GOVERNMENT AFFAIRS WEEKLY

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IN THIS REPORT…

NEXT WEEK IN WASHINGTON…

- The Open Enrollment period for Marketplace health insurance in 2016 begins November 1, and ends January 31, 2016
- On Tuesday, November 3, the Health Subcommittee of the House Energy and Commerce Committee will hold a hearing to examine legislation to improve Medicare and Medicaid.
- Also on November 3, the House Ways and Means Health Subcommittee has a hearing to examine the health care law's Consumer Operated and Oriented Plan (CO-OP) program.
- On Thursday, November 5, the Oversight and Investigations Subcommittee of the House Energy and Commerce Committee will hold a hearing on the record of the *Affordable Care Act*'s CO-OP insurance loans.
- On Thursday, November 5 and Friday, November 6, the Medicare Payment Advisory Commission (MedPAC) will meet to discuss, among other topics, "next steps in continuing to support primary care."

1. BUDGET DEAL CLEARS CONGRESS, ALLOWS FOR INCREASED SPENDING

President Barack Obama is expected to sign the *Bipartisan Budget Act* (HR 1314) which passed the House by a vote of 266 to 167 on Wednesday, October 28 and cleared the Senate 64 to 35 early Friday. The AAFP commented on the budget deal noting that it suspends the U.S. debt limit, and mitigates draconian premium increases for millions of Medicare Part B enrollees. In addition, the deal increases by $80 billion federal spending caps for two years. The higher caps provide an additional $33 billion for non-defense discretionary spending in fiscal year 2016. Between now and the December 11 expiration of the current stopgap spending law, House and Senate Appropriations Committee members will be working to finalize FY2016 spending plans. Next week, AAFP board officers will be meeting with legislators and staff to reiterate our spending priorities for FY2016.

2. PAYMENTS USING ICD-10 ARE PROCEEDING SMOOTHLY, ACCORDING TO CMS

Less than one in a thousand Medicare claims filed this month were rejected because of invalid ICD-10 codes, CMS said Thursday, October 29. An average of 4.6 million claims were submitted each day between Oct. 1 and Oct. 27, and 2 percent of them were rejected "due to incomplete or invalid information" - but that's a broader category that can include a number of problems, the agency said. The total number of claims denied - roughly 10 percent - is about the same of those denied in an average period before the ICD-10 switch, according to CMS.

3. BILL TO SET UP PRIMARY CARE PHYSICIAN REENTRY PROGRAM INTRODUCED

On October 29, the AAFP wrote a letter to Rep. John Sarbanes (D-MD) in support of his legislation, the *Primary Care Physician Reentry Act*, which would establish a demonstration program to help physicians reenter clinical practice. The bill recognizes that primary care physicians who step away from the practice of medicine for a period of time could still be important contributors to the workforce. It acknowledges the challenges physicians face in obtaining appropriate licensure, credentials and privileges when resuming practice and it directs HHS to assist state regulatory authorities and hospital credentialing committees to structure requirements for physicians returning to practice to help to make the process more integrated and transparent.

4. AAFP ASKS FOR CONTINUOUS ELIGIBILITY FOR MEDICAID & CHIP

The AAFP signed a coalition letter sent to Congress on October 27. Healthcare organizations asked Congressional legislators to cosponsor a bill to authorize continuous eligibility in the Medicaid and Children's Health Insurance Program (CHIP). The *Stabilize Medicaid and CHIP Coverage Act* (HR 700/S 428) would provide 12-month continuous enrollment for Medicaid and CHIP enrollees. Currently, the House bill has 22 bipartisan cosponsors, and the Senate version introduced by Sen. Sherrod Brown (D-OH) has no cosponsors at this time.

5. CONGRESS BEGINS WORK ON MENTAL HEALTH REFORMS

In recent months, mental health and substance use reform bills have advanced and comprehensive reform is possible in the coming months. The House Energy and Commerce Committee has held several hearings on mental health and substance use issues. Bipartisan bills have are also advancing in the House and the Senate.

On October 29, the Senate Health, Education, Labor and Pensions (HELP) Committee held its first hearing on mental health and related issues focusing on mental health and substance use disorders. The committee may conduct additional hearings later in the year. During his opening statement, HELP Committee chairman, Senator Lamar Alexander (R-TN) indicated that legislators were interested comprehensive mental health reform efforts that may address barriers to care, research and federal program reforms. Senator Patty Murray (D-WA), the committee's senior Democratic member, highlighted her priorities: improving the mental health workforce, integrating primary care and mental health, reducing stigma, improving suicide prevention, and expanding collaborative care models that utilize telehealth services. Training and supporting primary care physicians and their role in providing and detecting mental health issues were key themes throughout the hearing.

The House Energy and Commerce Committee's Health Subcommittee announced a November 3 meeting to debate several bills, including the *Helping Families in Mental Health Crisis Act* (H.R. 2646). Rep. Tim Murphy (R-PA) is the lead sponsor. H.R. 2646 addresses numerous changes such as reforming the Substance Abuse and Mental Health Services Administration (SAMHSA), strengthening mental health parity enforcement, increasing anti-violence research, improving treatment for those with serious mental illness, and amending patient privacy laws for certain mentally ill patients. Senators Bill Cassidy (R-LA) and Chris Murphy (D-CT) introduced a similar bill, the *Mental Health Reform Act* (S 1945). The Subcommittee also will consider the

Medical Controlled Substance Transportation Act (H.R. 3014), legislation that allows certain physicians to transport controlled substances across state lines.

6. AFFORDABLE CARE ACT MARKETPLACES SEEING CHANGES

Individuals trying to enroll in the marketplace exchange may face limited options. Health insurance companies participating in the *Affordable Care Act* are shuffling in and out of the marketplace. Some insurers are finding it difficult to make a profit, while others see an eventual profitable opportunity. There is widespread state news of health insurers dropping out of various marketplaces.

- Most recently in **Oklahoma**, two private health insurance companies are expected to leave the program and one is expected to join, leaving three insurance companies left on the exchange.
- In **Washington**, **D.C.**, Aetna dropped out of the preferred provider organization (PPO) market leaving only one insurer, CareFirst, providing residents with PPO plans.
- In **Alaska**, Aetna, State Farm, and Assurant Health have all decided to stop offering individual health insurance plans. With those companies out of the market, only Premera Blue Cross and Moda Health remain.
- Coventry in **Kansas** will not offer health plans on the federally facilitated marketplace for 2016, though they will continue to offer coverage outside of the marketplace. Approximately 45,000 Kansans will be required to select new coverage either outside the marketplace or through one of the four remaining insurers.

7. FamMedPAC HELPING PRMOTE AAFP'S LEGISLATIVE AGENDA

FamMedPAC continues to raise the profile of AAFP in Washington, D.C. by participating in several events for important legislators this week.

If you would like to help promote the PAC to your colleagues, download the new FamMedPAC promotional video, an easy way to let your colleagues know about the importance of our efforts. You can download the video at this link: PAC VIDEO Password: AAFP2015

The PAC supported the following legislators this week:

- **Rep. Ben Ray Lujan (D-NM)**, a new member of the Health Subcommittee of the House Energy and Commerce Committee and the Chair of the Democratic Congressional Campaign Committee.
- **Rep. Kevin Brady (R-TX)**, the Chair of the Health Subcommittee of the House Ways and Means Committee.
- **Rep. Leonard Lance (R-NJ)**, a member of the Health Subcommittee of the House Energy and Commerce Committee.
- **Sen. John Barrasso, MD (R-WY)**, Chair of the Senate Republican Policy Committee.

8. VA ISSUES DISAPPOINTING FINAL RULE ON NON-VA CARE

On October 29, the Department of Veterans Affairs (VA) released a final rule titled, "Expanded Access to Non-VA Care through the Veterans Choice Program." In a February 24 letter, the AAFP had sent comments in response to the proposed rule that, among other things asked that:

- Payment rates equal Medicare and be paid promptly;
- The collection of copayments be done at the time of service;
- Rural Health Clinics be included; and
- The VA should expand access to primary care by allowing civilian family physicians to:
    - Provide primary care services to eligible veterans;
    - Allow prescriptions prescribed by civilian family physicians to be filled at VA pharmacies;
    - Allow civilian family physicians to order diagnostic tests at VA facilities;

- Allow civilian family physicians to refer patients to specialist physicians and other health care providers at VA facilities; and
- Allow civilian family physicians to provide care to eligible veterans under the protections of the Federal Tort Claims Act (FTCA).

In the final rule, the VA responded that payment rates in the Non-VA Care Program are subject to contracts between contractors and providers. The final rule indicated that the VA would welcome suggestions on how to pay more promptly but that "it is not appropriate to include such operational details in their regulations." In addition, the VA final rule discussed how it is too difficult for the VA to calculate copayment rates for veterans receiving care by non-VA providers. Regarding allowing civilian family physicians the ability to prescribe, order, and refer within the VA system, the final rule outlined how the VA is required to coordinate care through the Non-VA Care coordination program and that veterans can at any time return to the VA for care. Finally, it notes that the FTCA only covers federal agencies and agency employees acting within the scope of their employment and that non-VA providers that participate in the program cannot be VA employees..

9. REGULATORY BRIEFS

- On October 26, HHS released the 2016 Marketplace Affordability Snapshot, which shows that about 8 out of 10 consumers returning to the Marketplace will be able to buy a plan with premiums less than $100 dollars a month after tax credits; and about 7 out of 10 will have a plan available for less than $75 a month. Open Enrollment begins on November 1 consumers will be encouraged to visit HealthCare.gov to browse their coverage options to find the plan that best meets their budget and health needs.
- On October 27 the Government Accountability Office released a report titled, “Electronic Health Records: VA and DOD Need to Establish Goals and Metrics for Their Interoperability Efforts.”
- On October 28, CMS announced that the Physician Compare preview period has been extended to allow more time for individuals and group practices to preview their measures. Practices can now preview 2014 quality measures until Monday, November 16, 2015 and can access the secured measures preview site through the PQRS portal-Provider Quality Information Portal (PQIP).
- On October 29, CMS announced a proposal to revise discharge planning requirements that hospitals, including long-term care hospitals and inpatient rehabilitation facilities, critical access hospitals, and home health agencies, must meet in order to participate in the Medicare and Medicaid programs. CMS will accept comments for 60 days and the AAFP is reviewing the regulation for its impact on family physicians.
- On October 29 CMS issued a press release about a final rule titled, “Methods for Assuring Access to Covered Medicaid Services” and a related request for information. Both involve a 60 day public comment period. The AAFP had commented on the proposed version of this regulation when it was released in 2011.
- On October 29, CMS issued the a final rule that updates payment policies and rates under the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) for renal dialysis services furnished to beneficiaries on or after January 1, 2016. The finalized 2016 ESRD PPS base rate is $230.39.
- On October 29 released the final rule regarding Medicare home health prospective payment system for calendar year 2016. CMS projects that Medicare payments to home health agencies in 2016 will be cut by 1.4 percent, or $260 million.
- CMS will host the following free educational calls, registration is required:
    - Clinical Diagnostic Laboratory Test Payment System Proposed Rule, November 10, 2:00 PM
    - National Partnership to Improve Dementia Care and QAPI, December 1, 1:30 PM