare payment.