AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

WASHINGTON UPDATE

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

January 6, 2017

On the Horizon …

* The Senate will continue debate on the fiscal 2017 budget resolution (S Con Res 3) to create a path for swift action on a budget reconciliation bill to repeal much of the *Affordable Care Act*.

U.S. CONGRESS

1. 115th Congress Opens to Early Action on Obamacare Repeal

Anticipating early Senate action to begin the process of repealing the *Affordable Care Act*, AAFP Board Chair Wanda D. Filer, MD, MBA wrote to the bipartisan, bicameral leadership of the Congress. Her communications outlines insights and recommendations as they proceed to deliberate on reforms to our nation's health care system. The AAFP letter to House and Senate leadership dated December 28, 2016 urged that no currently insured individuals lose their health care coverage. Further, the letter offers guidance to the Congress on key insurance reforms and patient protections and the need for a robust investment in primary care and protection of the health care safety-net. The letter also highlights steps that the Congress should take to address our country's physician workforce needs and expressed continuing concerns about the trend toward legislative interference in the practice of medicine.

The AAFP also joined the American Academy of Pediatrics, the American College of Physicians, and the American Congress of Obstetricians and Gynecologists in sending a joint letter dated January 2, 2017 to Congressional leaders urging them to work collaboratively, and in a bipartisan and bicameral manner, to ensure that patient-centered protections created by the ACA and other laws be preserved.

On Wednesday, January 4, the Senate voted 51-48 to consider the fiscal year 2017 budget resolution (S.Con.Res. 3) which provides the path for the partial repeal of the *Affordable Care Act* to move through a fast-track "reconciliation" process and pass by a simple majority in the Senate. The debate on the budget resolution is expected to conclude next week. More about the timing of the process can be found in the AAFP's In the Trenches blog.

2. AAFP Co-Hosts Capitol Hill Briefing on Direct Primary Care

On Wednesday, January 4, the AAFP, along with the Direct Primary Care (DPC) Coalition, hosted a Capitol Hill briefing on the reintroduction of the *Primary Care Enhancement Act*. The bill, sponsored by Sens. Bill Cassidy, MD (R-LA) and Maria Cantwell (D-WA) and Reps. Erik Paulsen (R-MN) and Earl Blumenauer (D-OR), would remove a legal barrier preventing Americans with Health Savings Accounts from becoming DPC patients. The bill was introduced as S. 1989 and HR 6015 in the 114th Congress, and was endorsed by the AAFP. Senator Cassidy and Reps. Paulsen and Blumenauer gave introductory remarks at the briefing, followed by a panel discussion of DPC experts. The panel featured two DPC practitioners—Garrison Bliss, MD and Rushika Fernandopulle, MD—as well as Mason Reiner, founder of R-Health, and

Jed Constantz, founder of Employer Advantage Health Care Solutions. We expect the sponsors to reintroduce the bill before Congress gavels out on Friday, January 6.

3. Primary Care Organizations Urge Congress to Protect the Doctor-Patient Relationship
On January 3, 2017, the AAFP, American Academy of Pediatrics, and American Congress of Obstetricians and Gynecologists sent a letter to Congressional leaders urging them to avoid political interference in the doctor-patient relationship or policies denying reimbursement for reasons other than qualifications. The letter generally addressed longstanding concerns about efforts to undermine or amend section 1902(a)(23) of the Social Security Act, also known as the "Free Choice of Provider" requirement. That permits Medicaid beneficiaries to obtain medical services from qualified providers. The AAFP expressed similar concerns in a 2015 letter in opposition to the *Women's Public Health and Safety Act* (HR 3495.)

CENTERING ON THE STATES

1. Bills of Interest

This week 19 states and the District of Columbia began their 2017 legislative sessions. The Center for State Policy staff will be monitoring legislation throughout the session and provide weekly updates on bills that may be of interest to members.

- **Antitrust** – Virginia HB 1566 encourages innovation and promotes competition among health care providers and adds consumer protections. The bill also provides active supervision of state regulatory boards that includes active market participants among its membership, pursuant to the U.S. Supreme Court decision in North Carolina State Board of Dental Examiners v. Federal Trade Commission.
- **Delivery Reform**—New York SB 77 would require a health care provider, prior to performing any health care services, advise patients in writing of the fee to be charged to the patient for services if such fee is not paid for by insurance.
- **Direct Primary Care** – Florida SB 240 specifies that a direct primary care agreement does not constitute insurance and is not subject to insurance laws, regulations, or any other chapter of the Florida Insurance Code.
- **Medical Marijuana**—A group of bills were introduced in New Hampshire (HB 157, HB 158, HB 159, and SB 15) aimed at adding chronic pain and opioid addiction as qualifying medical conditions under the therapeutic use of cannabis.
- **Network Adequacy** – Montana LC 59, known as the *Montana Right to Shop Act*, creates an incentive program for patients/consumers to shop for health care services and requires insurers to allow for comparison shopping. The bill requires health care providers and health insurers to provide information on costs before treatment is provided.

2. Hawaii State Innovation Waiver Approved

On December 30, Hawaii became the first state to be granted a State Innovation Waiver under Section 1332 of the ACA. The waiver allows Hawaii to forgo the ACA requirement of establishing a Small Business Health Options Program (SHOP) and other relevant provisions. In addition, the waiver will allow the small business tax credit amounts that would have been paid to employers who purchased coverage through SHOP to be provided to the state and used to support a fund that helps small businesses in Hawaii offer health coverage. However, CMS denied Hawaii's request to seek flexibility to permit state agencies other than the State Medicaid Agency to have a role in an exchange. Alaska and California have pending Section 1332 Waivers.

3. Judge Set to Rule on Aetna-Humana Merger Lawsuit

U.S. District Judge John D. Bates heard final arguments on December 30, 2016 from lawyers representing Aetna, Humana, and the U.S. Justice Department (DOJ). A central dispute in the case was whether Medicare Advantage (MA) is a distinct market or whether it competes with traditional Medicare. The DOJ alleged the two are different because many seniors prefer MA and because they would see higher premiums if the merger closes. The insurers countered that the two programs are alternatives to each other and that seniors can switch between them.

Judge Bates said he would issue his ruling in a “timely manner," but did not specify a date; court observers believe he will issue his ruling in January.

4. Anthem-Cigna Merger Lawsuit Awaits Judge's Ruling

The second phase of the Anthem-Cigna merger trial, which concentrated on regional implications of the merger, ended with closing arguments on January 4, 2016. During this phase, U.S. Justice Department (DOJ) lawyers alleged local competition in 35 markets would be adversely affected by the market power of the combined Anthem-Cigna entity in both the sale of health plans and negotiations with doctors and hospitals. Phase one, which ended on December 13, 2016, focused on how the merger would produce significant market concentration in the sale of health plans to large national employers. Court observers believe U.S. District Judge Amy Berman Jackson may issue her ruling in January.

THE EXECUTIVE BRANCH

1. AAFP Comments on MACRA Final Rule

In a regulatory comment letter sent to CMS on December 15, the AAFP responded in detail to the MACRA final rule with comment period. To improve the implementation of the MIPS and APM pathways, in summary the AAFP:

- Encouraged CMS to consider primary care and small practices in their model design as new APMs are developed. The AAFP encouraged CMS to release these models in a timely fashion so that practices can participate.
- Believes virtual groups are critical to the ability of small practices, especially those in rural areas, to participate successfully in MIPS and requested to be included in the stakeholder group engaged with CMS to structure and implement virtual groups.
- Appreciated CMS’ close alignment of final measures with the core measures and encourage continued effort at further alignment in the future.
- Urges CMS to exclude family physicians from being held accountable for total cost of care.
- Believes patients must be prospectively attributed, based on who can control those specific costs. Attribution should include a reconciliation process for clinicians to review, add, or remove patients from the list.
- Believes patients should be attributed to the physician billing the largest portion of Part B allowable charges. Attributing patients based on the number of visits, does not attribute patients to the physician that can make the biggest impact on reducing costs, and would disproportionately hold primary care physicians responsible for the costs of specialists.
- Recommended that CMS approve for fulfillment of improvement activities any continuing medical education activities that measurably improve performance and patient outcomes.
- Recommended that PerformanceNavigator® be an approved improvement activity.
- Recommended that CMS utilize AAFP’s reporting capabilities to reduce the administrative burden on ECs and the burden on CMS of verifying completion of improvement activities.
- Appreciated the flexibility to use both 2014 and 2015 edition products in 2017, and the 90-day reporting of ACI in 2018 to support clinicians’ transition to the 2015 edition for 2018.
- Recommends CMS continue to move away from using health IT utilization measures, due to the negative unintended consequences experienced in the MU program.
- Strongly encourages CMS to work with third party vendors (registries, QCDRs and qualified registries) to provide more timely and actionable feedback in the quality category.
- Supported moving a larger percentage of payments from traditional FFS payments towards alternative payment models (APMs). The AAFP believes APMs should support the delivery of comprehensive, longitudinal care for patients and promote quality of care over volume.
- Supports patient-centered advanced primary care models that promote comprehensive, longitudinal care across settings and hold clinicians appropriately accountable for outcomes and costs. One example is the Comprehensive Primary Care Plus initiative.

- Continues to adamantly oppose the financial risk and nominal risk standard for all Medical Home Models and urges CMS to remove these requirements.
- Urges CMS to make APM incentive payments directly to QPs (i.e. “to such professional”) as identified by either the QP’s NPI or TIN/NPI combination.

2. AAFP Reacts to 2017 Final Medicare Physician Fee Schedule
The AAFP sent CMS a letter on December 22 reacting to the Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for 2017 final rule. The AAFP letter urged that more must be done to truly realize the value of family medicine and primary care and suggested that public and private payers cannot simply rely on delivery system reforms, but must also appropriately value the delivery of primary care services. The AAFP letter also listed multiple areas of frustration for practicing physicians and urged CMS to address them and promote administrative simplification.

3. AAFP Creates Whitepapers on Alternative Payment Models
In December the AAFP released a position paper on an advanced alternative payment model (APM) for primary care. The paper, "Advanced Primary Care: A Foundational Alternative Payment Model (APM) for Delivering Patient-Centered, Longitudinal and Coordinated Care," covers in substantial detail all the pieces this model must include. The AAFP also created and released AAFP Principles to Support Patient-Centered Alternative Payment Models.

4. MACRA Required Patient Relationship Codes Commented upon Again by AAFP
On December 21, the AAFP sent CMS a letter in response to the patient relationship categories and codes document the agency posted early that month. After expressing AAFP’s continued support for MACRA, which includes section 101(f) requiring establishment and use of patient relationship categories and codes, the AAFP letter outlined continued reinforced AAFP’s grave concerns that this reporting requirement will significantly increase the administrative burden that Medicare participating physicians already experience. The AAFP urged CMS to provide additional information on how these patient relationship categories and codes will be used to attribute cost and patient outcomes to physicians and also how this information will be used with episode groups. The AAFP called on CMS to thoroughly pilot test these patient relationship categories before their use impacts payments.

5. Support Sent for Site of Service Neutrality in 2017 Final OPPS Regulation
The AAFP sent a December 21 letter to CMS regarding the hospital outpatient prospective payment and ambulatory surgical center payment systems final rule. In this letter the AAFP supported CMS efforts to align payment policies for physicians in independent practice with those owned by hospitals. The AAFP believes the finalized policies in this rule will lead to a more level economic playing field for independent practices while also being more equitable for Medicare beneficiaries. The AAFP continued to encourage CMS to consider site-of-service payment parity polices from a broader perspective. Namely, CMS should not pay more for the same services in the inpatient, outpatient, or ambulatory surgical center setting than in the physician office setting. From a global cost perspective, the AAFP encouraged CMS to create incentives for services to be performed in the most cost-effective location, such as a physician’s office. The AAFP considers the artificial distinction between “inpatient,” “outpatient,” and other sites of service as a product of the equally artificial distinction between Part A and Part B.

6. Comments Sent to HHS on Draft Vaccine Plan
In a December 21 letter, the AAFP commented on a “Mid-Course Review Working Group Draft Report and Draft Recommendations for Consideration by the National Vaccine Advisory Committee.” The letter asked that the AAFP be included in future focus groups that created the draft and called on HHS to study vaccines across the entire lifespan including adolescent and adult immunization policies and terminologies.

7. AAFP Urges Revised Tobacco Cessation FAQ
On December 21, the AAFP sent a letter to the Secretaries from the U.S. Department of Health & Human Services, U.S. Department of Labor, and U.S. Department of the Treasury regarding a frequently asked questions (FAQ) document regarding coverage of tobacco cessation interventions. Unfortunately, instead of the FAQ clarifying which items and services insurers must cover without cost sharing in order to comply with the updated U.S. Preventive Services Task Force (USPSTF) tobacco cessation recommendation issued in September 2015, the Departments request comments from stakeholders before providing future guidance. The AAFP urged the Departments to promptly issue a new FAQ on tobacco cessation benefits with updated USPSTF recommendations.

8. Nominations

- On December 15, the AAFP nominated David Schmitz, MD, to serve on the Veterans Rural Health Advisory Committee.
- On January 3, the VA announced that Karen O'Brien, MD, COL (retired) was selected to the VA's Advisory Committee on Women Veterans. The AAFP had nominated her in a July 27, 2016 letter.
- On January 4, the AAFP sent a letter to the U.S. Department of Agriculture that nominated Roger J. Zoorob, MD, MPH; Anne Eglash MD, IBCLC, FABM; Anne M. Montgomery, MD, MBA; Timothy J. Tobolic, MD; and Julie Wood, MD, MPH, IBCLC, FABM to serve on the National Advisory Council on Maternal, Infant and Fetal Nutrition.
- On January 4, Melissa Martinez MD, was appointed to serve as a member of the National Vaccine Advisory Committee. The AAFP had nominated her to this committee in a June 1, 2016 letter.

9. Regulatory Briefs

- On December 9, the GAO released a report titled, "Medicare Value-Based Payment Models: Participation Challenges and Available Assistance for Small and Rural Practices."
- On December 12, the HHS Secretary outlined her vision for the future of health care.
- On December 12, the VA released a regulation that decreases the cost of outpatient medication copays for most veterans
- On December 13, CMS announced the release of the CMS Person and Family Engagement Strategy.
- On December 13, despite steadfast opposition from the AAFP and other physician organizations, the VA issued a final rule that grants full practice authority to certain advanced practice nurses within the VA. In this rule, VA exercised federal preemption of state nursing licensure laws to the extent such state laws conflict with the full practice authority granted to VA APRNs while acting within the scope of their VA employment.
- On December 14, HHS issued a final rule to clarify the regulations for family planning services under Title X of the Public Health Service Act and protect access to family planning services.
- On December 15, CMS announced the Medicare-Medicaid Accountable Care Organization (ACO) Model, which builds on the current Medicare Shared Savings Program and advances efforts to partner with states in transforming the health care delivery system.
- On December 15, CMS announced more new opportunities for clinicians to join Advanced Alternative Payment Models (APMs) to improve care and earn additional incentive payments under the Quality Payment Program. Beginning in January and February 2017, CMS will open applications for new rounds of two CMS Innovation Center models for the 2018 performance year – for new practices and payers in the Comprehensive Primary Care Plus (CPC+) model and new participants in the Next Generation Accountable Care Organization (ACO) model. With these new opportunities, CMS expects that by the 2018 performance period, 25% of clinicians in the Quality Payment Program would be a part of these advanced models and may be eligible to earn incentive payments.

- On December 16, CMS issued the Notice of Benefit and Payment Parameters final rule and the final Annual Letter to Issuers for 2018.
- On December 20, CMS released the "2017 Medicare Electronic Health Record (EHR) Incentive Program Payment Adjustment Fact Sheet for Eligible Professionals."
- On December 20, HHS finalized new Medicare alternative payment models that
    - Improve cardiac care: Three new payment models will support clinicians in providing care to patients who receive treatment for heart attacks, heart surgery to bypass blocked coronary arteries, or cardiac rehabilitation.
    - Further improve orthopedic care: One new payment model will support clinicians in providing care to patients who receive surgery after a hip fracture beyond hip replacement. In addition, HHS is finalizing updates to the Comprehensive Care for Joint Replacement Model, which began in April 2016.
    - Provides an ACO opportunity for small practices: In order to encourage more practices, especially small practices, to advance to performance-based risk, the new Medicare ACO Track 1+ Model will have more limited downside risk than in Tracks 2 or 3 of the Medicare Shared Savings Program. The model also allows hospitals, including small rural hospitals, to participate in this new ACO model. Stakeholders, including physician groups, have requested this type of ACO model be added to the portfolio of options. This approach will provide opportunities for an estimated 70,000 clinicians to qualify for Advanced Alternative Payment Model (APM) incentive payments in 2018.
- On December 20, HRSA issued final updated guidelines for which women's preventive health services must be covered by health insurance plans without a copayment, coinsurance, deductible, or other cost-sharing. These changes took effect for plan years beginning on or after Dec. 20, 2017.
- On December 21, OIG released a report on the CMS QPP.
- On January 5, CMS posted a blog titled, "Addressing the Opioid Epidemic: Keeping Medicare and Medicaid Beneficiaries Healthy."
- On January 5, CMS released a report on the CMMI.
- CMS will host the following free educational call, registration is required:
    - IRF-PAI Therapy Information Data Collection Call, January 12 at 1:30 pm.
    - ESRD QIP: Payment Year 2020 Final Rule Call, Jan. 17, 1:30 pm
    - Home Health Groupings Model Technical Report Call, Jan. 18, 1:30 pm
    - Home Health Quality of Patient Care Star Rating Call, Jan. 19, 1:30 pm
    - Medicare Quality Programs: Transitioning from PQRS to MIPS Call, Jan. 24, 2:00 pm

TAKE ACTION

1. FamMedPAC

FamMedPAC had a strong 2016 election cycle, with 89% of FamMedPAC-supported candidates winning. The PAC made a record $1,020,200 in contributions this cycle to 155 candidates or committees. After receiving over $500,000 in donations in 2015, our best fundraising year ever, FamMedPAC received $474,000 in donations in 2016. While falling short of our $1 million goal for the cycle, the $975,000 total is a new record for the PAC. With your continued help, we know we can reach our goal! If every active member of AAFP contributed at the Club George level ($365 per year), we would have over $25 million dollars in the PAC, making us one of the largest PACs of any type in the country.

It's a new election cycle and FamMedPAC must gear up to work with the 115th Congress and to continue to support family medicine friendly candidates. Let's work together to encourage fellow AAFP members to support FamMedPAC. Please click on the FamMedPAC Donation Page to make your 2017 contribution on-line and help us fight for you and your patients!

2. AAFP President Enlists Grassroots Support for Health Care Coverage Protection
On January 2, AAFP President John Meigs Jr., MD, sent a letter to Academy members asking them to send a message to elected officials in support of preserving health care coverage. With over 3,650 letters sent in the first three days, this has become one of the most widely utilized Speak Out campaigns in recent AAFP history. To join your fellow family physicians in letting elected officials know you want to preserve health care coverage, click here.