THE CRD ASSOCIATES'

HEALTH POLICY REPORT

September 2016

Much Ado…But Little Getting Done

The 114th Congress started strong, with a burst of achievements that lent credence to lawmakers' pledge to "get things done." In 2015, 115 laws were enacted, the most in the first year of a new Congress since 2009.

Then someone hit the pause button.

Election years, especially presidential election years, are usually slow. But unless Congress manages to pass another 65 bills between now and year's end, this will be the least productive Congress in modern times.

After a seven-week break, on September 6, lawmakers returned to work with some huge issues still left to be resolved: a Supreme Court seat has been vacant since February; a controversial trade pact with Asian Pacific nations has been left

hanging in the wind; an important energy bill remains in legislative limbo; and Congress has yet to mount an attack on the Zika virus.

Current plans call for Congress to only be in session until late September before returning to the campaign trail. And at this point, the only "must-do" legislation remaining the docket is a short-term spending measure to avoid a government shutdown when the current fiscal year ends on September 30.

Even that task follows a complicated path. Some hard-core conservatives argue that a temporary spending bill, called a continuing resolution, should extend six months, until after a new president and a new Congress are sworn in. Driving conservatives' resistance to working out a budget deal sooner rather than later is their reluctance to engage in a year-end bargaining session with President Obama.

But an unlikely coalition of Republican appropriators, defense hawks and Democrats counter that the continuing resolution should only run until December, leaving enough time for Congress to get its work done during a lame-duck session. A six-month continuing resolution, they argue, would leave federal agencies in limbo for half the year, unable to start new programs or operate with any predictable funding stream.

With only about 17 legislative days left before lawmakers head back to the campaign trail, hanging over the heads of both sides is the risk that failure to broker a spending deal will trigger a government shutdown, and risk infuriating voters just before the November elections.

Opioid Battle Continues

Tied to the battle over funding is what Congress plans to do to address the opioid crisis in this country.

In July, Congress passed opioid legislation, the Comprehensive Addiction and Recovery Act (CARA), which included a number of treatment and prevention measures intended to reduce prescription opioid and heroin misuse, including evidence-based interventions for the treatment of opioid and heroin addiction and prevention of overdose deaths.

The bill authorizes $181 million in new spending, with an expectation that lawmakers will approve nearly $500 million for opioid programs in the next

budget year. *The measure, however, failed to provide any new federal funding to launch these programs.*

In the meantime, the president announced in late August that grants totaling $53 million have been awarded to 44 states, DC and tribal organizations to combat prescription opioid and heroin abuse. Eleven states with the highest rates of primary care admissions to treat opioid abuse will receive up to $11 million to expand access to medication-assisted treatment, drugs that ease the symptoms of withdrawal.

A $9 million grant will be split among 21 states and four tribal organizations to raise awareness about the dangers of sharing medication and overprescribing, and $22 million was awarded by the Centers for Disease Control and Prevention to help states track abuse through drug monitoring programs and to improve the timeliness of overdose reporting.

Searching for a Path to NIH Funding

While Congress was away, staff for two congressional health committees worked to broker a bipartisan deal on legislation creating a mandatory funding stream for NIH.

During the seven-week summer break, key House and Senate staff and White House officials searched for a way to pass a trimmed-down version of the 21st Century Cures bill adopted by the House several months ago. That bill included $8.75 billion in mandatory funding for NIH, spread over five years.

One approach being considered is to introduce a new version of the bill in the House, and send that version to the Senate.

The original House-passed bill was much broader than the package passed by the Senate HELP committee earlier this year. The Senate committee version did *not* include mandatory NIH funding because Senate lawmakers have thus far been unable to identify offsetting budget cuts.

SGIM Weighs in on Proposed Fee Schedule

On July 7, 2016, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that updates payment policies, payment rates, and quality

provisions for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2017.

The fee schedule pays for services furnished by physicians and other practitioners in all sites of service, including but not limited to visits, surgical procedures, diagnostic tests, therapy services, and specified preventive services. CMS closed the comment period on the proposed rule on September 6, 2016, and will issue the final rule by November 1, 2016. Following are excerpts from SGIM's formal comments back to CMS, SGIM focused on the following areas of particular interest to its members:

Global Services: As mandated by the Medicare Access and CHIP Reauthorization Act (MACRA), CMS is proposing to collect data on the work performed during 10 and 90 day global services and proposed that surgeons report on a series of G-codes that describe the care delivered to patients during the post-surgical periods.

- *SGIM supports CMS' proposal to collect data on the resources used and care delivered to patients during the 10 and 90 day global periods. As a founding member of the Cognitive Care Alliance (Alliance), we have proposed that CMS commit to developing an evidence base from which E/M services can be redefined and quantified to more accurately describe and value the work performed by cognitive physicians.*

Improving Payment Accuracy for Primary Care, Care Management Services, and Patient-Centered Services:

- CMS has engaged in a multi-year effort to improve the reimbursement for primary care services, and the proposed fee schedule describes multiple ways the agency thinks they can meaningful impact reimbursement.
- Non-Face-to-Face Prolonged Evaluation and Management Services: CMS proposes to pay for two existing codes that describe non-face-to-face work associated with an E/M visit. This proposal would provide separate payment for work previously assumed to be included in the E/M service code.

- CCM Services: Since its implementation in 2015, utilization of the CCM services has been lower than expected. CMS is proposing changes to simplify the billing requirements for these services in an effort to increase utilization. CMS is also proposing to pay for the other two services in the CCM family.

- *SGIM commends CMS for proposing to reimburse for currently uncompensated care provided by primary care physicians. The imbalance in payment that has shifted Medicare part B payments toward procedural services has undermined the value of the work of primary care physicians. Beneficiary access to the very services that are required to improve the value of our nation's health care investment is being threatened. We applaud CMS for proposing new codes that will improve patient access to primary care services and improve reimbursement for the care being delivered. However, we remain concerned that the documentation requirements associated with these new services will limit their utilization. Moving forward, SGIM would welcome the opportunity to continue working with CMS in its efforts to improve payment for ongoing primary care, care management and coordination, and cognitive services.*

Improving Payment Accuracy for Diabetes Self-management Training (DSMT): CMS would like to increase the utilization of DSMT and will be providing specific proposals in a separate communication.

- *SGIM supports the agency's efforts to increase the utilization of DSMT services, and looks forward to working with CMS to clarify the issues that have been identified that limit utilization. SGIM recommends that CMS not require that these training programs have an ADA certification for these services to be reimbursed. By provided this flexibility, we believe primary care physicians will be able to successfully refer patients for this training.*

VA Commission on Care Report Issued

As part of the Veterans Access, Choice, and Accountability Act of 2014, Congress established a 15-member Commission on Care, charging it to examine veterans' access to Department of Veterans Affairs health care and to examine strategically how best to organize the Veterans Health Administration, locate health resources, and deliver health care to veterans during the next 20 years.

The Commission's final report was completed on June 30 and is available here.

In a letter to Congress, President Obama stated, "I concur with 15 of the 18 Commission recommendations, many of which are already being implemented as part of the ongoing MyVA transformation that the Secretary of Veterans Affairs (Secretary) has put in place. These include areas such as enhancing clinical operations, establishing a more consistent policy for appealing clinical decisions, eliminating disparities in how health care is delivered to veterans from different backgrounds, modernizing IT systems, and establishing new processes for leadership development and performance management. These reforms are steps in the right direction and will help put VA on a trajectory to ensure veterans continue to receive timely and high quality care, while strengthening the VA health care system that millions of veterans depend on every day. I appreciate and applaud the Commission for their work.

"Of particular note," he added, "I strongly support the Commission's principle that creating a high-performing, integrated health care system that encompasses both VA and private care is critical to serving the needs of veterans."

However, President Obama took issue with some of the Commission's recommendations, noting that "it is critical that we preserve and continue to improve the VA health care system and ensure that VA has the ability to serve veterans. Research shows that in many areas, such as mental health, VA delivers care that is often better than that delivered in the private sector. VA also provides unique, highly specialized care for many medical conditions, such as spinal cord and traumatic brain injuries, which are simply not available to the same extent outside of VA. In addition, VA provides a comprehensive approach to wellness that includes the treatment of physical injuries and mental health. This multidisciplinary approach allows providers to address the full spectrum of veteran needs beyond medical care, including other VA benefits and services."

SGIM Moves to Enhance Ties to AHRQ

It is no surprise to SGIM members that they and their colleagues hold a disproportionate sway in the halls of government. SGIM members have traditionally been leaders in a wide variety of offices and agencies in and around Washington DC.

For example, Dr. Karen DeSalvo is currently the Acting Assistant Secretary of Health in the Department of Health and Human Services. Dr. Eliseo J. Perez-Stable is the Director of the National Institute of Minority Health and Health Disparities (NIMHC), one of the 27 institutes and centers at the National Institutes of Health.

Most recently, Dr. Andy Bindman has been appointed as the Director of the Agency for Healthcare Research and Quality (AHRQ) by HHS Secretary Sylvia Mathews Burwell. At the Annual Meeting in Florida, Dr. Bindman was actively engaged in meeting with SGIM members from Society's leadership to the Research Subcommittee of the Health Policy Committee to the general membership.

Beginning this month, Dr. Bindman will participating in Health Policy Committee conference calls on a quarterly basis – either with the Research Subcommittee or with the HPC Executive Committee to share thoughts and plans as appropriate. SGIM benefits greatly from having its outstanding member in key positions.

PCORI Sponsoring Free Workshop

The Patient-Centered Outcomes Research Institute (PCORI) is sponsoring a free workshop called "Getting to Know PCORI: From Application to Closeout." The workshop will be held on September 20, 2016 from 9:00 am to 5:00 pm at the Royal Sonesta Hotel Boston, 40 Edwin Land Blvd, Cambridge, MA.

This free interactive workshop will provide applicants with the tools and strategies to develop a winning application. The workshop will offer an overview of PCORI, and its:

- Priority Topics for Research;
- Funding Announcements
- Application Process;
- Large Pragmatic Clinical Studies;
- Research Partnerships and Engagements;
- Clinical Research Network (PCORNet); and,
- Contract Award and Administrative Requirements.

The workshop will provide opportunities to meet PCORI staff, ask questions, obtain resources, and network with other participants. The goal is to continue building a community of researchers who have the passion to participate in patient-centered outcomes research.

For those arriving the day before, there will be a networking reception and dinner on Monday, September 19 from 5:00 pm to 8:00 pm. Registration is free and can be accessed at http://www.pcori.org/events/2016/getting-know-pcori-application-closeout-september-2016.

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