AAFP
STRONG MEDICINE FOR AMERICA

GOVERNMENT AFFAIRS UPDATE

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NEXT WEEK IN WASHINGTON…

* The Senate is expected to pass a short-term spending bill through December 9.
* On September 12, the House Energy and Commerce Health Subcommittee will consider five public health bills.
* On September 14, the House Ways and Means Health Subcommittee will hold a hearing health information technology.

1. AAFP ASKS CONGRESS TO PRESERVE STATE LICENSURE

The AAFP has weighed in with Congress on a proposed telehealth benefit in the TRICARE program, which provides health benefits to over 8 million military personnel, retirees and their dependents. The Senate version of the *National Defense Authorization Act* (NDAA)—an annual bill that reauthorizes the nation's military programs, contains a new TRICARE telehealth benefit to "improve access to primary care, urgent care, behavioral health care, and specialty care." As drafted, the new benefit would also preempt existing state law which generally provides that the location of care in a telehealth visit is the location of the patient—not the physician. The Senate bill would change the location of care to that of the physician. On September 1, the AAFP wrote to the members of the conference committee now negotiating the final version of the bill, expressing support for the new telehealth benefit but opposition to the proposal to change the location of care, which would erode the existing state-based licensure system. The NDAA is expected to pass Congress and be signed by the President this fall.

2. CONGRESS FACES ANNUAL APPROPRIATIONS DEADLINE

Congress reconvened facing the September 30 end of the fiscal year with no FY 2017 spending bills enacted. As they work on a continuing resolution (CR) to fund government operations, the House and Senate must also agree on a package to combat the Zika virus. The AAFP was one of more than 50 groups to sign a letter dated September 6 urging Congress to take immediate action on a funding package to combat Zika. In addition, the AAFP wrote to the House and Senate opposing cuts to reproductive health services and urging them to strike any provision that would prohibit funds from being used for family planning activities. The AAFP also joined a letter from 53 organizations urging the House and Senate Appropriations Committee to allow the FDA's final rule on e-cigarettes and cigars to continue to be implemented and reject any effort to include the House tobacco policy riders in the appropriations bills for FY2017.

3. HOUSE COMMITTEE REVIEWS PUBLIC HEALTH BILLS

On September 8, the House Energy and Commerce Committee's Subcommittee on Health held a hearing to review bills that focus on preventive health and treatment priorities. The bills focused on diabetes education and care standards, increasing underage drinking prevention efforts, improving access to Sickle Cell Disease treatment, and efforts to improve research, and surveillance for pediatric congenital heart disease. During the hearing, participants talked about the important role primary care physicians play in educating patients about pre-diabetes and the necessity of care coordination for effective diabetes treatment. The *National Diabetes Clinical Care Commission Act (HR 1192)*, which the AAFP supports, would establish an interagency commission to review prevention and care outcomes for diabetes. The committee scheduled a September 12 meeting to approve the bills.

4. AAFP SUPPORTS INNOVATIVE HOME-BASED PRIMARY CARE DELIVERY MODEL

The AAFP has delivered a letter of support, dated September 7, to the Senate sponsors of the *Independence at Home Act of 2016.* Independence at Home (IAH) is a primary-care Medicare demonstration program currently being tested by the Centers for Medicare and Medicaid Services (CMS). Congress authorized IAH by statute in *the Affordable Care Act*. IAH pairs qualifying practices with beneficiaries who suffer from multiple chronic conditions and have a recent history of non-elective hospital admissions and 2 or more functional dependencies requiring the assistance of another person. The IAH practices provide to those beneficiaries 24/7 availability, in-home visits, and carry out plans of care that are designed to keep frail elderly patients out of the hospital and emergency department. Of the 15 practices currently enrolled in the IAH demonstration, many of them rely heavily on family physicians. Data released by CMS for the first two years of experience under IAH show substantial quality improvements and cost savings. The *Independence at Home Act* would make IAH a permanent national benefit within the Medicare program. Without further Congressional intervention, the IAH program will expire on September 30, 2017.

5. AAFP URGES HOUSE PASSAGE OF FAMILY CAREGIVER MEASURE

The AAFP joined more than 50 organizations in writing to House Education and Workforce Committee urging them to pass the *Recognize, Assist, Include, Support, and Engage (RAISE) Family Caregivers Act* (S.1719 and HR 3099) which calls on the Department of Health and Human Services (HHS) to convene a Family Caregiving Advisory Council to advise it on recognizing and supporting family caregivers and directs the HHS to develop and maintain a National Family Caregiving Strategy. The Senate passed the *RAISE Act* last December; and the House version now has 107 bipartisan cosponsors. The AAFP highlighted our support for family caregivers as part of the 2015 Family Medicine Congressional Conference.

6. HOUSE COMMITTEE EXAMINES MENTAL HEALTH PARITY

On September 9, the House Energy and Commerce Committee's Subcommittee on Health held a hearing on the challenges to fully implementing the *Mental Health Parity and Addiction Equity*

Act. Rep. Joe Kennedy, III (D-RI), who authored mental health parity legislation, spoke on the need for greater transparency and enforcement. He highlighted his bill's language to require insurance company accountability and a provision establishing hub for complaints. Rep. Chris Collins (R-NY) expressed concerns about veterans' mental health care. Rep. Larry Buschon, MD (R-IN) spoke about integrated physical and mental health treatment available in this district. One witness, Michael Trangle, MD, highlighted the importance of mental health screening in primary care settings. Other witnesses described access barriers associated with low Medicaid payment and clinicians' refusal to accept insurance. On July 17, the House of Representatives approved *Helping Families in Mental Health Crisis Act* (HR 2646), which included language to improve mental health parity enforcement. The AAFP commented on parity last March.

7. CMS ANNOUNCES PLANS FOR MACRA REPORTING IN FIRST YEAR

On September 8, the CMS released a blog announcing a plan for the reporting in the Quality Payment Program set to begin on January 1, 2017. After recognizing a wide diversity of practices, CMS announced their intention for physicians to pick their pace of participation for the first performance period that begins January 1, 2017. CMS stated that, "choosing one of these options would ensure you do not receive a negative payment adjustment in 2019." While these options will be fully described in a forthcoming final regulation, the options include:

- First Option: Test the Quality Payment Program. With this option, as long as you submit some data to the Quality Payment Program, including data from after January 1, 2017, you will avoid a negative payment adjustment. This first option is designed to ensure that your system is working and that you are prepared for broader participation in 2018 and 2019 as you learn more.
- Second Option: Participate for part of the calendar year. You may choose to submit Quality Payment Program information for a reduced number of days. This means your first performance period could begin later than January 1, 2017 and your practice could still qualify for a small positive payment adjustment. For example, if you submit information for part of the calendar year for quality measures, how your practice uses technology, and what improvement activities your practice is undertaking, you could qualify for a small positive payment adjustment. You could select from the list of quality measures and improvement activities available under the Quality Payment Program.
- Third Option: Participate for the full calendar year. For practices that are ready to go on January 1, 2017, you may choose to submit Quality Payment Program information for a full calendar year. This means your first performance period would begin on January 1, 2017. For example, if you submit information for the entire year on quality measures, how your practice uses technology, and what improvement activities your practice is undertaking, you could qualify for a modest positive payment adjustment. We've seen physician practices of all sizes successfully submit a full year's quality data, and expect many will be ready to do so.
- Fourth Option: Participate in an Advanced Alternative Payment Model in 2017. If you receive enough of your Medicare payments or see enough of your Medicare patients through the Advanced Alternative Payment Model in 2017, then you would qualify for a 5 percent incentive payment in 2019.

On September 9, the AAFP released a related Getting Paid blog and press release relating to this announcement. On September 6, House leaders signed a letter to the HHS Secretary asking for regulatory flexibility in MACRA implementation.

8. FAMILY PHYSICIANS NOMINATED TO MEDICARE COVERAGE COMMITTEE

The AAFP sent a letter to CMS on September 1 in response to a request for nominations for the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC). The letter nominated Steven R. Brown MD, FAAFP, Mark H. Ebell MD, MS, and Joy Melnikow, MD, MPH

to the this committee which provides advice and guidance concerning the adequacy of scientific evidence available to CMS in making coverage determinations under the Medicare program.

9. AAFP RESPONDS TO 2017 PROPOSED MEDICARE OUTPATIENT REGULATION

On August 24, the AAFP sent CMS a regulatory comment letter in response to the a proposed rule that would, among several other policy changes, revise the Medicare hospital outpatient prospective payment system (OPPS) and the Medicare ambulatory surgical center (ASC) payment system for 2017. Of particular interest to family physicians, this proposed rule would:

- Implement section 603 of the *Bipartisan Budget Act of 2015* relating to payment for items and services furnished by certain off-campus outpatient departments of a provider.
    - The AAFP supported CMS implementing proposals to better align payment policies for physicians in independent practice with those owned by hospitals which will lead to a more level economic playing field and be more equitable for patients. The AAFP encouraged CMS to consider site-of-service payment parity polices from a broader perspective and not pay significantly more for the same services in different settings.
- Change the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.
    - The AAFP supported the agency's proposal to change the EHR reporting periods in 2016 for returning participants from the full 2016 to any continuous 90-day period within 2016. The letter applauded the agency for being responsive to stakeholder feedback, including feedback from the AAFP, which requested that CMS allow a 90-day EHR reporting period for eligible professionals (EPs), eligible hospitals and CAHs in 2016 in order to reduce the reporting burden and increase flexibility in the program.
- Remove the HCAHPS Pain Management dimension from the Hospital Value-Based Purchasing (VBP) Program.
    - To mitigate the perception that there is financial pressure to overprescribe opioids, the AAFP supported the proposal to remove the HCAHPS survey pain management questions from the hospital payment scoring calculation. The AAFP called on CMS to extend this laudable policy to all patient experience measures.

10. AAFP COMMENTS ON 2017 PROPOSED ESRD REGULATION

In an August 23 letter to CMS, the AAFP commented on a proposed rule that, among other policy changes, updates and make revisions to the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) for 2017. Within this proposed rule, CMS asks, "How could primary-care based models better integrate with Alternative Payment Models (APMs) or Advanced Alternative Payment Models (AAPMs) focused on kidney care to help prevent development of chronic kidney disease in patients and progression to ESRD? Primary-care based models may include patient-centered medical homes or other APMs." While the AAFP supports CMS efforts to comprehensively address and appropriately pay for ESRD services, the letter made the point that we do not want to see fragmented care under fee-for-service replaced with fragmented care under APMs. Regarding specialty- or disease- focused APMs, the AAFP cautioned the agency about needlessly fragmenting care through a plethora of specialty or disease-focused APMs. The AAFP continues to call for APMs to be primary care-centered, since there is ample evidence that primary care-oriented health systems are more effective, more efficient, and yield better outcomes for patients than systems that are not.

11. AAFP COMMENTS ON OPIOID PRESCRIBER EDUCATION

On September 2, the AAFP wrote to the HHS Acting Assistant Secretary for Planning and Evaluation (ASPE) in response to a request for information on opioid analgesic prescriber education and training opportunities to prevent opioid overdose and opioid use disorder as published in the July 8, 2016 Federal Register. The Conjoint Committee on Continuing Education (CCCE) also commented to ASPE in a letter dated September 6. The CCCE letter

noted that "nineteen states have instituted mandatory CE on one or more subjects." They went on to say that "seductive as it is, *mandatory CE has not been shown to result in the desired outcomes, while voluntary CE results in learning and practice change*."

12. STATES BEGIN TO INVESTIGATE MYLAN OVER EPIPEN PRICING

New York Attorney General Eric Schneiderman (D) opened an antitrust investigation into Mylan. A preliminary review showed the company may have inserted anticompetitive terms into sales contracts with school systems. Additionally, Minnesota Attorney General Lori Swanson (DFL) has requested the company's pricing and sales data since 2007. The Minnesota Department of Human Services has estimated that if EpiPen was misclassified as a "non-innovator" drug, instead of a generic classification, this will cost Minnesota more than $4 million in overpayment in 2016. Citing this overpayment, Sen. Chuck Grassley (R-IA) asked Iowa Attorney General Tom Miller (D) to see if Iowa taxpayers have overpaid for EpiPens under Medicaid. Mylan has responded by saying that they have complied with all Medicaid rules and federal laws.

13. CALIFORNIA DEFEATS SCOPE OF PRACTICE MEASURES

The California Academy of Family Physicians was successful in defeating two scope of practice measures. SB 538 would have allowed naturopaths to prescribe Schedule V controlled substances without physician supervision. AB 1306 sought to allow certified nurse midwives to independently diagnose and treat complex chronic diseases. CAFP worked with coalition partners and key contacts to inform legislators about these dangerous pieces of legislation.

14. 2017 CHAPTER ADVOCACY RECIPIENTS ANNOUNCED

We congratulate the Maine AFP, Maryland AFP, Mississippi AFP, Nebraska AFP, Nevada AFP, North Dakota AFP and Rhode Island AFP; they are recipients of the AAFP Chapter Advocacy Day Assistance Grants Program for 2017. Advocacy day events provide chapters an opportunity for members to meet with elected officials. These events reinforce family medicine's advocacy messages and introduce family physicians to serve as expert resources for legislators on public policy issues. Small and medium chapters can apply for up to $5,000 in grant funds, provided that the chapter show evidence that it is contributing $1 for every $2 applied for from AAFP.

15. OHIO DEMONSTRATION WAIVER DECLINED

CMS has rejected Ohio's request for a new section 1115 demonstration waiver. The waiver request sought to require monthly contributions to health savings accounts and drop coverage for failure to pay. CMS stated in the letter that they were concerned about the state's request to charge premiums, and were apprehensive that these premiums would undermine access to coverage and the affordability of care. They also stated that the application would exclude individuals from coverage indefinitely until they pay all arrears, a policy CMS explained would not be authorized in any state. This decision could have consequences for other Republican-led states, particularly Arizona and Kentucky, which plan Medicaid expansion changes.

16. FamMedPAC STARTS PUSH TO ELECTION DAY

Thanks to strong support from AAFP members, FamMedPAC is well positioned as this election cycle wraps up. The PAC has almost $400,000 in the bank and will be supporting key legislators and candidates in the next few weeks. The PAC provided support to two first-time candidates in August and supported events in Washington, DC this week, specifically:

- **Dr. Roger Marshall (R-1-KS).** Dr. Marshall won his primary and will be elected in November. FamMedPAC supported him in the primary and general elections.
- **Raja Krishnamoorthi (D-8-IL).** Mr. Krishnamoorthi won his primary and will be the new Congressman from this district following the general election. Members of the Illinois Academy met with Mr. Krishnamoorthi in August.
- **Rep. Evan Jenkins (R-3-WV),** a member of the House Appropriations Committee.

- **Rep. Morgan Griffith (R-9-VA),** a member of the Health Subcommittee of the House Energy and Commerce Committee.

17. REGULATORY BRIEF

- On August 18, CMS released a press release and fact sheet on new drug cost data.
- In August, CMS posted an educational document regarding how to code for Advance Care Planning services for Medicare beneficiaries.
- On August 25, CMS announced by press release and fact sheet the 2015 performance year results for the Medicare Shared Savings Program and the Pioneer Accountable Care Organization (ACO) Model. The results show that physicians, hospitals, and health care providers participating in ACOs continue to make significant improvements in the quality of care for Medicare beneficiaries, while achieving cost savings. Medicare ACOs have generated more than $1.29 billion in total Medicare savings since 2012.
- On August 31, HHS awarded $53 million to help address opioid epidemic.
- On September 2, HHS released a fact sheet relating to the 2017 Medicare Electronic Health Record (EHR) Incentive Program Payment Adjustment for Hospitals.
- On September 6, the Physician-Focused Payment Model Technical Advisory Committee (PTAC) published several documents to its website. The next PTAC public meeting is on September 16.
- On September 6, CMS awarded consumer assistance funding to support 2017 Health Insurance Marketplace enrollment.
- On September 8, CMS released a final rule regarding emergency preparedness of certain facilities participating in Medicare and Medicaid.
- On September 8, HHS awarded $350,000 to American Academy of Pediatrics to help children affected by the Zika Virus.
- On September 8, CMS announced the new single payment amounts and began sending contract offers to successful bidders for Medicare's Round 1 2017 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. These new payment amounts and contracts go into effect on January 1, 2017.
- On September 8, CMS announced partnering with Mathematica to Implement Alternative Payment Models. Mathematica will help CMS identify clinicians who meet participation thresholds in a portfolio of Advanced Alternative Payment Models (APMs) and calculating incentive payments to qualifying participants. Mathematica is also providing technical assistance to CMS in developing, monitoring, and implementing new APM initiatives and helping to ensure that APMs meet key objectives of improving quality of care and reducing spending.
- On September 8, CMS released a fact sheet that announced Track 1 funding for the Accountable Health Communities Model. This model addresses a gap between clinical care and community services in the current health care delivery system by testing whether systematically identifying and addressing the health-related social needs of beneficiaries' impacts total health care costs, improves health, and quality of care.
- On September 8, CMS released a fact sheet regarding next steps for the State Innovation Models. The State Innovation Models (SIM) Initiative was launched in 2013 to test the ability of state governments to use their policy and regulatory levers to accelerate healthcare transformation efforts in their states, with a primary goal to transform over 80 percent of payments to providers into innovative payments and service delivery models.
- CMS will host the following free educational call, registration is required:
  - SNF Quality Reporting Program Webcast, Sep 14, 1:30pm ET
  - National Partnership to Improve Dementia Care and QAPI, Sep 15, 1:30pm ET
  - SNF Value-Based Purchasing Program Call, Sep 28, 1:30pm ET
  - 2015 Annual QRURs Webcast, Sep 29, 1:30 pm ET