GOVERNMENT AFFAIRS WEEKLY

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NEXT WEEK IN WASHINGTON…

* On October 5-9 CMS hosts National Heath IT Week
* On Wednesday, October 7, the Senate Appropriations Subcommittee on Labor, Health and Human Services and Education plans a hearing: "NIH: Investing in a Healthier Future."
* On October 8, the House Energy and Commerce Subcommittee on Health will hold a hearing to examine legislative proposals to combat our nation's drug abuse crisis.

1. TEMPORARY SPENDING BILL WILL KEEP GOVERNMENT OPEN UNTIL DECEMBER

On Wednesday, September 30, the eve of the new federal fiscal year, the House voted 277 to 151 to clear a 10-week continuing resolution or "CR" (HR 719) for President Barack Obama's signature. The Senate approved it earlier that day, 78 to 20. The new law provides funding to federal agencies through December 11. Most federal programs will be funded at a rate that is 0.21 percent less than FY 2015 levels in order to keep the overall bill below the level of the FY 2016 spending cap.

2. CONGRESS PROBES HEALTH INSURANCE CONSOLIDATION

On September 22, the Senate Judiciary Subcommittee on Antitrust, Competition Policy and Consumer Rights held a hearing on *Examining Consolidation in the Health Insurance Industry and its Impact on Consumers.* Sen. Mike Lee (R-UT), who chairs the subcommittee, began the hearing by discussing the proposed mergers between four of the major health insurance companies. Sen. Lee described the need for policy makers to assess the impact of the *Affordable Care Act* (ACA) on consolidation in health care. Witnesses criticized the insurance mergers and discussed how they would harm competition, while two representatives from health plans told the committee that consolidation could promote competition and benefit consumers.

Earlier this week, September 29, the House Judiciary Subcommittee on Regulatory Reform, Commercial and Antitrust Law held the second hearing in a series on health care consolidation. This hearing in comparison to the previous House hearing focused solely on the proposed health insurance mergers and their impact on consolidation. There were a number of witnesses from insurers, associations, and scholars; the subcommittee directed most of their questions to the insurers. The messages have been consistent with hospitals and providers stating that the insurance mergers would harm competition and the insurers saying competition would benefit. The AAFP has been following the this issue and has written to Congress, the Federal Trade Commission, and the Department of Justice calling for attention and careful review of these proposed mergers.

3. CONGRESSIONAL LEADERS QUESTION "MEANINGFUL USE" PROGRAM

This week, members of the House and Senate called on the administration to delay Meaningful Use Stage 3 and asked that the 2015 Modifications Rule be implemented as soon as possible. Over 117 members of the House of Representatives, led by Reps. Renee Ellmers (R-NC), Tom Price (R-GA) and David Scott (D-GA) organized a cosponsor letter to key administration officials asking for a reasonable delay to the Stage 3 rule. In addition, Sens. Lamar Alexander (R-TN) and John Thune (R-SD), issued a joint statement asking for the immediate release of the 2015 modifications rule and a delay on Stage 3 rulemaking until January 1, 2017.

These actions occurred after months of education and outreach by the AAFP, including a request for delay within the May 26 regulatory letter, support for Meaningful Use flexibility legislation in July and a joint medical associations letter to HHS officials. In addition, the message to the administration was consistent with discussions that occurred during a series of health IT hearings within the Senate Health, Education, Labor and Pension (HELP) Committee.

During the sixth and final October 1 hearing titled "Achieving the Promise of Health Information Technology," Sen. Alexander, the committee chair, told HHS officials that Meaningful Use Stage 3 should be delayed until 2017. Specifically, he asked the hearing witnesses, Karen DeSalvo, MD MPH and Patrick Conway MD Msc, why Stage 3 was moving forward despite the low attestation numbers under Stage 2. In addition, Alexander outlined five reasons why Stage 3 would be important for physicians, hospitals and the administration, including the need to harmonize the rule with the new alternative payment models approved within *Medicare Access and CHIP Reauthorization Act* (MACRA), the imperative to improve interoperability and the need to listen physicians' concerns.

4. AAFP OPPOSES EXCLUDING PROVIDERS FROM MEDICAID

On Wednesday, September 30, the House passed the *Women's Public Health and Safety Act* (HR 3495), sponsored by Rep. Sean Duffy (R-WI). The bill as introduced would have granted state Medicaid programs authority to exclude physicians from Medicaid participation based on their "involvement in abortions." The AAFP sent a letter to House Leadership expressing deep concern with the "overall intent of this legislation and, more specifically, its attempts to interfere with the patient-physician relationship." House managers subsequently amended the language to give states authority to exclude providers who "perform, or participate in the performance of, abortions." The House passed the amended bill 236-193, predominantly along party lines.

5. THREE PUBLIC HEALTH BILLS ADVANCE

During the week of September 28, the following health bills advanced in House or Senate committees:

- HR 3242, *the Child Nicotine Poisoning Prevention Act*, the bill introduced by Reps. Susan Brooks (R-IN) and Elizabeth Etsy (D-CT), would provide the Consumer Product Safety Commission with greater authority to require child-resistant packaging for liquid

nicotine containers. The bill was approved in the House Energy and Commerce Committee and is consistent with the AAFP's recent letter asking for stronger child-resistant packing and labeling requirements for all nicotine and nicotine delivery devices.

- S 799, the *Protecting Our Infants Act*, a bill introduced by Sens. Mitch McConnell (R-KY) and Bob Casey (D-PA), would require the federal government to issue a report on prenatal opioid abuse and neonatal abstinence syndrome. The report will include an assessment of current research, treatment options for pregnant women and infants and an analysis of common substance use treatment barriers. The legislation also requires that health agencies make policy recommendations on preventing, identifying, and treating opioid dependency in women and neonatal abstinence syndrome. The bill was approved in the Senate HELP Committee on September 29.
- S 1893, *the Mental Health Awareness and Improvement Act*, reauthorizes and updates programs focused on suicide prevention, mental health training for emergency personnel, child trauma, national violent death surveillance, geriatric mental health and education/training for opioid abuse treatment. Also, S 1893 would require a study on barriers to primary care and mental health integration. Second, it would require an evaluation of the 2007 Virginia Tech mass shooting recommendations. Sens. Lamar Alexander (R-TN) and Patty Murray (R-WA) are the lead bill sponsors.

6. BUDGET RECONCILIATION PROCESS INCLUDES HEALTH-RELATED PROVISIONS

Three House Committees this week debated a budget implementation bill, which if enacted, would repeal significant provisions of the ACA. The recommendations reported that could impact family physicians are:

Ways and Means Committee (reported on Tuesday, September 29)

- Repeal of the ACA individual mandate
- Repeal of the ACA employer mandate
- Repeal of the excise tax on medical devices
- Repeal of the excise tax on "Cadillac" health-plans, set to go into effect in 2018
- Repeal of the Independent Payment Advisory Board (IPAB)

Energy and Commerce Committee (reported on Wednesday, September 30)

- Repeal the ACA Prevention and Public Health Fund
- Withdraw federal Medicaid dollars for a one-year period to entities that provide abortions

Education and Workforce Committee (reported on Wednesday, September 30)

- Repeal of the ACA "auto-enrollment mandate"

The House Budget committee will ultimately merge these recommendations into a single bill that is widely expected to pass both House and Senate, but the President has informed Congress that he would veto such legislation.

7. PRESIDENT WILL SIGN CHANGE IN ACA TREATMENT OF SOME EMPLOYERS

On Thursday, October 1, the Senate cleared by voice vote legislation amending the ACA to relieve mid-sized employers from having to comply with more stringent insurance coverage requirements. The House had passed it by voice vote Monday. The *Protecting Affordable Coverage for Employees Act* (HR 1624) amends the ACA to include employers with 51 to 100 employees as large employers for purposes of health insurance markets.

8. JOINT LETTER SENT WITH APPROPRIATE USE CRITERIA CONCERNS

In a September 28 letter to the Senate Finance Committee, House Ways and Means Committee, and House Energy and Commerce Committee, the AAFP and other organizations whose members frequently order and rely on advanced diagnostic imaging expressed deep concerns

with the timeline for implementation of the Medicare Appropriate Use Criteria Program. The letter noted the disproportional burden primary care physicians will face in 2017 when trying to comply with these new requirements, which will fall at the same time as those physicians are expected to meet new requirements of the SGR-repeal legislation. The letter recognized the importance of encouraging appropriate utilization of high-cost services, but expressed reservations with CMS' proposed implementation timeline and requested that Congress delay the program.

9. CMS RELEASES REQUEST FOR INFORMATION

On September 28, the Centers for Medicare & Medicaid Services (CMS) released a request for information regarding the *Medicare Access and Children's Health Insurance Reauthorization Act* (MACRA). It seeks comments on Section 101 which repeals the Medicare Sustainable Growth Rate methodology and implements scheduled updates including a higher update rate for "qualifying participants in Alternative Payment Models (APMs)" beginning in 2026. It also seeks comment on the new Merit-based Incentive Payment System (MIPS) for providers, which sunsets payment adjustments under the current Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VM), and the Medicare Electronic Health Records (EHR) Incentive Program. It seeks comments on the development of APMs by providing incentive payments for certain providers who participate in APMs and encourages the creation of additional Physician-Focused Payment Models. The AAFP is preparing a response to this request and comments are due to CMS on November 2. As part of this release CMS also published a FAQ document and a blog in Health Affairs.

10. AAFP COMMENTS ON PHYSICIAN PARTICIPATION IN INSURANCE NETWORKS

In a letter sent September 28 to CMS, the AAFP expressed recommendations on CMS' current work to establish requirements governing the collection and dissemination of information regarding physician participation in insurance networks offered through Medicare Advantage and the health insurance marketplaces. CMS suggested that insurers participating in these programs be required to update their respective physician network directories every 30 days. The AAFP letter expressed concern that the frequency of reporting recommended by CMS will have significant unintended consequences and may actually hinder the collection of accurate information. Though the AAFP supports efforts to ensure that patients have accurate information on the participation of physicians in all insurance networks, the letter highlighted family physicians' frustrations with the increasing level of administrative burden being placed on their practices which do not lead to better patient care. Based on these concerns, the AAFP encourages CMS to consider a reporting interval of 90 days versus 30 days.

11. STATES CONTINUE TO WORK ON BUDGETS

Congress is not the only one struggling to pass a budget. After three sessions, Governor Robert Bentley (R) signed the state budget for Alabama into law on September 17. The budget included over $88 million in cuts to state agencies. Pennsylvania and Illinois are still without a finalized budget. Three months in, Illinois is in stalemate and the state comptroller said that Illinois could have $8.5 billion in unpaid bills by the end of the year. Pennsylvania, also in a three-month budget impasse, tried for a short-term fix: a stopgap budget authorizing the state to temporarily spend money. Governor Tom Wolf (D-PA) vetoed the emergency funding bill; House and Senate leaders are scheduled to vote on the governor's latest tax package proposal on October 7. The plan calls for $5 billion in tax increases over two years including taxes on smokeless tobacco.

12. HEALTH INSURANCE COVERAGE INCREASES

Earlier this week, the CMS released the most recent enrollment report. As of July 2015, over 72 million individuals are enrolled in Medicaid and CHIP. In the 46 states that reported data for the month of July, approximately 30 million individuals are enrolled in CHIP or are children enrolled in the Medicaid program. The Center for Budget on Policy and Priorities reported that if the

uninsured rate had improved everywhere in the country at the same rate as in expansion states 2.6 million more Americans would have attained health insurance last year.

13. REGULATORY BRIEFS

- On September 21, CMS announced that Medicare Advantage premiums will remain stable and enrollees will have access to higher quality plans and that for a sixth straight year, enrollment is projected to increase to a new all-time high.
- On September 21, HHS released the updated Federal Health IT Strategic Plan 2015–2020 and a related press release.
- On September 23, CMS released a FAQ that clarifies that providers that have switched Certified Electronic Health Record (EHR) Technology vendors can apply for a hardship exception to avoid the Medicare payment adjustment. For example, if a provider switches EHR vendors in 2015 and is unable to demonstrate meaningful use in 2015, the provider can apply for an EHR Vendor Issue hardship, before the July 1, 2016 submission deadline, and be exempt from the payment adjustment in 2017.
- On September 23, CMS released the final 2016 Medicaid Managed Care Rate Development Guide for states to use in development of any Medicaid managed care rates with rating periods starting on or after January 1, 2016.
- On September 25, CMS awarded $110 million in ACA funding to fund 17 national, regional, or state hospital associations and health system organizations to continue efforts in reducing preventable hospital-acquired conditions and readmissions.
- On September 25, CMS announced its next step in implementing the *Protecting Access to Medicare Act* which requires clinical laboratories to report on private insurance payment amounts and volumes for lab tests. This data will be used to determine Medicare's payment for lab tests beginning January 1, 2017.
- On September 28, CMS made available the 2014 Supplemental Quality and Resource Use Reports (QRURs) to every medical group practice and solo practitioner nationwide. The 2014 Supplemental QRURs provide information to TINs on the management of their Medicare fee-for-service (FFS) patients based on episodes of care ("episodes"). An episode is a resource use measure that includes the set of services provided to treat, manage, diagnose, and follow-up on a clinical condition or treatment. The 2014 Supplemental QRURs are for informational purposes only and complement the per capita cost and quality information provided in the 2014 Annual QRURs.
- On September 29, CMS announced $685 million in awards to 39 national and regional health care networks and supporting organizations to help equip more than 140,000 clinicians with the tools and support needed to improve quality of care, increase patients' access to information, and reduce costs. The Transforming Clinical Practice Initiative is one of the largest federal investments designed to support doctors and other clinicians in all 50 states through collaborative and peer-based learning networks.
- On September 29, HHS announced funding to advance development of a monoclonal antibody therapeutic drug, which is a novel approach to treating patients with influenza
- On October 1, CMS posted a message on how the U.S. health care system moves to the International Classification of Diseases, 10th Revision – ICD-10. Even after submission, Medicare claims take several days to be processed, and Medicare – by law – must wait two weeks before issuing payment. Medicaid claims can take up to 30 days to be submitted and processed by states. Because of these timeframes, CMS expects to know more about the transition to ICD-10 after completion of a full billing cycle.
- CMS will host the following free educational calls, registration is required:
    - Dialysis Facility Compare: Rollout of Five Star Rating, October 7, 1:30pm ET
    - 2014 Supplemental QRUR Physician Feedback, October 15, 1:30pm ET
    - Improving Medicare Post-Acute Care Transformation, October 21, 1:30pm ET