GOVERNMENT AFFAIRS WEEKLY

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IN THIS REPORT…

NEXT WEEK IN WASHINGTON…

*On June 26, Finance Committee will hold a hearing on Health Care Quality: The Path Forward.

*On June 26, Energy & Commerce Subcommittee on Oversight and Investigations has a hearing on challenges facing America's businesses under the *Affordable Care Act.*

*On June 26, Energy & Commerce Health Subcommittee will hold a hearing to review Medicare Benefit Design.

*On June 28, Energy & Commerce Health Subcommittee will hold a hearing on reforms to improve the Medicare part B drug program for seniors.

1. HOUSE FAILS TO PASS FARM BILL WHICH CUT FARM SUBSIDIES, FOOD STAMPS

On June 20, the House of Representatives failed to pass the *Federal Agriculture Reform and Risk Management "FARRM" Act* (HR 1947) by a vote of 195 to 234. Legislators on both sides of the aisle found something to dislike in the FARRM Act. Most Democrats opposed its $20.5 billion cut to food stamps, and some Republicans found the cuts insufficient.

2. AAFP ADVISES SENATE TO EXTEND HEALTH CARE COVERAGE TO ALL

On June 21, the AAFP wrote to the leaders of the Senate advising them that the AAFP policy on health care coverage for all leads the organization to support extension of subsidies for health care coverage to those who join the new classification of Registered Provision Immigrant (RPI). In addition, the AAFP supports the reforms to the J-1 visa waivers and the H-1 B visa programs.

3. AAFP URGES CONGRESS TO PREVENT STUDENT LOAN INTEREST RATE HIKE

On July 1, the interest rate charged on subsidized Stafford loans is scheduled to double from 3.4 percent to 6.8 percent. The AAFP sent to every U.S. Representative and Senator a letter dated June 18 addressed to the bipartisan House and Senate leadership urging Congress to enact legislation to prevent any increase in student loan interest rates. The letter also called for expanded funding for federal loan programs targeted to support family medicine, allowing the deferment of interest and principal payments during education and training and allowing the tax-deductibility of interest on principal payment for such loans after program completion.

The House on May 23 passed the *Smarter Solutions for Students Act* (HR 1911) which drew a veto threat from the White House and would change the interest rate from a fixed to a variable one, adjusted annually and pegged to the 10-year Treasury bill rate. Senate negotiators from both parties are working on an alternative which could be signed by the President before July 1.

4. SENATE APPROPRIATIONS ADOPTS SPENDING LIMITS SUPPORTED BY AAFP

The Senate Appropriations Committee on Thursday, June 20 adopted a blueprint for fiscal year 2014 spending bills which proposes to set a cap of $1.058 trillion compared to a $967 billion level being used in the House. The blueprint passed by a 15 to 14 partisan vote. The lower allocations approved by the House Appropriations Committee threaten to undermine investment in important domestic programs including primary care research and training. On June 18, the AAFP wrote to the House Appropriations Committee members to encourage them to adopt the Senate's higher cap for FY 2014 in order to support the federal investment needed for education, training and research that provide a health care delivery system built on primary care needed for high quality, cost-efficient health care.

5. SENATE FINANCE SCRUTINIZES THE HIGH PRICE OF HEALTH CARE

On Tuesday, June 19, the Senate Finance Committee held a hearing entitled "High Prices, Low Transparency: The Bitter Pill of Health Care Costs" to explore ways to improve transparency in health care pricing so that informed consumers save money and obtain quality health care. The Committee Chairman, Senator Max Baucus (D-MT), lauded Steven Brill for his March 4, 2013, *TIME* magazine article, "The Bitter Pill: Why Medical Bills Are Killing Us," in his opening statement.

The Committee and the witnesses agreed that health care costs impose a staggering burden and that while provider consolidation could produce more integrated care, it might also lead to higher prices. There was consensus that health prices vary without explanation and do not correlate with quality. The senior Republican, Senator Orrin G. Hatch (R-UT), said Congress should bring health care pricing under control and not worry about increased transparency only.

6. HOUSE HEALTH SUBCOMMITTEE EXAMINES DRUG ABUSE CRISIS

The House Energy and Commerce Committee's Subcommittee on Health held a hearing on June 14 examining the federal government's response to the prescription drug abuse crisis. The background memo for the hearing describes prescription drug abuse as a growing problem that has plagued the U.S. for many years. Subcommittee Chairman Rep. Joe Pitts (D-PA) pointed out that prescription drug abuse is most prominent among young adults and that nearly all of the abused drugs were originally prescribed by a physician. The consensus seemed to support increased education for both providers and consumers to ensure safe use of pain medications. The subcommittee seemed to agree that greater use of electronic prescribing records and improved interstate prescribing information will help reduce rates of abuse. Some called for rescheduling and new labeling for certain drugs, in addition to reformulating them to deter abuse. There was agreement that the federal government should recognize the needs of patients with chronic pain and ensure their access to care.

7. MORNING-AFTER PILL GOES OVER THE COUNTER

The FDA approved Plan B One-Step, an emergency contraceptive (EC) for over-the-counter (OTC) sale without any age restrictions to comply with a court order by a federal judge in New York. The Obama administration had been fighting in court to preserve restricting OTC access to women 17 or older, but recently dropped the case after legal setbacks. The FDA then told the court that it would quickly approve an application for over-the-counter sale by Teva, the manufacturer of Plan B One-Step. It is not yet clear when the drug will be available as some packaging changes will be needed.

The issue of over-the-counter access to EC dates back to the George W. Bush administration. The AAFP has weighed in on this issue a number of times, most recently in a letter circulated by the American Congress of Obstetricians and Gynecologists, dated June 7, 2013 and signed by 18 other health care groups.

8. AAFP LEADER APPOINTED TO ADVISORY PANEL ON TRANSITIONAL CARE

Dr. Gretchen Dickson, a family physician from Wichita, Kansas and Chair of the Commission on Quality and Practice, will represent the AAFP on the Patient-Centered Outcomes Research Institute (PCORI) Workgroup on Transitional Care. This invitation-only workgroup of experts from patient, stakeholder and research communities will play a key role in addressing the effects of different models of transitional care on patient safety and other patient-centered outcomes.

9. FamMedPAC KEEPING HIGH PROFILE

Thanks to strong support from AAFP members in the first half of the year, FamMedPAC is able to keep a high profile in Washington and participate in several meetings each week for key Congressional leaders. Since the first of the year the PAC contributed to 70 candidates and committees. This week, the PAC supported the following legislators:

- **Rep. Steve Stivers (R-OH)**, serving his second year in Congress, has a good relationship with the Ohio chapter from his time in the Ohio legislature.
- **Rep. John Dingell (D-MI)**, the Dean of the House, is the longest serving Representative in the history of the U.S. Congress and serves on the Health Subcommittee of the House Energy and Commerce Committee.
- **Rep. John Shimkus (R-IL)** is a member of the Health Subcommittee of the House Energy and Commerce Committee.
- **Rep. Earl Blumenauer (D-OR)** serves as a member of the Health Subcommittee of the House Ways and Means Committee.
- **Sen. John Cornyn (R-TX)** is a member of the Senate Finance Committee and the Minority Whip of the Senate.
- **Rep. Nancy Pelosi (D-CA)** is the Minority Leader in the House.
- **Rep. Kurt Schrader (D-OR)**, a good friend of family medicine, he is serving his third term in Congress.

10. LETTER SENT ON INCENTIVE REWARD PROGRAM AND PROVIDER ENROLLMENT

In a regulatory comment letter sent June 18, the AAFP supported a CMS proposal to increase the Medicare Incentive Reward Program's (IRP) potential reward amount for tips and information on fraud. CMS proposed these changes based on similar successful modifications that the Internal Revenue Service made to its fraud prevention program. To discourage frivolous tips, the AAFP recommends that CMS hold individuals liable for the provider's costs in responding to the resulting inquiry from CMS when an attestation or related tip is false.

This proposed rule also would expand the instances in which CMS can deny a provider or supplier's enrollment. After expressing the AAFP's support for efforts to prevent fraud, the letter then notes our concern that well intended fraud-detection efforts could inadvertently snare law-

abiding physicians who unintentionally make a mistake during the enrollment process. The AAFP did not support a proposal to allow Medicare to deny enrollment to a physician based on "debt" that might occur within the enrolling entity. Furthermore, the AAFP opposes the CMS proposal to expand dramatically the ability of the agencies or its contractor to revoke billing privileges in cases where a "pattern or practice of billing for services that do not meet Medicare requirements." The AAFP opposes this approach since the proposed rule did not thoroughly discuss when CMS and its contractors would apply this new authority. The letter argues that billing and coding rules change frequently and errors will be made by well-meaning providers; thus, CMS should more thoroughly define "pattern or practice" before making this change.

11. REGULATORY BRIEFS

- On June 14, the Medicare Payment Advisory Commission posted its June 2013 report to Congress. The report addresses broad issues confronting Medicare, such as how to incorporate private plan and fee-for-service in one system and the new hospital readmissions policy. Also included are chapters on:
    - A new payment model, referred to as “competitively determined plan contributions,”
    - Medicare payment differences across ambulatory settings,
    - Creation of bundled payments for hospitalization episodes that include post-acute care and other services
    - Options for refining the new hospital readmissions reduction program, hospice payment policy issues
    - Care needs for dual-eligible beneficiaries
    - Medicare ambulance add-on payments
    - Geographic adjustment of payments for the work of physicians and other health professionals under the physician fee schedule.

- On June 20, CMS announced that 77.8 million consumers saved $3.4 billion on their premiums because insurance companies were operating more efficiently as required under the *Affordable Care Act’s* Medical Loss Ratio (MLR) policies. As part of this announcement, CMS stated that consumers will receive $500 million in rebates, with 8.5 million enrollees due to receive an average rebate of around $100 per family.

12. STUDY HIGHLIGHTS MEDICARE PART D CONCERNS

In a recent study, the HHS Inspector General flagged more than 700 doctors nationwide who wrote prescriptions for elderly and disabled patients in questionable and potentially harmful ways. Over 1 million individual prescribers ordered drugs paid by Part D in 2009. Prescribing patterns varied widely by specialty. Over 700 “general-care” physicians had questionable prescribing patterns. Moreover, more than half of the 736 general-care physicians with questionable prescribing patterns ordered extremely high percentages of Schedule II or III drugs, which have potential for addiction and abuse.

Medicare’s prescription drug program was started in 2006 and accounts for about one of every four drugs dispensed nationwide. Last year the government spent $62 billion subsidizing the drugs of 32 million people.

The Inspector General’s report calls on CMS, which oversees the program, to step up scrutiny of doctors with questionable prescribing patterns. It urged CMS to direct its fraud contractor to expand its analysis of prescribers and train the private insurers that administer Part D on how to spot problem prescribers. The report also said that Medicare should send doctors report cards comparing their prescribing to that of their peers. CMS responded to the inspector general

stating that they have been working to reduce overuse of narcotics and plans to expand the use of data to flag questionable prescribing.

13. MAINE GOVERNOR VETOES MEDICAID EXPANSION FOR THE SECOND TIME
On Tuesday, Governor Paul LePage (R) vetoed the bill that would have expanded Medicaid coverage to an additional 60,000 people in the state. Democratic legislators scrambled to collect the two-thirds of votes needed to override the veto. The bill was a compromise between Republicans and Democrats in the legislature, and passed the House in a 97-51 vote and in the Senate by a 23-12 margin. Included in the bill is a sunset provision that would cut off the expansion after the full-federal funding period expired in three years by requiring a reauthorization by the state legislature to continue after that time**.**

14. MICHIGAN SENATE DELAYS VOTE ON MEDICAID EXPANSION
The Michigan Senate declined to vote on Medicaid expansion on Thursday, leaving little time to pass the bill before summer recess. Governor Rick Snyder (R) urged lawmakers to support the bill, which would add more than 400,000 low-income Michigan residents to the Medicaid program. The Senate is not scheduled to meet again until August 27.

15. PENNSYLVANIA MEDICAID EXPANSION UP FOR FLOOR VOTE
Medicaid expansion will come to a floor vote in the Pennsylvania Senate next week. Senate President Pro Tempore Joe Scarnati (R) has expressed his support for it, which would cover hundreds of thousands of uninsured working adults. Conditions of the Senate bill are still under discussion as lawmakers work out details.

16. FOUR MORE STATES RELEASE HEALTH INSURANCE MARKETPLACE RATES
During the week of June 10, four additional states released proposed health insurance marketplace rates. Connecticut, Colorado, the District of Columbia, and Ohio have each published information on the proposed rates for plans in their states. States will continue to release and update rate information ahead of the October 1, 2013 open enrollment.

17. WAYS AND MEANS SUBCOMMITTEE EXAMINES MEDICARE TRUSTEES' REPORT
The House Ways and Means Health Subcommittee convened a hearing on June 20 to review the 2013 Medicare Trustees Report. Testifying were two witnesses, Charles Blahous and Robert Reischauer, both Medicare Trustees. The Subcommittee Chairman, Rep. Kevin Brady (R-TX), opened by saying that even though the Trustees' report estimates two added years of solvency, it should still be considered a wake-up call as Medicare is going broke too quickly. However, the senior Democrat, Rep. Jim McDermott, MD (D-WA) said that he views two additional years as pretty significant by historical standards.