

## American Nephrology Nurses Association

Weekly Capitol Hill Update - Tuesday, October 11, 2016

### Congressional Schedule

#### House and Senate

- Not in session. The House will return on November 14th; the Senate will return on November 15th.

### Legislative Updates

- ***The Next Big Reform Challenge is Mental Health.*** “After decades of taking a back seat to other social issues, fixing the nation's broken system of care for millions of Americans suffering from mental illness and drug addiction has risen to the top of Congress' agenda. Lawmakers are poised to pass a sweeping package of mental healthcare reforms during the lame-duck session next month, following enactment in July of legislation to address the epidemic of opioid addiction. They and advocacy groups are optimistic the Senate will follow the House in approving bipartisan legislation to revamp the government's mental healthcare efforts and increase funding for prevention and treatment. The big question is whether Congress will have enough time during the 20 days of the lame-duck session following the November election to pass the legislation, given the need to approve a continuing budget resolution and potentially address tough issues such as the Trans-Pacific Partnership trade agreement and a revamp in the federal approval process for prescription drugs and medical devices. There's also the chance that partisan rancor after the election could derail cross-the-aisle cooperation.” (Modern Healthcare)
- ***Government Funding and Medical Research to Dominate Lame-Duck Session.*** “Last week, lawmakers raced to find a funding deal to avert a government shutdown, and they'll be back in a few weeks to do it all over again. Congress returns from the campaign trail on Nov. 14 for the so-called lame-duck session, which describes the period after the November election and before a new Congress takes effect in January. One of the few items likely to get done is funding the government through the 2017 fiscal year. Leaders say that recently arduous negotiations over extending the funding deadline to Dec. 9 do not foreshadow tough spending talks during the lame-duck.”
  - To read more: <http://www.rollcall.com/news/policy/government-funding-medical-research-dominate-lame-duck-session>

## Regulatory Updates

- **Medicare Payment Advisory Commission (MedPAC)**
  - On October 6-7th, MedPAC met and discussed Medicare accountable care organizations (ACOs), measures on hospital use for long-stay nursing facility residents, Part B drug payment policy issues, and biosimilars in Part D, among other issues.

### Status Report on Medicare ACOs

- MedPAC staff presented an update on the Medicare ACO 2016 program status and discussed 2015 program results. MedPAC staff noted that “according to the Centers for Medicare and Medicaid Services (CMS), Pioneer and MSSP [Medicare Shared Savings Program] ACOs scored high on quality measures, with an average of about 90%.” Not only was quality high, but it also improved over the last year. However, MedPAC staff indicated there is a weak relationship, if any, between quality and savings. Staff stated that in 2015, physician ACOs, small ACOs, and ACOs in the South all showed greater savings than other types of ACOs. Staff noted, however, that it is the historical service use in the market area which is the key determinant of ACO savings.

### Measures on Hospital Use for Long-Stay Nursing Facility Residents

- During the presentation portion, MedPAC staff reviewed their study of hospital use measures and rates of skilled nursing facility [SNF] (e.g., providing more specialized, comprehensive care, including physical or occupational therapy) use for long-stay nursing facility residents, specifically:
  1. **Potentially-avoidable hospital use**, which measures hospital admissions across 20 conditions that can be managed in a nursing facility and should be prevented from occurring with high-quality care.
  2. **All-cause emergency department and observation use**, which measures the extent to which beneficiaries are transferred to a hospital without an admission (Staff noted they didn’t expect ED and observation rates to be zero).
  3. **Rate of SNF days**, which measures the SNF days facility residents use (Higher rates may indicate either longer than average use of SNF benefit and more frequent use of the SNF benefit).
- For discussion, staff encouraged MedPAC Commissioners to determine whether they are interested in incorporating the measure(s) into the SNF quality program included for public reporting on Nursing Home Compare or if there is interest in incorporating a measure into the SNF Value-Based Purchasing Program.

### Medicare Part B Drug Payment Policy Issues

- MedPAC is interested in refining the current Part B payment policy options, outlined below, which will then be used to form the basis of the Commission’s recommendations to Congress and/or to the Secretary of Health and Human Services.

- *Options that seek to increase price competition and address Part B drug growth:*
  1. Consolidated billing codes: Group drugs with similar health effects in a common billing code and group biologics with similar health effects in a common billing code.
  2. Average sales price (ASP) inflation limit: Place a statutory limit on how much Medicare's ASP +6 payment can grow over time.
  3. Restructured competitive acquisition program (CAP): Give the Secretary the authority to restructure and implement an improved CAP.
- *Options that seek to improve the current payment formula and data:*
  1. Modify the ASP add-on formula (discussed in the June 2016 Report to Congress): In the June 2016 report, MedPAC modeled a hybrid option: 103.5% ASP + \$5 drug per day.
  2. Modify the payment formula for drugs paid wholesale acquisition cost (WAC) plus 6 percent: Require the Secretary of HHS to reduce payment rate for WAC-priced drugs by 2 percentage points (i.e., WAC + 4 percent).
  3. Strengthening manufacturer reporting requirements for ASP data: Require manufacturers report ASP data for all Part B drugs and give the Secretary authority to enforce the requirement.
- Staff asked the Commissioners to provide feedback on the policy options.

#### **Biosimilars in Medicare Part D**

- MedPAC staff provided Commissioners with a background on biologics and biosimilars, discussed recent use of and spending on biologics, and factors affecting the taking up of biosimilars. Such factors include patients and prescribers' perceptions about safety and effectiveness; for payers and patients, the issues are relative prices and out-of-pocket costs compared to reference biologics; and finally, a third factor is Part D law and regulations on biosimilars.
- Staff requested Commissioners discuss their level of interest in pursuing changes to the formulary rules around biosimilars as well as treatment of biosimilars in the coverage gap. While no concrete recommendations were discerned from this discussion, it is obvious the Commission is interested in further examining how biosimilars can be used to bring down Medicare Part D spending.
  - For more information, please visit: <http://medpac.gov/-public-meetings-/meeting-details/october-2016-public-meeting>
- ***CMS Dialysis Facility Compare Call.*** CMS will release the slides from last week's presentation on Dialysis Facility Compare in the coming weeks. During the presentation, CMS discussed updates to Dialysis Facility Compare and the Five Star methodology and measures.
  - To view the Dialysis Facility Compare website: <https://www.medicare.gov/dialysisfacilitycompare/>

- ***CMS Launches Web Resource on Provider Transition to Medicare Beneficiary Identifier.*** “CMS has launched a webpage to help health care providers prepare for the Medicare Beneficiary Identifier, which will replace the Health Insurance Claim Number on transactions such as billing, eligibility status and claim status by April 2019. The agency expects a transition period to begin no earlier than April 1, 2018 and run through Dec. 31, 2019, during which providers can use either the HICN or the MBI to exchange data with CMS. The Medicare Access and CHIP Reauthorization Act of 2015 requires CMS to remove Social Security Numbers from all Medicare cards by April 2019. The HICN is SSN-based.”

  - For more information: <http://news.aha.org/article/161003-cms-launches-web-resource-on-provider-transition-to-medicare-beneficiary-identifier>
  
- ***Can't Find a Plan on HealthCare.gov? One May Be Picked for You.*** “That's the assertion in a headline and story implying that the government will choose plans for hundreds of thousands of Obamacare shoppers, if their insurers have left the marketplace. ‘Consumers may be surprised to learn that they have been placed in a health plan offered by a different insurance company,’ Robert Pear writes.”

  - For more information: [http://www.nytimes.com/2016/10/09/us/politics/cant-find-a-plan-on-healthcaregov-one-may-be-picked-for-you.html?\\_r=1](http://www.nytimes.com/2016/10/09/us/politics/cant-find-a-plan-on-healthcaregov-one-may-be-picked-for-you.html?_r=1)
  
- ***ICD-10 One Year Later: The Drama is Over, The Rewards Yet to Materialize.*** “The Oct. 1, 2015 launch went smoothly compared with the warnings of technological meltdown and cash-flow Armageddon that provoked three delays totaling four years. Claims flows, measured by claims denial rates, returned to normal after a few months, according to the CMS and confirmed by industry experts. “This is the Y2K of coding,” said Dr. John Cuddeback, chief medical informatics officer of the American Medical Group Association. “I think people did a pretty good job of preparing.” But this month, physicians face a new ICD-10 challenge. Last year, the CMS granted physicians a one-year grace period, promising not to deny Medicare Part B claims for lack of specificity of ICD-10 coding. Many commercial payers similarly gave physicians “flexibility,” but that grace period ended Oct. 1. Earlier this year, the CMS and HHS released updates to the codes that contained what Sue Bowman, senior director of coding policy and compliance at the American Health Information Management Association, called “some hiccups in the hospital DRG system,” But, she added, “I think we're past most of that.” Experts say it's too early to tell whether the switch to more stringent coding requirements will snag docs' claims. “We're keeping our ears open to see if that has had any impact on claims,” said Robert Tennant, director of health information policy for the Medical Group Management Association, a trade association for managers of physician office-based practices. But the promise of ICD-10 involved more than a revenue-cycle upgrade. The new codes were touted as essential paving stones on the road to value-based purchasing, leading to improvements in healthcare data analytics, population health management, care quality and lower costs. Those benefits have yet to materialize. “I don't expect to see anything along those lines until another year or two,” said Rhonda Buckholtz, a 25-year health IT veteran and vice president of strategic development at the American Association of Professional Coders, which represents the workers who ensure healthcare claims are affixed with the appropriate ICD-10 codes.” (Modern Healthcare)

### Articles of Interest

- ***How Florida NPs Are Meeting the IOM's Goals.*** “Florida legislators made important strides in moving the nursing profession forward during the first 2016 legislative session, passing bills that will help us implement the recommendations outlined in the landmark report issued by the Institute of Medicine (IOM): *The Future of Nursing: Leading Change, Advancing Health*. This report, which was published in 2010, set a course for advancing the role of nurses across the United States. Passage of the Nurse Licensure Compact and the Advanced Registered Nurse Practitioner (ARNP) prescribing legislation, re-named the Barbara Lumpkin Prescribing Act in honor of longtime Florida Nurses Association (FNA) lobbyist Barbara Lumpkin, marks more than two decades of committed effort coming to fruition. The passage of ARNP makes Florida the 50th state to allow its nurse practitioners to prescribe controlled substances.”
  - To read the article: <http://nurse-practitioners-and-physician-assistants.advanceweb.com/Features/Articles/How-Florida-NPs-Are-Meeting-the-IOMs-Goals.aspx>
- ***VA Nurse Proposal Lobbying Fight Plays Out in Comments.*** “A controversial proposal could boost the role of advance practice registered nurses in the Veterans Health Administration in 29 states and has garnered record-setting public input – 174,411 responses during the open comment period – with interest groups trying to sway the Department of Veterans Affairs (VA) with the sheer volume of comments. The American Association of Nurse Practitioners touts that at least 60,000 comments came from proponents of the rule, which would give advance practice registered nurses who work for the department's healthcare division the ability manage a patient's care without the supervision of a physician. The 174,411 comments are nearly double the previous record of 92,377 public comments on a rule proposal by the U.S. Copyright Office. The proposal is the latest effort to increase the number of healthcare professionals able to take on patients. As of Sept. 15, more than 500,000 veterans were waiting more than 30 days for care, according to the most recent VA data.”
  - For the full article, please see the following link: <http://origin-ny1.thehill.com/policy/healthcare/299054-va-nurse-proposal-lobbying-fight-plays-out-in-comments>
- ***At 18 years old, he donated a kidney. Now, he regrets it.*** “When I was 18, my stepfather's brother had been on dialysis for just over a year. He was thin, he exercised regularly and he seemingly was in perfect health, but inexplicably his kidneys began to fail him. Although I was just about to leave for college, I'd heard enough about the misery of dialysis to decide to get tested as a possible donor. In the back of my mind, I knew that the chances of our compatibility were incredibly low because we were not related by blood. Perhaps that made it easy for me to decide to get tested. When we received the results, I was stunned to find out that he and I were a match. The transplant team gave me plenty of opportunities to back out of the donation, and it put me through countless evaluations, physical and psychological. Much of my family was steadfast against my becoming a donor. Looking back, who could blame them? Their son-grandson-nephew was going to undergo a major operation with no benefit to himself. However, I continued to be confident in my choice. I relied on the one fact that would be

repeated to me many times: “The rate of kidney failure in kidney donors is the same as the general population.” Why wouldn’t everyone donate a kidney, I wondered.”

- For the full article, please see the following link:

[https://www.washingtonpost.com/national/health-science/at-18-years-old-he-donated-a-kidney-now-he-regrets-it/2016/09/30/cc9407d8-5ff9-11e6-8e45-477372e89d78\\_story.html?tid=pm\\_pop\\_b](https://www.washingtonpost.com/national/health-science/at-18-years-old-he-donated-a-kidney-now-he-regrets-it/2016/09/30/cc9407d8-5ff9-11e6-8e45-477372e89d78_story.html?tid=pm_pop_b)