FY 2007 Federal Budget

Early in the morning on Thursday, May 18, by a vote of 218-210, the House approved its version of the $2.8 trillion federal budget for FY 2007. Passage of the resolution was a significant victory after weeks of stalemate resulting from moderate Republicans' demands that it contain more funding for labor, health and education programs and conservative GOP members' advocacy that the framework show greater fiscal discipline.

The final agreement included not only the additional $4 billion supported by Rep. Michael Castle (R-DE) and agreed to by GOP leaders earlier for labor, health and education, but also the promise of $3.1 billion more. While the total $7 billion figure mirrors the amount included in the Senate budget resolution, it is not clear which programs will be cut to provide the additional $3 billion in funding. However, at least $1 billion would be taken from the Iraq reconstruction funds. Rep. Castle has announced that the remaining funds will not be taken from Medicare, Medicaid, food stamps or other programs for low-income Americans. The $7 billion will support programs in the health, education and labor appropriations bill equal to the FY 2006 spending level, plus 2 percent for inflation.

A conference committee to reconcile the differences in the House and Senate versions is not going to be formed. Instead, leaders in both chambers will consider their budget numbers as the limits that their appropriations committees will use.

Appropriations

On Thursday, May 4, the Chairman of the House Appropriations Committee, Rep. Jerry Lewis (R-CA), announced the allocations for each subcommittee. While the proposed FY 2007 allocation for the Labor/HHS subcommittee was slightly larger than FY 2006 (0.6 percent), it was significantly greater than the amount requested by the President ($4 billion more), reflecting pressure from moderate Republicans.
Specialty Hospitals
On Wednesday, May 17, the Senate Finance Committee held a hearing on specialty hospitals. Mark McClellan, Administrator of the Centers for Medicare and Medicaid Services (CMS) testified. Senator Charles Grassley (R-IA), who is the chair of the Finance Committee, and who opposes the development of specialty hospitals, questioned whether CMS is enforcing the Congressional ban on the establishment of new physician-owned specialty hospitals pending a review of the agency’s payment policies. CMS plans to finalize those policies by August, but Sen. Grassley noted that since 2004 over 40 specialty hospitals have opened.

Dr. McClellan said that CMS is developing comprehensive new policies that would reform Medicare’s payment system to remove financial incentives that make some specialty hospital services more profitable than local hospitals. He noted that CMS also would ensure that all facilities classified as hospitals are able to provide emergency services and institute safeguards against financial conflicts of interest.

Medicare Part D Drug Benefit
Following the May 15 deadline for signing up for the Medicare Part D benefit, CMS announced that 38 million people had signed up for the plan, which is approximately 90 percent of beneficiaries. In the next few days, however, two influential legislators, Sen. Charles Grassley (R-IA), Chairman of the Senate Finance Committee, and Rep. Nancy Johnson (R-CT), Chair of the House Ways and Means Health subcommittee, introduced bipartisan measures that would waive the 1-percent per month penalty for seniors who did not enroll by May 15.

This action followed Rep. Johnson’s hearings May 3 and 4 on the implementation of the Medicare prescription drug benefit. At the hearing, CMS Administrator Mark McClellan testified that not only was the Part D benefit saving people money, but that beneficiaries were enrolling at a rapid pace in light of the (then) impending May 15 deadline. Dr. McClellan also strongly refuted a study by the Government Accountability Office, which reported that information provided by CMS customer services representatives was accurate and complete only two-thirds of the time. Other witnesses included representatives from Medicare Today; WellCare Health Plans; the Medicare Rights Center and Rite Aid.

Legislation to waive the 1-percent penalty followed the introduction of bills authored by Sens. Max Baucus (D-MT) and Blanche Lincoln (D-AR) on April 27, which would create only six drug plans so that beneficiaries could compare their options more easily, and require pharmacies to be reimbursed more quickly.

During the same week, CMS announced that health plans would be required to continue to pay for drugs through the coverage year, even when a drug was removed from a plan’s formulary. In addition, on May 9, CMS announced it would not impose a penalty on low-income seniors who did not sign up for the benefit by the May 15 deadline.
Health Information Technology
On April 8, Dr. Chris Normile, a family physician from St. Charles, Missouri testified on behalf of the Academy before the House Small Business Subcommittee on Regulatory Reform and Oversight. The focus of the hearing was the practicality of implementing an electronic medical record system in small and medium sized practices. Dr. Normile specifically addressed the financial and time pressures that he experienced and might discourage small to medium-sized physician practices from implementing EHR systems. He concluded his testimony by asking Congress to put policies in place to ease those pressures.

The Certification Commission for Health Information Technology (CCHIT) launched the application for commercial certification of ambulatory EHR products on May 1. The voluntary certification process will confirm the EHRs that meet the goals of CCHIT, which are to reduce the risk of HIT investment by providers, ensure interoperability, enhance HIT adoption incentives from purchasers and payers, and protect the privacy of personal health information. Vendors will be required to demonstrate their products before a panel of judges.

The House Energy & Commerce Committee and the House Ways & Means Committee are expected to mark up the HIT bill in next week, with possible floor consideration expected during the House "Health Week" tentatively scheduled for the third week of June. Democratic committee members will push for additional privacy provisions, as well as some level of funding for physicians who purchase these systems. AAFP sent a letter to majority and minority leadership on both committees reiterating our support for certain components of the bill, while asking for funding and ensured patient privacy protections.

Medical Liability Reform
Over the April recess, AAFP Board members contacted AAFP key contacts or chapter executives to encourage them to meet with targeted Senators to discuss medical liability reform. In addition, AAFP was joined by the American College of Osteopathic Family Physicians in bringing a combined message to Congress about the importance of medical liability reform. The AAFP also sent out a Speak Out on this issue, which resulted in more than 7500 emails to Capitol Hill.

Senate "Health Week" was twice delayed and finally began May 8 with two Monday night votes on medical liability. The previous week, Senate leaders introduced the two bills, the Medical Care Access Protection Act (S. 22) and the Healthy Mothers and Healthy Babies Access to Care Act (S. 23). The comprehensive liability measure included the Texas "stacked cap" provision, which imposes a $250,000 cap on physician payments for non economic damages, (along with additional caps for hospitals and other institutions that might be involved in the litigation). The sponsors of the bill removed pharmaceutical and medical device protection that had been included in the House version. This did not appear to gain any additional support from reluctant Senators as this vote failed 48-42. The second bill was a limited bill with protections for physicians and health care providers who deliver obstetrical and gynecological services. It failed on a vote of 49 to 44.
The House is still expected to consider some medical liability measure during its "Health Week," possibly modeled on the Texas stacked cap.

**FamMedPAC**

FamMedPAC hosted a reception on Tuesday, May 9, the first night of the Family Medicine Congressional Conference. The reception featured a short talk by Rep. Pat Tiberi (R-OH), who talked about the outlook for healthcare in the current Congress and the prospects in the upcoming election.

The FamMedPAC Board Chair, Dr. Michael Fleming, encouraged FMCC attendees to contribute while they were in Washington. These efforts resulted in the PAC collecting almost $20,000 in contributions.

Dr. Michael Fleming also gave an update on PAC activities to the Commission on Governmental Advocacy. During the meeting, Commission Chair Dr. Roland Goertz challenged all members of his commission to make a contribution to the PAC. Dr. Goertz will challenge the members of each of the AAFP Commissions to make a contribution, with the goal of having 100 percent of Commission members making a contribution to the PAC this year.

FamMedPAC participated in two healthcare events this week.

Mark Cribben attended an event for Sen. Jon Kyl (R-AZ). Sen. Kyl serves on the healthcare subcommittee of the Senate Finance Committee. The AAFP was a cosponsor of the event. Sen. Kyl talked about the recent failed vote on medical liability reform whether it is a good idea to try and bring the bill back up for another vote. Sen. Kyl is leaning against that approach. He also talked about the need to address the Medicare physician fee schedule, but was not optimistic that a fix could be passed this year. He felt that a freeze in the payment rate was the best that could be hoped for. Dr. Jim Dearing will deliver the FamMedPAC contribution to Sen. Kyl in Arizona later this week.

Kevin Burke attended a healthcare event for Rep. Deborah Pryce (R-OH), who serves as Chair of the House Republican Conference. She reflected on the relief she and the other members of the GOP leadership felt at passing a budget in the House. She noted that the budget would not go to conference. Instead, it would provide the House appropriators with a means of controlling the Senate’s higher spending numbers. She was particularly pleased that the moderate Republicans found the means to add over $3 billion for the Labor/HHS appropriations.

She discussed health week, which is scheduled for the third week in June in the House. She noted that the leadership wanted to cover medical liability, HIT and any other “low-cost, high-interest” items that they could. They mentioned both NIH and CHC reauthorizations, so we suggested that family physicians had a strong interest in helping get translational research incorporated into the NIH bill and possibly adding Title VII Health Professions reauthorization to the CHC bill.
There was considerable discussion about the Medicare Part D experience. Rep. Pryce noted several times that CMS was so wholly concentrating on implementing the drug benefit, that many other functions were probably short changed. She thought that everyone who had signed up was extremely pleased with the benefit. She attributed the shortfall from 100 percent sign-up to Democratic demagoguery. She said she had a conversation with Sec. Leavitt who told her that some 6 million beneficiaries signed up even though they did not have prescription drug requirements at this time and that they would be angry if Congress reduced the penalty for those who didn’t sign up.

Several participants mentioned the physician payment issue, along with particular concerns with the CMS voluntary pay-for-performance program. We also briefly touched on medical liability as a continuing issue. The discussion of HIT concerned mostly the preservation of privacy.

STATE GOVERNMENT RELATIONS
May is the month when most states adjourn sine die. Only 14 states (AZ, CA, LA, MA, MI, MN, NC, NJ, OH, OK, RI, SC, TN) and the District of Columbia remain in session through May 19. We currently are tracking 1,396 pieces of legislation on behalf of constituent chapters and an additional 162 pieces of legislation on behalf of AAFP staff.

While chapters report that the 2006 sessions have been contentious, gains were made in the areas of scope and liability, as well as in a variety of Medicaid reform proposals taking shape for further legislative action in the coming year.

Health Care Coverage for All
Massachusetts - The MA-AFP’s priority was the passage of the Health Care Access Law. The aim of the legislation is to provide health insurance coverage to at least 90 percent of the state’s approximately 550,000 uninsured over the next three years through a variety of mechanisms. The MA-AFP was an active member of the Steering Committee of the ACT! Coalition comprised of physicians, hospitals, labor, and consumer groups. The MA-AFP priorities in the Health Care bill were affordability, comprehensive coverage, including mental health and substance abuse, and Medicaid rate increases for physicians. All were addressed in the final bill, although specifics will have to be worked out in regulations and budget appropriations. The measure specifically provides substantial Medicaid reimbursement increases for physicians, totaling approximately $180 million over three years. The MA-AFP will continue to monitor implementation of the law in the budget and regulations.

Scope of Practice
Georgia - The legislature completed its legislative year on Thursday, March 30. Because this was the end of a two-year session, any pending legislation is now dead and will have to be reintroduced in 2007. This includes the Anatomical Pathology legislation filed in 2005. The GA-AFP was successful in defeating scope expansion legislation for chiropractors and optometrist prescribing. Legislative successes included modified prescribing for nurse practitioners, which will have medical board oversight, and the ability of physician assistants to render assistance during state and public health emergencies.
Missouri – Despite a flurry of activity toward the end of the session on Friday, May 12, the MO-AFP was successful in defeating several scope challenges that included a geographic expansion for physician assistants between the collaborative physician and physician assistant, prescriptive authority for a variety of non-physician providers, pharmacists’ collaborative practice expansion, independent practice for certified (non-nurse) midwives, and the passage of a comprehensive insurance reform that will augment the medical liability reform passed last year.

New Jersey – The NJ-AFP is drafting legislation that would tighten up the existing APN-physician collaborative relationship – specifically geared toward APNs practicing off-site from the physician’s office location. Their collaborative requirements are minimal at this time – no written agreement and no on-site requirements. They will be requiring the following in their legislation:

- a physician may not collaborate with more than a specified number of APNs;
- an APN and the collaborating physician must be credentialed in the same health plans and hospitals;
- an APN working offsite from the collaborating physician may not locate a practice more than a certain number of miles from the physician practice location;
- an APN working offsite from the collaborating physician must post information about the collaborating physician for patients; and
- a physician must file information identifying a collaborative relationship with an APN with the Board of Medical Examiners, specifically identifying the practice locations, if different from the physicians.

Medicaid

Illinois - Governor Blagojevich’s initiative, All Kids Covered, passed the General Assembly during a veto session in November 2005. An estimated 250,000 children are uninsured and will qualify for health insurance coverage. Approximately 100,000 parents in Illinois who qualify for FamilyCare are still not enrolled. Starting July 1, 2006, all public medical program enrollees including those in KidCare, FamilyCare, All Kids, and Medicaid will be converted into Primary Care Case Management.

IAFP has been involved from the onset at all stakeholder meetings coordinated through the Department of Health and Family Services (Public Aid). The goal in participating included:

- passing along information disseminated by IDHFS to IAFP members,
- offering input from a family medicine perspective,
- analyzing and synthesizing the complexities of the program and its impact on family medicine, and
- voicing suggestions, concerns, reticence, and openness, as appropriate.

The IAFP leaders also are hoping that their role helps smooth the transition for both patients and providers as All Kids rolls out and gets implemented.

Medical Liability

Illinois - The Illinois Department of Financial and Professional Regulation (IDFPR), Division of Insurance, ordered ISMIE Mutual Insurance Company, Illinois’ largest medical malpractice insurance company, to make changes that will reduce the rates
paid by Illinois doctors and will disclose its rate structure. These changes will increase competition in the medical malpractice insurance market, resulting in lower malpractice premiums.

The medical malpractice reform legislation imposed a condition of openness on the rate filings of medical malpractice insurers, with the intention of fostering additional competition in Illinois, where ISMIE collects more than 65 percent of all written premiums from physicians and surgeons in the state. The agency’s order imposes on ISMIE the obligation to file rate-related information that conforms to industry standards, so that its rate filings are accessible and comprehensible for other companies. Medical malpractice reform legislation signed by Gov. Blagojevich (D) last summer also made it possible for Illinois, for the first time, to deny, adjust, or limit medical malpractice rates.

**Flu Vaccine**

*New Jersey* – The NJAFP, along with other medical specialty societies, has requested that the New Jersey Public Health Council within the state’s Department of Health and Senior Services, investigate and hold hearings on the distribution problems experienced by community physicians in New Jersey.

*New York* – The NYAFP is especially interested in addressing the supply and distribution of flu vaccine. As the chapter awaits developments regarding a possible pandemic or avian flu, its leaders believe the state must address the supply and distribution issues. The chapter will propose that the state purchase a supply of seasonal flu vaccine to meet the anticipated needs of their population and that it give physician practices the highest priority in distributing this supply of vaccine. They also believe the state should prepare to acquire a sufficient supply of avian flu vaccine when such a vaccine is developed and available, and assure that this vaccine is available to physician practices. The chapter is working with the Assembly and Senate Health Committees to develop legislation.