GOVERNMENT AFFAIRS WEEKLY

AAFP Government Relations — 1133 Connecticut Avenue, NW (Suite 1100) — Washington, DC 20036

February 12, 2016

IN THIS REPORT…

NEXT WEEK IN WASHINGTON…
***** Congress is in recess to mark the Presidents' Day holiday.

1. COMMITTEE CONSIDERS FEDERAL RESPONSE TO THE ZIKA VIRUS

The Senate Appropriations Committee held a hearing on Thursday, February 11 on emerging health threats and funding needed to combat the Zika virus. The committee's witnesses were Thomas Frieden, MD, Director of the Centers for Disease Control and Prevention, and Anthony Fauci, MD, the Director of the National Institute of Allergy and Infectious Disease. The administration has asked for $1.8 billion in emergency funding to enhance mosquito control programs, stock up on the supply of diagnostic tests and support vaccine research. Dr. Frieden discouraged legislators from trying to pay for the Zika response by diverting money from the Ebola fight noting that those funds have been committed and redirecting them would risk letting down our guard in the fight against Ebola.

2. SENATE COMMITTEE APPROVES BILLS ON PRESCRIPTION DRUG ABUSE

On Thursday, February 11, the Senate Judiciary Committee advanced, by voice vote, a pair of bills to address the abuse of prescription drugs. The *Comprehensive Addiction and Recovery Act* (S 524), sponsored by Sens. Sheldon Whitehouse (D-RI) and Rob Portman (R-OH), would provide grants to states to support prescription drug monitoring programs, increase access to naloxone, as well as expand prevention and treatment efforts. In addition, the bill would require that states, to receive grant funds, include educating physicians, residents, medical students, and other prescribers of Schedule II, III, or IV controlled substances as part of a comprehensive effort.

The second measure approved by the committee was the *Ensuring Patient Access and Effective Drug Enforcement Act* (S 483), introduced by Sen. Orrin Hatch (R-UT). It would instruct the Drug Enforcement Agency and the Department of Health and Human Services to collaborate on strategies to prevent prescription drug abuse while ensuring that patients who legitimately need the drugs can still access them. The House approved a similar bill, HR 471, by voice vote last April.

The bipartisan leaders of the Senate Health, Education, Labor and Pensions Committee, Sen. Lamar Alexander (R-TN), who chairs the committee, and Sen. Patty Murray (D-WA), are working with the administration on comprehensive mental health legislation that would also address prescription drug abuse. Democrats are expected to press for emergency funding to fight addiction when the Senate returns after the Presidents' Day recess.

3. WHITE HOUSE SENDS ADMINISTRATION'S BUDGET PROPOSALS TO CONGRESS

On Tuesday, February 9, the President submitted to Congress his $4.1 trillion budget request for fiscal year 2017. The budget proposes $82.8 billion in discretionary funding for the Department of Health and Human Services (HHS). Highlights of the President's budget request impact on AAFP priorities follows this report.

4. AAFP RECOMMENDS SITE-NEUTRAL PAYMENT FOR PHYSICIANS

On Thursday, February 11, the AAFP responded to a request for feedback by the leaders of the House Energy and Commerce Committee and its Health Subcommittee. The committee leaders asked for recommendations on a site-neutral payment policy that was part of last year's *Bipartisan Budget Act*. The new provision requires physicians in hospital outpatient departments (HOPD) acquired after November 2, 2016 to be paid under the most applicable of existing fee schedules rather than under the Hospital Outpatient Prospective Payment System. The AAFP letter applauded the move to site-neutral payment policy and recommended that it be expanded so that the same payment is made for the same care provided at any site.

5. HOUSE COMMITTEE REVIEWS FEDERAL MEDICAID FORMULA FUNDING

On February 10, the House Energy and Commerce's Health Subcommittee held a hearing to examine the Federal Medical Assistance Percentage (FMAP) for Medicaid and the Children's Health Insurance Program (CHIP). The FMAP rate is the statutorily defined reimbursement rate for states to pay a portion of Medicaid services. The rate is influenced by economic conditions, a policy the AAFP supports.

During the hearing, Rep. Kurt Schrader (D-OR) asked if the federal government could consider FMAP rates that factor in value-based health delivery. Rep. Ben Lujan (D-NM) commented that the federal rate should be higher for mental health services. Rep. Billy Long (R-MO) inquired about the policy implication of replacing the current formula with a federal block grant. The witnesses said that a value-based formula would be overly complicated to administer and did not provide recommendations about block grants. Currently, several members of the Energy and Commerce Committee are reviewing Medicaid policy and may introduce reform proposals in next year's legislative session.

6. SENATE COMMITTEE APPROVES BILL TO REDUCE TECHNOLOGY REGULATIONS

On February 9, the Senate Health, Education, Labor, and Pensions (HELP) Committee approved the *Improving Health Information Technology Act* (S 2511). The legislation would require HHS to review regulatory burdens associated with health information technology. It also would enhance interoperability standards and establish a quality rating system for electronic health record systems. The AAFP commented on an earlier draft and will continue monitoring the issue.

7. HOUSE APPROVES RELAXING MENU LABELING REGULATIONS

On Friday, February 12, the House of Representatives approved the *Common Sense Nutrition Disclosure Act* (HR 2017) by a vote of 266-144. Rep. Cathy McMorris-Rogers (R-WA) introduced the legislation that would weaken and delay the Food and Drug Administration's (FDA) proposed menu labeling standards. The FDA would require chain restaurants and vending machines provide "clear and consistent" nutrition and calorie information for consumers at the point of service. The AAFP submitted a letter supporting the FDA's menu labeling rule and expressed concerns about the association between eating out and the rise in rates of overweight and obesity. The letter also urged the administration to begin enforcing the rule as soon as possible. The bill is in response to the food industry that indicated that additional time and flexibility was needed. A group of over 100 health organizations signed a statement opposing HR 2017. President Obama also issued a Statement of Administration Policy expressing opposition. The Senate has not taken action on the bill.

8. HOUSE APPROVES A LEAD POISONING PUBLIC NOTIFICATION BILL

On Wednesday, February 10, the House of Representatives passed the *Safe Drinking Water Improved Compliance Act* (HR 4470) by a vote of 416 to 2. Reps. Fred Upton (R-MI) and Dan Kildee (D-MI) sponsored the measure. It would require public water utilities to notify consumers of excessive lead in drinking water. It also would require the Environmental Protection Agency (EPA) to create a strategic plan to improve information sharing among water utilities, the states, the EPA, and drinking water consumers when there is evidence of lead contamination. The AAFP supported a Senate amendment that included a version of this language.

9. FamMedPAC BEGINS ACTIVE FEBRUARY, SUPPORTS KEY LEGISLATORS

February marks the start of a busy political season in Washington, with legislators raising funds for their upcoming primary and general elections. FamMedPAC this week helped several physician-legislators and those who serve on key committees.

The PAC supported the following legislators this week:

- **Rep. Phil Roe (R-TN)**, a physician and member of the GOP House Doctors Caucus, serves on the Veterans' Affairs Committee and the Education and Workforce Committee.
- **Rep. Renee Ellmers (R-NC)** is a member of the Health Subcommittee of the House Energy and Commerce Committee.
- **Rep. Tim Murphy (R-PA)** is a psychologist and member of the Health Subcommittee of the House Energy and Commerce Committee.
- **Rep. Michael Burgess (R-TX)**, a physician and member of the House Doctors Caucus, serves on the Health Subcommittee of the House Energy and Commerce Committee.
- **Rep. Mike Simpson (R-ID)** is a dentist and member of the Health Subcommittee of the House Appropriations Committee.

10. AAFP EXPRESSES CONCERNS ON THE PQRS REVIEW PROCESS

On February 9, the AAFP and other organizations wrote CMS expressing concerns that physicians and group practices will be incorrectly penalized under the PQRS Program as a result of the inadequate feedback and informal review request processes of CMS. The AAFP is recommending improved processes moving forward. The letter pointed out that without complete and actionable data as well as a streamlined process for correcting data inaccuracies and unwarranted penalties, physicians and group practices may be subjected to unfair Medicare reductions not only in the immediate payment year, but also in future years as they are unable to correct unidentified reporting issues.

11. TWO FAMILY PHYSICIANS APPOINTED TO USPSTF

On February 8, the U.S. Preventive Services Task Force announced the addition of four new members, two of whom are family physicians. John Epling, MD, MS Ed, who is a professor and chair of family medicine at the State University of New York (SUNY) Upstate Medical University, and Diane Harper, MD, MPH, MS, who is a professor at the University of Louisville School of Medicine, were appointed to serve four-year terms.

12. AAFP COMMENTS ON RESOURCE USE AND EPISODE GROUPS

On February 11, the AAFP sent CMS a response to a request for information regarding implementation of episode groups. The letter's key points regarding the use of episode groups for the purpose of measuring resource use were:

- Because the *Medicare Access and CHIP Reauthorization Act* (MACRA) allows for the use of episode groups "as appropriate," the AAFP urges CMS to carefully consider how this is implemented and the eventual impact on physicians and their patients. If CMS finds it appropriate to implement episode groups, the AAFP recommends that CMS implement this form of resource measurement in a slow, phased-in approach.
- Family physicians also need access to sub-specialists' quality performance outcomes to make informed decisions with their patients when referral becomes necessary. Having both cost and quality information related to services furnished to their patients by other clinicians will enable family physicians and their patients to make fully informed decisions that take into account both cost and quality. It's crucial for a family physician to have this information before they will be responsible for a patient's total cost of care or episode-based costs.
- An increase in upfront, primary care costs that reduce downstream, more expensive costs, should not negatively impact how a family physician is evaluated under the use of episode groups or in the resource use category.

13. REGULATORY BRIEFS

- On February 8, CMS announced that nearly 10.7 million Medicare beneficiaries received discounts of over $20.8 billion on prescription drugs and that in 2015 alone, nearly 5.2 million seniors and people with disabilities received discounts of over $5.4 billion. CMS also announced that an estimated 39.2 million people with Medicare and Medicare Advantage utilized at least one preventive service with no copays or deductibles in 2015. Nearly 9 million Medicare and Medicare Advantage beneficiaries received an Annual Wellness Visit in 2015.
- On February 11, CMS released a final rule and related fact sheet that requires Medicare Parts A and B providers and suppliers to report and return overpayments by the later of the date that is 60 days after the date an overpayment was identified, or the due date of any corresponding cost report. CMS had proposed a 10-year look back but finalized a 6-year look back period. In an April 11, 2012 letter the AAFP urged CMS to limit the look-back period to 3-years which was reiterated in a sign-on letter sent April 16, 2012.
- On February 11, CMS sent a letter to State Medicaid Directors to provide additional guidance on the Covered Outpatient Drug final rule. The letter outlines the final rule's key changes states need to address when determining their reimbursement methodologies.
- CMS will host the following free educational call, registration is required:
    - Provider Enrollment Revalidation Call on March 1 at 2:00pm ET

14. STATE LEGISLATIVE BILLS OF INTEREST

Following are a few bills of interest in the 2016 session:

- Direct Primary Care—Direct primary care continues to gain states' interests as Georgia, Tennessee, and Wyoming are recent states introducing this measure.

- Health Care Reform—Idaho is seeking health care reform with Medicaid expansion or an alternative. SB 1204 expands Medicaid eligibility to include all individuals whose income is below 138% of the federal poverty level. This initiative would provide access to medical care for approximately 78,000 Idahoans. SB 1205 would make people earning less than 100% of the federal poverty level eligible for managed Medicaid enrollment. Idahoans earning between 100%-138% of federal poverty level would be enrolled in the state exchange and their premium supported by state and federal funds.
- Medical Education— Colorado and Maryland introduced legislation that would allow for a health care preceptor tax credit. This legislation would authorize a credit against the state income tax for certain individuals who, under certain circumstances, serve as physician preceptors in certain preceptorship programs and work in certain areas of the state with health care workforce shortages.
- Patient Centered Medical Homes—New Jersey AB 318 establishes patient-centered medical homes programs.
- State Innovation Waivers—Two states have introduced legislation seeking a state innovation waiver. Oklahoma HB 2549 authorizes the creation and submission of a waiver for the purpose of creating Oklahoma health insurance products that improve health and health care quality while controlling costs. The waiver must be created consistent with the innovation design plan developed through the Oklahoma Health Improvement Plan. Washington SB 6488 requires the state health care authority to apply to a waiver to permit employers to integrate certain employer health care arrangements with individual market policies.

ATTACHMENT
Obama Administration Fiscal Year 2017 Budget Request Summary

The White House released on February 9 President Obama's budget which stays within the overall spending limits set in the balanced budget agreement. (See the Health and Human Services, factsheet, budget in brief and the more detailed appendix.)

Centers for Medicare & Medicaid Services (CMS)
The FY17 request from CMS for its four annually appropriated accounts—Program Management, discretionary HCFAC, Grants to States for Medicaid, and Payments to the Health Care Trust Funds—is $681.6 billion in FY17, an increase of $37 billion above FY16.

Medicaid
The President's budget would support Medicaid expansion by offering further incentive for states by covering the full cost of expansion for the first three years regardless of the date a State expands. The ACA had covered the full costs through calendar year 2016 before gradually reducing the level of support to 90 percent. [$2.6 billion cost over ten years]

It also calls on Congress to reestablish the Medicaid Primary Care Payment Increase, known as Medicaid parity, through calendar year 2017 and expand it to include additional providers. Under the Medicaid Primary Care Payment Increase, states were required to reimburse qualified providers at the rate that would be paid for the primary care service under Medicare. The federal government covered 100 percent of the difference between the Medicaid and Medicare payment rate. The parity payment rate expired at the end of calendar year 2014. This proposal reestablishes the enhanced rate through December 31, 2017; expands eligibility to obstetricians, gynecologists, and non-physician practitioners, including physician assistants and nurse practitioners; and excludes emergency room codes to better target primary care. [$9.5 billion in costs over 10 years]

The budget would remove the cap on Medicaid funding in Puerto Rico and the other territories; gradually increase the federal support territories receive through the Medicaid match by transitioning them to the same level that is received on the mainland; and expand eligibility to 100 percent of the federal poverty level in territories currently below this level. To be eligible for maximum financial support, territories will have to meet financial management and program integrity requirements and achieve milestones related to providing full Medicaid benefits.

It includes targeted policies to lower drug costs in Medicaid by offering states a new, voluntary tool to negotiate lower drug prices through the creation of a federal-state Medicaid negotiating pool for high-cost drugs. In addition, the budget builds on previously proposed reforms to the Medicaid drug rebate program. These reforms enhance manufacturer compliance with rebate requirements, and improve access to medications.

Medicare
The budget includes legislative proposals that reward value and care coordination, including proposals to provide new payments for primary care, and enhanced value-based purchasing programs. The budget encourages participation in alternative payment models through a number of proposals, including creating a bonus payment for hospitals that collaborate with certain alternative payment models. It also includes net projected Medicare savings of $419.4 billion over 10 years – including $77.2 billion by reforming Medicare Advantage payments to improve efficiency and achieve sustainability.

Agency for Healthcare Research Quality (AHRQ)
The budget request for AHRQ is $469.7 million, an increase of $41.2 million which includes:

- $76 million for patient safety research, an increase of $2 million.
- $34 million for research to prevent health care-associated infections, a $3.3 million cut.
- $23 million – an increase of $1 million – to support investigator-initiated research into health information technology.
- $12 million in support for the U.S. Preventive Services Task Force or level funding.
- $113 million for work to advance Health Services Research, Data, and Dissemination, an increase of $24 million from FY16. This increase would reverse the FY16 cuts in the HSRD portfolio and includes $9 million for research on improving care for patients with multiple chronic conditions, $1 million for work on paying for value, and $3 million for continued research on reducing opioid and prescription drug abuse.
- $69 million for the Medical Expenditure Panel Survey, an increase of $3 million.
- $71 million for program support, the same level as FY16.

Health Resources and Services Administration (HRSA)
The FY17 budget provides HRSA with a total of $10.7 billion, including $4.9 billion in mandatory funding including:

- **Title VII Health Professions** – $231.3 million, which is a reduction of $31.2 million (11.9 percent) below FY16. Within Title VII, Sec. 747 level funding of $38.924 million was requested for the **Primary Care Training and Enhancement** program; the Area Health Education Centers was again targeted for elimination; and the request for Scholarships for Disadvantaged Students was increased by $3.1 million to $49 million.
- **National Health Service Corps –** $380 million in FY17 to support nearly 10,200 clinicians in health professional shortage areas in FY17. This includes $70 million in additional mandatory and discretionary funding for behavioral health and supports the administration's opioid treatment and mental health initiatives. The President's budget calls for all new NHSC funding in FY17 to be directed to expand access to behavioral health services.
- **Teaching Health Centers Graduate Medical Education Program –** $60 million in the MACRA-enacted mandatory funding for residency training in primary care medicine and dentistry in community-based, ambulatory settings. The budget also proposes to extend mandatory funding through FY20 for an additional investment of $527 million.
- **Rural Health** – $144.2 million ($5.4 million below FY16) which includes $10 million for an expanded Rural Opioid Overdose Reversal program that focuses on prevention, treatment, and intervention of opioid use in rural communities. The Rural Hospital Flexibility Program request is decreased by $15.4 million which will continue to support 45 Flex grants to support critical access hospitals.
- **Children's Hospital Graduate Medical Education Program –** $295 million of mandatory resources for each of FYs 2017 through 2021. This program helps eligible hospitals provide graduate training for physicians to provide quality care to children, and enhance their ability to care for low-income patients.
- **Family Planning** – $300 million in FY17, an increase of $13.5 million, to expand family planning services to low-income individuals by improving access to family planning centers and preventive services.

Indian Health Service (IHS)
The IHS has asked for $6.6 billion, an increase of $402 million above FY 2016 and 53 percent since FY08.

Centers for Disease Control and Prevention (CDC)
The CDC budget request includes $1.1 billion for chronic disease prevention and health promotion activities, $60 million below FY16. This funding will provide critical support to combating the most significant chronic disease issues facing Americans, including tobacco use, heart disease, stroke, diabetes, and cancer.

National Institutes of Health (NIH)
The budget request for NIH is $33.1 billion, an increase of $825 million over FY16, which includes an increase of $755 million for the “cancer moonshot” initiative.

Substance Abuse and Mental Health Services Administration (SAMHSA)
The request for SAMHSA is $4.3 billion, $590 million above FY16. In addition, the budget includes $1 billion in new mandatory funding in SAMHSA and HRSA over two years to expand access to treatment for prescription drug abuse and heroin use to address the **opioid abuse crisis**, as well as a total increase of $559 million in FY 2017 for HHS programs to address the opioid abuse, misuse, and overdose crisis.