

Government RELATIONS REPORT 108th Congress

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I. Medical Liability Reform

Medical liability reform remains the top legislative priority for the American Osteopathic Association (AOA). The AOA continues to advocate for comprehensive reforms that include the six principles ratified by the AOA House of Delegates. These reforms demonstrate the ability, if enacted together, to reduce the frequency and severity of medical liability claims.

The AOA's six principles are:

1. Limitations on non-economic damages
2. Collateral source reform
3. Joint and several liability reform
4. Uniform statute of limitations
5. Limitations on attorney contingency fees
6. Periodic payment of damages

In July 2004, the AOA House of Delegates authorized the Council on Federal Health Programs ("Council") to evaluate the impact of other medical liability reform proposals and their potential impact upon the crisis. These include binding arbitration, pre-litigation panels, and insurance reforms.

Prior to the 108th Congress, the Council developed a comprehensive lobbying and grassroots advocacy strategy aimed at enacting medical liability reform legislation and increasing awareness among osteopathic physicians, Members of Congress, and the general public. This included the development of the Every Patient Counts web site and improvements to the D.O. Advocacy Action Center. Additionally, the use of print advertisements in Washington and across the country was increased substantially to increase awareness and promote reform. We continue to participate with other physician organizations in coalitions such as the Healthcare Coalition on Liability and Access (HCLA), informal lobbying workgroups, as well as House and Senate "kitchen cabinet" workgroups on medical liability reform.

Significant progress was made during the 108th Congress. The issue emerged as one of the top domestic agenda items in the 2004 Presidential race and received significant attention from both Chambers of Congress. Additionally, it is important to note that the issue garnered the largest support in terms of total votes it has ever received in the House and in the Senate—even though it failed to secure enough votes to override a procedural motion in that body.

The AOA will continue to express concern about legislative proposals that fail to incorporate our core principles; proposals that offer studies and demonstrations versus change in Federal law, and other proposals that include provisions unfavorable to physicians.

U.S. House of Representatives

The House approved AOA-supported medical liability reform legislation on two occasions during the 108th Congress. Additionally, it approved legislation aimed at reforming Federal laws governing the filing of frivolous lawsuits.

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- March 13, 2003—Approved the “Help, Efficient, Accessible, Low-Cost, Timely, Health Care Act of 2003 (HEALTH Act) (H.R. 5). H.R. 5 is a comprehensive medical liability reform proposal that contains the six medical liability reform principles adopted by the AOA. It provides coverage to all physicians regardless of specialty.
- May 12, 2004—Approved an updated version of the “Help, Efficient, Accessible, Low-Cost, Timely, Health Care Act of 2004 (HEALTH Act) (H.R. 4280). H.R. 4280 is a comprehensive medical liability reform proposal that contains the six medical liability reform principles adopted by the AOA. It provides coverage to all physicians regardless of specialty.
- September 14, 2004—Approved the “Lawsuit Abuse Reduction Act of 2004” (H.R. 4571). H.R. 4571 amends Rule 11 of the Federal Rules of Civil Procedure. The bill requires *mandatory* sanctions for parties who bring meritless lawsuits in federal court. Any parties who bring three or more such lawsuits in the same federal court would face additional sanctions. Furthermore, the bill removes a provision currently in Rule 11 that allows an attorney to avoid sanctions by withdrawing the suit within twenty-one days.

United States Senate

The Senate attempted to consider medical liability reform legislation on three occasions during the 108th Congress. In each attempt the Republican leadership was unable to secure the 60 votes needed to invoke cloture. Due to Senate rules, if a unanimous consent agreement is not reached, 60 votes are needed to debate and vote on a piece of legislation.

- July 9, 2003—Attempted to consider the “Patients First Act of 2003” (S. 11), but failed to approve a motion granting the Senate the ability to debate and vote on the legislation. S. 11 is a comprehensive medical liability reform proposal that contains the six medical liability reform principles adopted by the AOA. It provides coverage to all physicians regardless of specialty. The motion to proceed failed.
- February 24, 2004—Attempted to consider the “Healthy Mothers Healthy Babies Access to Care Act” (S. 2061). S. 2061 contains the six medical liability reform principles adopted by the AOA, but limits applicability to physicians and other health care providers providing obstetrical and gynecological services only. The motion to proceed failed.
- April 7, 2004—Attempted to consider the “Pregnancy and Trauma Care Access Protection Act of 2004” (S. 2207). S. 2207 contains the six medical liability reform principles adopted by the AOA, but limits applicability to health care services provided in an emergency or trauma situation and obstetrical/gynecological related services. The motion to proceed failed.

II. Medicare Reform and Prescription Drug Benefit

On December 8, 2003 President Bush signed into law the bipartisan “Medicare Prescription Drug, Improvement, and Modernization Act of 2003” (P.L. 108-173). The enactment of this historic legislation capped a 5-year lobbying and grassroots effort by the AOA. Public Law 108-173 includes numerous

provisions that benefit osteopathic physicians and the patients they serve. Additionally, it marks the largest expansion of the Medicare program since its enactment in 1965.

The AOA did not take a formal position on provisions relating to the establishment and implementation of the prescription drug program authorized by Title I of the MMA. While we acknowledged that the establishment of a drug benefit was in the best interests of beneficiaries, we did not feel we possessed the knowledge or expertise to comment on the structure of this new program. The following is a summary of key provisions included in the MMA for which the AOA advocated.

a. Physician Payment Update

Provided a two-year fix for the Medicare physician payment update. Physicians will receive at least a 1.5 percent increase in reimbursements for 2004 and 2005. Additionally, the law modifies the use of the gross domestic product (GDP) in the payment formula from an annual factor to a ten-year rolling average. This provision is designed to reduce the economic volatility of the payment formula.

b. Rural Physician Payment

Reformed the work geographical practice cost indices (GPCI) to establish a 1.0 floor for all providers in all geographic locations for the years 2004-2006. The law also includes provisions establishing a 5 percent add-on for physicians in “scarcity” areas for 2005-2007. The GAO will study both provisions to determine the costs and whether or not they lead to an increase in the number of physicians practicing in rural areas.

c. Graduate Medical Education

Establishes a redistribution process for funded-unfilled residency slots. Rural, small urban hospitals and hospitals with the only specialty program in a state will receive priority in applying for these positions. The Indirect Medical Education (IME) percentage was modified for the next 4 years. The IME percentage for 2004 will be 6.0, falling to 5.8 in 2005, 5.55 in 2006, and 5.35 in 2007.

Additionally the law provides a 12-month moratorium on CMS regulations disallowing the utilization of volunteer faculty in graduate medical education (see Graduate Medical Education). This provision was strongly supported by the AOA.

d. Regulatory and Contractor Reform

Contained AOA-supported Medicare regulatory and contractor reforms. These reforms are designed to decrease the regulatory burden placed upon physicians participating in the Medicare program. The provisions help accomplish the AOA’s goal of changing the environment at the Centers for Medicare and Medicaid Services (CMS) from one of blame to one of cooperation and assistance.

e. International Classification of Disease-10

All provisions relating to the implementation of the ICD-10 PCS and CM were removed. Physicians continue utilizing the current procedural terminology (CPT) coding system.

f. Electronic Prescribing

Requires the Secretary of Health and Human Services to develop electronic prescription standards. The standards are to provide for the electronic transmittal of information on eligibility and benefits, information on the drug being prescribed, other drugs listed in the patient's medical history, and information on the availability of lower-cost, therapeutically appropriate alternatives. The initial standards are to be promulgated by September 1, 2005, with a one-year pilot program beginning January 1, 2006. Final uniform standards are to be promulgated by the Secretary no later than April 1, 2008.

In addition, the Act authorizes the Secretary to make grants available to physicians to facilitate implementation of electronic prescription drug programs. The grants are slated to be available from 2007 through 2009.

g. Prescription Drug Benefit

For the first time since the inception of the Medicare program, beneficiaries have access to prescription drugs dispensed on an outpatient basis through the use of a prescription drug discount card program. The card is offered through sponsors whose programs have been reviewed and approved by the Secretary. Annual enrollee fees cannot exceed \$30 per enrollee. The program expires when the Medicare beneficiary begins to receive the new Part D benefits.

In 2006, the Part D standard benefit will include a \$250 deductible, 75 percent coverage up to \$2,250, and \$3,600 out-of-pocket catastrophic coverage limit (\$5,100 total spending). In addition, it is estimated that the monthly premium will be approximately \$35. Premium and cost-sharing subsidies will be available for eligible low-income beneficiaries.

h. Average Wholesale Pricing (AWP)

Established a new funding formula for certain pharmaceutical treatments covered under the Medicare program. Beginning in 2004, reimbursements will be AWP minus 15 percent. The Secretary is authorized to increase or decrease reimbursement based on market surveys. Beginning in 2005, the formula will be based upon the average sales price (ASP) plus an additional percentage versus the AWP. Competitive bidding begins in 2006.

i. Specialty Hospitals

Included an 18-month moratorium on the construction of "new" specialty hospitals. "New" hospitals do not include existing hospitals or those under construction. Existing hospitals can add up to the greater of 5 beds or 50 percent of the beds on their current campus. During the moratorium period, MedPAC must conduct an analysis of the costs of the specialty hospitals and whether the payment system should be refined.

j. Non-Physician Providers

Included a chiropractic demonstration project, a study of physical therapy services, and other provisions related to non-physician providers.

House of Representatives

The House of Representatives approved the Conference Report for the “Medicare Prescription Drug, Improvement, and Modernization Act of 2003” (H.R. 1) on November 22, 2003.

United States Senate

The Senate approved the Conference Report for the “Medicare Prescription Drug, Improvement, and Modernization Act of 2003” (H.R. 1) on November 25, 2003.

On November 24th the Senate approved two key procedural motions that cleared the way for consideration of the bill and ultimately final passage. The Senate approved a motion to invoke cloture and a motion to waive budget points of order against the bill.

III. Patient Safety

The AOA worked during the 108th Congress to secure enactment of patient safety legislation. For the first time, both Chambers of Congress approved legislation, representing a significant step toward achievement of this goal. The legislation passed by the House and the Senate would take important steps toward the establishment of a non-punitive environment in which information can be shared and analyzed to improve the health care available to patients. In light of the litigious society in which physicians currently practice, it is essential to develop legislation that promotes the sharing of information and advancement of practicing medicine without creating additional avenues for lawsuits.

House of Representatives

On March 12, 2003, the House of Representatives approved the AOA-supported “Patient Safety and Quality Improvement Act of 2003” (H.R. 663). H.R. 663, introduced by Rep. Michael Bilirakis (R-FL), establishes a national network of data banks to collect confidential information about adverse medical events from physicians, nurses, hospitals, nursing homes and other health care providers. The reporting of adverse events to HHS-certified Patient Safety Organizations (PSOs) would be anonymous and voluntary.

United States Senate

On July 22, 2004 the Senate approved the AOA-supported “Patient Safety and Quality Improvement Act of 2003” (H.R. 663). Although the Senate considered the House-approved bill, prior to final approval, the language of H.R. 663 was struck and replaced with amended language of the Senate companion bill S. 720 introduced by Sens. Frist (R-TN) and Jeffords (I-VT). A conference to reconcile the differences between the two bills was not held.

IV. Graduate Medical Education**a. Utilization of Volunteer Faculty**

The AOA continues to pursue legislative remedies to regulatory actions taken by the Centers for Medicare and Medicaid Services (CMS) in regard to the utilization of volunteer faculty in graduate medical education. The AOA is reviewing legislative options to force CMS to reverse policies established in the final Fiscal-Year 2005 Hospital Inpatient Prospective Payment System rule.

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The Medicare Prescription Drug Modernization and Improvement Act (MMA) (Public Law 108-173) included a provision (Sec 713) which specifies that for one year beginning on January 1, 2004, CMS will not be allowed to continue the practice of disallowing volunteer faculty for selected programs. As a result, hospitals will be allowed to continue to count residents in family medicine residency programs in existence as of January 1, 2002, who are training in non-hospital sites without regard to the financial arrangement between the hospital and the supervisory physician.

Section 713 also requires the Inspector General to conduct a study on the appropriateness of “alternative payment methodologies” for the costs of training residents in non-hospital settings and issue a report with any potential recommendations to Congress no later than one year after the law’s enactment. The report is due on or before December 8, 2004.

U.S. House of Representatives

On July 30, 2004 117 Members of the U.S. House of Representatives sent a letter to Mark McClellan, M.D., Ph.D., Administrator of the Centers for Medicare and Medicaid Services (CMS) urging administrative action on this issue. The letter was authored and circulated by Reps. Kenny Hulshof (R-MO), Earl Pomeroy (D-ND), Greg Walden (R-OR), and John Tanner (D-TN).

United States Senate

On October 13, 2004 57 Senators sent a letter to the Chairman and Ranking Members of the Senate Appropriations Committee and Senate Leadership urging them to include provisions in a 2005 appropriations bill that would extend and expand the moratorium established under Section 713 of the MMA. Sens. Susan Collins (R-ME) and Richard Durbin (D-IL) authored the letter.

b. Redistribution of Residency Slots

The MMA included provisions that established a redistribution process for funded-unfilled residency slots. As of July 1, 2005, hospitals will have seventy-five percent of their funded unfilled residency slots captured by the Federal government. These slots then will be redistributed, with rural, small urban hospitals, and hospitals with the only specialty program in a state receiving priority. For purposes of determining whether a hospital has the only specialty program in the state, osteopathic and allopathic programs will be considered separately. Proposed new residency programs in any specialty, that can demonstrate they are the only program in that specialty within the state, also are eligible for funding.

c. Graduate Medical Education Funding

The MMA included provisions to stabilize indirect medical education (IME) funding over the next four years. The IME percentage for 2004 will be 6.0, falling to 5.8 in 2005, 5.55 in 2006, and 5.35 in 2007.

United States Senate

Sens. Kay Bailey Hutchison (R-TX) and Evan Bayh (D-IN) introduced the “American Hospital Preservation Act of 2004” (S. 2876). The bill would make permanent the IME percentage at 6 percent.

V. Access to Health Care and the Uninsured
a. Health Savings Accounts

The “Health Savings Account Availability Act of 2003” (H.R. 2351), introduced by Ways and Means Chairman William Thomas (R-CA) was included in the Medicare Modernization Act (P.L. 108-173). P.L. 108-173 creates personal savings accounts, called Health Savings Accounts (HSAs), to help individuals and families save for qualified health care and medical expenses.

b. Additional Efforts to Address the Rolls of the Uninsured
House of Representatives

Energy and Commerce Health Subcommittee Chairman Michael Bilirakis (R-FL) introduced the “Health Insurance Certificate Act of 2003” (H.R. 2698). H.R. 2698 would establish a program for the issuance of health insurance certificates for the purchase of health insurance coverage for qualified individuals. The Subcommittee held a hearing on July 17, 2003. No further action has been taken.

On June 19, 2003, the House approved the “Small Business Health Fairness Act of 2003” (H.R. 660). This legislation would create national Association Health Plans (AHPs). AHPs currently are permitted, but only on a state-by-state basis. As a result, they are subject to state regulations. The AHPs created under H.R. 660 would allow small businesses to join together to form purchasing pools and would give small businesses the same leverage that large companies and unions have in purchasing health coverage through increased competition and options. The Senate has not consider this or similar legislation.

On May 12, 2004, the House approved H.R. 4279 as part of the “Help Efficient, Accessible, Low-cost, Timely Health Care (HEALTH) Act of 2004” (H.R. 4280). This legislation would allow patients to roll over up to \$500 of unspent flexible spending arrangements (FSAs) into a Health Savings Account (HSA).

United States Senate

Senator Bill Frist (R-TN), in an effort to find ways to decrease the number of the uninsured, appointed Sen. Judd Gregg (R-NH), Chairman of the Senate Committee on Health, Education, Labor and Pensions (HELP), to head a task force focused on the issue of health care accessibility and affordability. The U.S. Senate Republican Task Force on Health Care Costs and the Uninsured put forth proposals to lower the cost of health coverage, increase coverage, and to strengthen the safety net system. The task force recommendations reflect proposals promoted by the Administration and the Republican Party in both the House of Representatives and the U.S. Senate through this session of Congress.

VI. Prescription Drug Issues**a. Access to Generic Drugs**

The “Medicare Prescription Drug, Improvement, and Modernization Act” (P.L. 108-173) ended existing loopholes in the Hatch-Waxman law by making changes to the 30-month stay and 180-day market exclusivity provisions. Under the law, new drug applicants will receive only one 30-month stay per product for patents submitted prior to the filing of a generic drug application. In addition, rules relating to a generic company’s 180-day market exclusivity are modified. Specifically, multiple companies may qualify for the 180-day exclusivity if they all file their applications on the first day of eligibility. Additionally, provisions are included relating to declaratory judgments, designed to accelerate generic company’s ability to enter the marketplace.

b. Importation—Reimportation

P.L. 108-173 allows for the importation of drugs from Canada only with safety certifications. In addition, the Secretary is required to study the major safety and trade issues regarding importation. It appears unlikely at this point that the Secretary will take the necessary steps to allow for the *legal* importation of prescription drugs.

House of Representatives

On July 25, 2003 the House approved the “Pharmaceutical Market Access Act of 2003” (H.R. 2427). H.R. 2427, sponsored by Rep. Gil Gutknecht (R-MN), allows for the reimportation of prescription drugs from Canada and other nations without the benefit of FDA oversight and safety protections.

On July 13, 2004, the House approved the “Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations Act, 2005” (H.R. 4766). H.R. 4766, as approved by the House, contains language that would prohibit the Food and Drug Administration (FDA) from utilizing appropriated funds to enforce the current ban on prescription drug importation. It does not appear that this language will be included in any final appropriations instrument.

United States Senate

The Senate Budget Resolution (S.Con.Res 95) contained language that would increase revenues by \$300 million over five years for savings associated with drug importation. The resolution is non-binding. The language appeared in S.Con.Res. 95 as a result of an amendment offered by Sen. Debbie Stabenow (D-MI) during committee markup of the resolution. The language will not result in imported prescription drugs.

Australian Free Trade Agreement

On August 3, 2004 President Bush signed into law the “United States-Australia Free Trade Agreement Implementation Act” (H.R. 4759 (P.L. 108-286). Australia ratified the agreement on August 13, 2004. The trade agreement bans the importation of prescription drugs from Australia.

c. Dietary Supplements

Both the House of Representatives and the Senate conducted hearings on the use and availability of dietary supplements. The AOA sent several letters urging reform of the “Dietary Supplement Health and Education Act (DSHEA) of 1994” (Public Law 103-417). The issue has garnered a great deal of attention and will remain an issue of importance in the 109th Congress.

House of Representatives

The House Energy and Commerce Oversight and Investigations Committee held a hearing to examine the safety risks to children associated with dietary supplements.

United States Senate

The Senate Government Reform Committee held an oversight hearing to examine dietary supplements and the effectiveness of the “Dietary Supplement Safety Act.” In addition to the hearings, Sen. Richard Durbin (D-IL) prepared an amendment to the Defense Appropriations bill for 2005 to regulate dietary supplements sold at military installations. The amendment was never offered.

d. Noninterference

P.L. 108-173 contains explicit language prohibiting the federal government from negotiating drug prices with the pharmaceutical manufacturers under the Medicare program. To address this matter, Sens. Tom Daschle (D-SD) and Russ Feingold (D-WI) introduced the “Efficiency in Government Health Care Spending Act” (S. 1994). This legislation would amend the Social Security Act to remove the prohibition on price negotiations. Rep. Peter Deutsch (D-FL) and Chet Edwards (D-TX) introduced similar legislation in the House—H.R. 3671 and H.R. 3672 respectively.

e. Steroids

The AOA is concerned about the quality, safety, and efficacy of dietary supplement products as well as their readily available nature. Since many of these products contain anabolic steroid-like ingredients, or have the potential to be converted into testosterone or other anabolic steroids, the AOA supported legislation to ban over-the-counter sales of these products.

House of Representatives

On June 2, 2004 the House approved the “Anabolic Steroid Control Act of 2004” (H.R. 3866). It differs from S. 2195 in that it increases penalties available to those who are convicted of trafficking anabolic steroids near sports facilities.

On October 8, 2004 the House approved the “Anabolic Steroid Control Act of 2004” (S. 2195). This President is expected to sign this legislation into law.

United States Senate

On October 6, 2004 the Senate approved the “Anabolic Steroid Control Act of 2004” (S. 2195). The bill would prohibit the sale of a number of performance-enhancing substances.

f. Prescription Drug Monitoring

On October 5, 2004 the House approved the “National All Schedules Prescription Electronic Reporting Act of 2003” (H.R. 3015). H.R. 3015 would promote the development of state monitoring systems for Schedule II, III, and IV narcotics. The information gathered through the state programs would be accessible for the purposes of investigation and/or research.

g. Pediatric Research

On December 3, 2003 the President signed the “Pediatric Research Equity Act of 2003” (P.L. 108-155). The new law authorizes the FDA to require certain research into drugs used for pediatric patients. Additionally, it codifies the ability of the FDA to require testing and addresses an earlier court ruling stating that the FDA does not have the statutory authority to require pediatric testing.

VII. Appropriations and Budget

The AOA continues to advocate for funding of programs that benefit the osteopathic profession, medical research, and the health care delivery workforce. Ensuring continued funding of Title VII health professions programs remains the AOA’s top appropriation priority. Other priorities are strengthening the National Health Service Corps, improving rural health programs, ensuring that Federal student loan issues are addressed, and maintaining medical research funding at the National Institutes of Health.

1st Session

Congress adjourned the first session on December 8, 2003 without completing work on 7 of the 13 FY 2004 spending bills. Prior to adjournment, the House adopted the conference report on the FY 2004 omnibus spending bill (H. Rept. 108-401 — H.R. 2673). The Senate did not take action on the report before adjourning. Congress adopted and President Bush signed, a continuing resolution (PL 108-185) that funded the Federal government through January 31, 2004.

2nd Session

Congress started the second session by completing FY 2004 appropriations four months after the fiscal year started on October 1, 2003. President Bush signed the \$820 billion spending measure into law (P.L. 108-199) on January 23, 2004.

FISCAL YEAR 2005: On September 9, 2004 the House approved its FY 2005 Labor-HHS-Education Appropriations bill (H.R. 5006) by a vote of 388-13.

The Senate Appropriations Committee unanimously approved its draft FY 05 Labor-HHS-Education bill on September 15, 2004, but it has not been considered by the full Senate. The Senate bill provides \$142.3 billion in discretionary spending, a \$3.1 billion increase from FY 04 levels and \$267 million above President Bush’s request. The Senate bill is slightly less than the \$142.5 billion House version.

On September 29, 2004 Congress approved a continuing resolution (CR) to fund government operations through November 20, 2004. The continuing resolution (H. J. Res. 107) provides funding at FY 2004 levels for all programs that were set to expire on September 30, 2004, which was the last day of fiscal year 2004. President signed the CR into law (PL 109-309) on September 30, 2004.

When Congress returns from adjournment November 16, 2004, appropriators are expected to prepare an omnibus FY 2005 spending bill for submission to President Bush.

VIII. Research

a. National Institutes of Health (NIH) Funding

In 2003, Congress fulfilled its commitment to double the NIH budget. Given the current fiscal climate, it is unlikely that Congress will be able to come close to the 15 percent increases that occurred between 1998 and 2003. It remains to be seen what effect the smaller increases will have on the NIH's ability to conduct and fund medical research at current levels. The AOA is a member of the Association of American Medical Colleges (AAMC) Ad Hoc Group for Medical Research Funding and supported its request for a 10 percent increase for the National Institutes of Health (NIH) for 2005. A single digit increase for FY2005 is a sure bet.

b. National Institutes of Health Roadmap for Medical Research

NIH Director Elias Zerhouni, M.D., in consultation with health care professionals and the public, developed an NIH Roadmap to speed the transition of medical research from the bench to the bedside. The Roadmap is comprised of three broad themes that are meant to involve the NIH as a whole: New Pathways to Discovery that would advance the understanding of biological systems; Research Teams of the Future that would explore new organizational models for team science; and Re-engineering the Clinical Research Enterprise that would recast the entire system of clinical research.

Some elements of the Roadmap are already under way. The project is expected to take about ten years and is dependent, to an extent, upon budget considerations and emerging needs.

c. National Institutes of Health Conflicts of Interest

The NIH increasingly was criticized by Congress during the 108th Congress over consulting contracts that a number of NIH scientists have with pharmaceutical and biotechnology companies. In May 2004, the NIH Blue Ribbon Panel on Conflicts of Interest presented its final report to NIH Director Elias Zerhouni, M.D. The report contained eighteen recommendations to address conflict of interest concerns and consulting payments that were previously undisclosed.

The House Energy and Commerce Committee Subcommittee on Oversight and Investigations held a hearing on the issue at which several lawmakers concluded that the recommendations fell short of what was needed to address the problems. Dr. Zerhouni stated that he had already implemented several policy changes, but conceded that there should be tighter rules and more transparency.

He cautioned against banning all paid outside consultancies because of the possible deleterious effect it would have on NIH's ability to recruit and retain outstanding scientists. However, bowing to significant pressure, he instituted a one-year moratorium prohibiting all

NIH staff from entering into consulting agreements with pharmaceutical and biotechnology companies. The moratorium will give him time to complete a new framework for outside activities.

IX. Medicaid

Medicaid is the largest of the joint federal/state entitlement programs. Currently, Medicaid provides long-term care for the chronically ill, disabled, and aged; comprehensive health insurance for low-income families and children; and assists hospitals with the costs accrued by providing uncompensated care. In light of state budgetary constraints and the growing cost of the Medicaid program, discussion has begun to examine approaches to reform the program.

House of Representatives

In an effort to advance Medicaid reform, Rep. Billy Tauzin (R-LA) created a Congressional Medicaid Task Force to look at strategies to reform the Medicaid program. The Task Force is comprised of Reps. Heather Wilson (R-NM), Nathan Deal (R-GA), Ed Whitfield (R-KY), and Mary Bono (R-CA). In addition, several hearings were held to explore efforts to rein in total Medicaid spending by focusing on inter-governmental transfers (IGTs), upper payment limits (UPLs), and other cost-shifting mechanisms. Unsuccessful efforts were made throughout the appropriations process to reduce federal Medicaid expenditures.

United States Senate

On May 6, 2004 the Senate approved the “Family Opportunity Act of 2004” (S. 622). The legislation would allow families with disabled children to purchase coverage for the children under the Medicaid program. P.L. 108-173 contains several provisions related to the Medicaid program. Most importantly, the law temporarily increases states’ disproportionate share hospital (DSH) allotments, raises the floor on DSH allotments for “extremely low DSH states”, and provides funding for federal reimbursement of emergency health services furnished to undocumented aliens.

As a result of the Medicaid program’s status as the second most expensive domestic program, falling behind only Social Security, Congress will be forced to address the skyrocketing costs and continue exploring options to reduce Medicaid spending during the 109th Congress. The fundamental differences in approaches to control costs will foster prolonged debate.

X. State Children’s Health Insurance Program (SCHIP)

SCHIP is a block-grant program established by the “Balanced Budget Act of 1997.” The program provides matching grants to the states to cover low-income children ineligible for Medicaid. Although the program is scheduled to expire in 2007, Congress is likely to take up SCHIP renewal in the 109th Congress. Several Congressional committees used the 108th Congress to hold hearings, gather data, and begin drafting reform legislation.

On August 15, 2003, President Bush signed Public Law 108-78. This law returned to the states \$1.2 billion in unspent funds from fiscal years 1998 and 1999 and \$1.5 billion in unused funds from FY 2000 and 2001.

The issue of expiring, unspent funds reappeared in 2004. Funds totaling \$1.1 billion were returned to the Treasury on September 30, 2004. As in previous years, legislation was proposed to redistribute the unused funds, but no action has been taken. Instead, the Administration took administrative action to return \$660 million in unused money from FY 2002 to the states.

House of Representatives

- June 2003—the House approved H.R. 531, which aimed to restore \$2.7 billion in expiring SCHIP funds. Congressional action was required to return unused funds from FY 1998, 1999, 2000 and 2001 that reverted to the Treasury on September 30, 2002.
- July 2003—the House approved H.R. 2854 to extend unspent State Children’s Health Insurance Program (SCHIP) funding.
- Reps. Joe Barton (R-TX) and John Dingell (D-MI) introduced H.R. 4936. The bill would redistribute funds to states that exhausted their allotment, nullifying the expiration of funds scheduled for September 30, 2004.

United States Senate

- July 2003—the Senate approved H.R. 2854 to extend unspent State Children’s Health Insurance Program (SCHIP) funding.
- June 2003—the Senate approved S. 312, which aimed to restore \$2.7 billion in expiring SCHIP funds. Congressional action was required in order to return unused funds from FY 1998, 1999, 2000 and 2001 that reverted to the Treasury on September 30, 2002.
- Senate Finance Committee Chairman Charles Grassley (R-IA), along with Sens. Lincoln Chafee (R-RI) and John Rockefeller (D-WV) introduced S.2759. The bill would redistribute funds to states that exhausted their allotment, nullifying the expiration of funds scheduled for September 30, 2004.

XI. Non-Physician Providers

The expansion of scope for non-physician providers is a major concern to the AOA. In each Congress there are numerous attempts by groups to expand their scope of practice or alter reimbursement formulas for non-physicians providers. The 108th Congress was somewhat less active than other Congresses due to the inclusion of two major studies in the MMA. One study is to examine the utilization and cost effectiveness of chiropractic care in the Medicare program. The other is to examine the benefit of allowing direct access to physical therapists. Both studies are due to Congress in 2005.

The major legislative thrust centered on reversing a Veterans Administration directive that allows optometrists to perform laser surgery in VA health care facilities. On July 29, 2004, the Veterans Health Administration issued Directive 2004-039, “Therapeutic Laser Eye Procedures.”



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To enhance our efforts, the AOA joined the VETS Coalition. This coalition, headed by the American Academy of Ophthalmology, consists of physician and veteran organizations. Philip Shettle, D.O., AOA President-Elect serves as the principal liaison to the coalition.

House of Representatives

Rep. John Sullivan (R-OK) introduced the "Veterans Eye Treatment Safety Act" (H.R. 3473). H.R. 3473 secured 74 cosponsors, but was not considered by any Committee or the full House. The legislation would prohibit the VA from honoring privileges established in one state and making them applicable to all VA facilities. Instead, VA facilities would honor licensure and scope of practice laws of the state(s) in which they operate.

United States Senate

The AOA strongly supports the "Veterans Eye Treatment Safety Act" (S. 2743) introduced by Sen. Peter Fitzgerald (R-IL). This is a companion bill to H.R. 3473. In June 2004, Sen. Fitzgerald attempted to include his bill as an amendment (Senate Amendment 3323) to the Department of Defense authorization bill. After intense negotiations, Senate leaders determined that Sen. Fitzgerald would not be allowed to offer his amendment.

XII. Public Health Service Act

a. National Health Service Corps

The National Health Service Corps (NHSC) was reauthorized for 5 years (2002-2006) during the 107th Congress. The AOA will continue to focus on securing appropriate funding for the Corps and supporting its mission of placing physicians in rural and underserved areas. The Corps received \$170 million in the FY 2004 Omnibus Appropriations Act (P.L. 108-199). This was an increase of \$25 million over fiscal-year 2003 levels.

President Bush proposed \$205 million for the Corps in his FY 2005 budget proposal, a \$35 million increase over FY 2004.

b. Title VII-Health Professions Education Programs

The AOA continues to advocate for reauthorization of the Health Professions Education Programs under Title VII of the Public Health Service Act. Title VII was last reauthorized in 1997. Its current authorization expired on September 30, 2002. The 108th Congress failed to approve reauthorization legislation, but funding was approved, ensuring continued operation of the program.

Programs offered under Title VII benefit greatly colleges of osteopathic medicine and osteopathic medical students. A majority of the twenty-one Colleges of Osteopathic Medicine receive funding through Title VII programs.

c. Children's Hospital Graduate Medical Education Program (CHGME)

The CHGME program was established under the Public Health Service Act. The law (PL 106-310) authorized CHGME funding for five years to train pediatric residents in GME programs. In the FY 2003, the program received \$290 million. In 2004, funding for the program increased

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to \$303 million. Currently, funding remains at the FY 2004 level since Congress has not approved the FY 2005 budget for the CHGME program. If the FY 2005 budget request is approved, funding levels would remain at \$303 million.

Legislation to extend the authorization of the CHGME program through FY 2010 is pending in the House and the Senate. Reps. Nancy Johnson (R-CT) and Sherrod Brown (D-OH) sponsored H.R. 4578 which is pending in the House Energy and Commerce Committee. In the Senate, Christopher Bond (R-MO) and Edward Kennedy (D-MA) sponsored S. 2526 which was approved by the Health, Education, Labor and Pensions committee on October 7, 2004. Full Senate approval is pending.

d. Community Health Centers (CHC)

Community Health Centers (CHC) is a federal grant program that provides primary, preventive and dental health care services for people in rural and urban medically underserved areas. CHCs provide health care to millions of people in over 3,000 CHCs. In the FY 2003, the CHC program received \$1.505 billion in funding. Funding for the program in FY 2004 increased to \$1.6 billion.

e. Council on Graduate Medical Education (COGME)

COGME provided Congress with valuable information on graduate medical education and health care workforce issues. The AOA strongly supported COGME and was pleased that the osteopathic profession is represented on the panel. COGME's authorization expired on September 30, 2004.

XIII. Higher Education Reauthorization Act

The Higher Education Act (HEA) was last amended in 1998. The HEA is subject to reauthorization at 5-year intervals, with an extension option of one year.

The AOA continues to pursue the reauthorization of the HEA and has proposed numerous revisions to student loan programs. It is the opinion of the AOA that the current student loan program should be reformed to increase the amount of Federally subsidized student loans, allow greater flexibility in student loan repayment options, and increase deferment options for students.

House of Representatives

On October 6, 2004 the House approved legislation (H.R. 5185) that extends, for one year, programs authorized under the Higher Education Act of 1965.

The House Committee on Education and the Workforce held numerous hearings on HEA reauthorization. Numerous bills were introduced, but only the "College Access and Opportunity Act" (H.R. 4283), introduced by the Education and the Workforce Committee Chairman John Boehner (R-OH) garnered Committee attention. The AOA submitted comments to Chairman Boehner outlining our support for several student loan provisions included in H.R. 4283 and expressing our support for the inclusion of other provisions.

United States Senate

The Senate approved H.R. 5185 on October 9, 2004. President Bush is expected to sign the legislation.

XIV. Educational Loan Financing and Related Tax Issues

a. The Higher Education Affordability and Equity Act

In an effort to address the soaring cost of higher education in America, Rep. Phil English (R-PA) introduced the “Higher Education Affordability and Equity Act” (H.R. 3412). H.R. 3412 would expand and make permanent the higher education affordability provisions of the “Economic Growth and Tax Relief Reconciliation Act” (EGTRRA).

XV. Other and Emerging Issues

a. Genetic Nondiscrimination

The AOA supports legislation to protect current and future genetic information of patients. As the utilization of genetic testing increases, so does the need to protect individuals from discrimination based on collected genetic information. The AOA passed a resolution in 1997 that was revised and reaffirmed in 2002 to support the public interest in prohibiting discrimination in employment, health insurance coverage, and access to care on the basis of genetic information.

There is widespread agreement that legislation is needed, but momentum stalled in the House where the Republican Leadership remained opposed. Proponents of the issue are committed to passing a bill and will begin again in the 109th Congress.

U.S. House of Representatives

The House has not considered the issue. Rep. Louise Slaughter (D-NY) introduced the “Genetic Nondiscrimination in Health Insurance and Employment Act” (H.R.1910), which secured 242 cosponsors. H.R. 1910 contained a broader definition of the information that would be protected for underwriting purposes. It also permits a private right of action in federal or state court with no cap on damages awarded. The Senate bill does not contain these provisions.

On July 22, 2004, the Subcommittee on Employer-Employee Relations of the House Education and Workforce Committee held a hearing to examine the issue of genetic discrimination and its implications for employers and employees. This committee is one of three in the House that has jurisdiction over the issue.

United States Senate

In October 2003, the Senate approved the “Genetic Nondiscrimination in Insurance Act” (S.1053) introduced by Senator Olympia Snowe (R-ME).

b. Mental Health Parity

In February 2003, Sens. Pete Domenici (R-NM) and Edward Kennedy (D-MA) introduced the “Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003” (S. 486). The bill was not considered by the Health, Education, Labor and Pensions (HELP) Committee or the

Senate. The measure enhances the 1996 Mental Health Parity Act by barring group health plans from requiring higher co-payments, deductibles, and coinsurance payments for mental health services. Current law requires group health plans to make annual and lifetime dollar limits for mental health benefits equal to those for medical and surgical benefits.

c. Tobacco Regulation

The 108th Congress saw renewed interest in government regulation of tobacco and tobacco products. For several years health care experts have advocated for greater scrutiny of the tobacco industry. The long-term health risks and increased health care costs associated with tobacco use are well documented.

The 108th Congress presented a unique opportunity to enact FDA oversight of tobacco due to strong bipartisan support for reforming the century old tobacco quota system through a buyout program for tobacco farmers. Proponents of the FDA oversight provisions saw this as an opportunity to include their provisions in a broader tobacco related bill.

U.S. House of Representatives

Reps. Tom Davis (R-VA) and Henry Waxman (D-CA) introduced “Family Smoking Prevention and Tobacco Control Act” (H.R. 4433). The legislation would give the FDA authority to regulate the sale, marketing, and advertisement of tobacco. Additionally, the legislation authorizes the FDA to require tobacco companies to list all ingredients added to products and requires that tobacco companies place stronger, more explicit language on packaging. On June 17, 2004, the House approved tobacco buyout legislation as part of the “American Jobs Creation Act of 2004” (H.R. 4520). H.R. 4520, as approved by the House, did not include language granting the FDA regulatory authority over tobacco.

United States Senate

Sens. Mike DeWine (R-OH) and Edward Kennedy (D-MA) introduced the “Family Smoking Prevention and Tobacco Control Act” (S. 2461). The legislation would give the FDA authority to regulate the sale, marketing, and advertisement of tobacco. Additionally, the legislation authorizes the FDA to require tobacco companies to list all ingredients added to products and requires that tobacco companies place stronger, more explicit language on packaging.

On July 15, 2004, the Senate approved the “American Jobs Creation Act of 2004” (H.R. 4520). Prior to final passage, the Senate adopted Senate Amendment 3563, the “Family Smoking Prevention and Tobacco Control Act.”

On October 10, 2004 the Senate approved the “Family Smoking Prevention and Tobacco Control Act” (S. 2974). The legislation, introduced by Sens. Mike DeWine (R-OH), Edward Kennedy (D-MA), and James Jeffords (I-VT), is identical to S. 2461 introduced earlier this year. Passage of the S. 2974 came after the FDA provisions were removed from the “American Jobs Creation Act of 2004” (H.R. 4520) by the conference committee. Supporters of the FDA provisions threatened to prevent passage of the package, but failed to secure enough votes. In return for their support for H.R. 4520, Senate Leaders granted the group a vote on the FDA

provisions as a stand-alone measure. The bill, adopted by unanimous consent, has little opportunity for consideration in the House.

d. J-1 Visa Program

In 1996, Congress enacted legislation (Public Law 104-208), which included a provision that granted U.S. trained foreign physicians a waiver on J-1 visa requirements that require physicians to return to their home country for two years before applying for U.S. residency. In return for the waiver, foreign physicians agree to serve in rural or urban underserved communities for three years. Underserved communities are those communities that have a low physician to patient ratio, as determined by the Department of Health and Human Services (HHS). The program is seen as a way to improve access to physicians in rural communities and is strongly supported by the House and Senate Rural Health Care Coalition.

U.S. House of Representatives

On October 6, 2004, the House approved H.R. 4453 by voice vote. The bill extends for two years a visa program to encourage U.S. trained foreign physicians to work in rural and urban underserved communities. The legislation waives a J-1 visa requirement that all physicians who complete their post-graduate training in the United States return to their home country for at least two years before applying for U.S. residency. Instead, physicians willing to serve for three years in underserved communities will receive a waiver relieving them of the two-year requirement.

United States Senate

On October 11, 2004 the Senate approved S. 2302 by unanimous consent. S. 2302 is identical to the House-passed bill.

e. Obesity

Public health officials increasingly are concerned that obesity is reaching epidemic levels. Data trends indicate that 65 percent of adults and 13 percent of children and adolescents are obese. A report by the Centers for Disease Control (CDC) indicates that obesity will exceed tobacco as the leading cause of preventable death. The prevalence of obesity is especially acute among African-Americans, Hispanic-Americans, and American Indians. In addition, Medicare and Medicaid increasingly pay more of the health costs related to obesity. The alarming obesity rates prompted several House and Senate Committees hearings in the second session.

U.S. House of Representatives

On July 22, 2004 Reps. Kay Granger (R-TX) and Steny Hoyer (D-MD) introduced the “Childhood Obesity Reduction Act” (H.R. 4941). The legislation encourages schools and school districts to develop obesity prevention and physical activity promotion programs.

United States Senate

On December 9, 2003 the Senate approved the “Improved Nutrition and Physical Activity (IMPACT) Act” (S. 1172) by voice vote. The bill, introduced by Senate Majority Leader Bill

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Frist (R-TN), proposes community grants for development of obesity prevention, increased physical activity and nutrition education programs. It also seeks to expand existing authority of HHS by which it operates its obesity reduction programs.

Sens. Bill Frist, M.D. and Ron Wyden (D-OR) introduced the “Childhood Obesity Reduction Act” (S. 2551). This is a companion bill to H.R. 4941. It encourages schools and school districts to develop obesity prevention and physical activity promotion programs.

f. Disparities

Senate Majority Leader Bill Frist (R-TN) introduced the “Closing the Health Care Gap Act of 2003” to increase access to care and increase funding for research, outreach, and training programs to address racial and ethnic disparities. The bill would provide more funding for health professions as well.

I. Medicare Physician Fee Schedule

The Centers for Medicare and Medicaid Services released the proposed 2005 Medicare Physician Fee Schedule. The AOA submitted comments on the following issues: 1) Payment Update/Sustainable Growth Rate; 2) Geographic Practice Cost Index; 3) Malpractice Relative Value Units; 4) Initial preventive physical examination; 5) Physician Scarcity Areas and HPSA incentive payment; 6) Payment reform for covered outpatient drugs and biologicals; 7) Clinical conditions for coverage of DME and supplies; and 8) Outpatient therapy services performed “incident to” physician services.

II. Sustainable Growth Rate

CMS Administrator Mark McClellan so far has not addressed correcting the Sustainable Growth Rate. The AOA along with other physician associations continue to call on CMS to remove drugs from the Sustainable Growth Rate formula. McClellan says CMS continues to look at all issues regarding SGR and will try to work with physicians particularly in the areas of quality improvement and disease prevention to provide savings overall.

III. Medicare Part D benefit

The AOA submitted comments on CMS’s proposed rule on the Part D Prescription drug benefit. The AOA emphasized that one of the fundamental principles of patient centered quality care is the ability of patients in our care to have access to appropriate drug therapies. While controlling costs is an important factor, access to appropriate treatments must be the primary focus.

IV. Medicare Advantage

The AOA submitted comments to CMS focusing on the establishment of Medicare Advantage (MA) regions (section 422.455). CMS is required to establish the regions that would constitute the service areas for the regional MA plans. The statute requires CMS to establish between 10 and 50 regions within the 50 states and the District of Columbia. The AOA believes that the establishment of regions should weigh the demographics and socioeconomic status of the beneficiaries in an effort to ensure that lower income or poor areas are not isolated, thus becoming less attractive to potential insurers. It is our opinion that there should be fewer regions that encompass larger numbers of beneficiaries.

V. HIPAA

As of July 1, CMS slowed payments for electronically submitted Medicare claims that are not HIPAA compliant. Payments take an additional 13 days. Currently 95 percent of electronic Medicare claims are HIPAA compliant. Last year, CMS implemented a contingency plan to allow more time for covered entities to come into compliance with HIPAA electronic claims standards. CMS expects to issue a proposed rule on submitting attachments with electronic claims by the end of this year.

VI. Limited English Proficiency

The AOA participated in a Limited English Proficiency (LEP) Roundtable to address the challenges facing the health care community in providing care to LEP individuals. The Roundtable developed a statement of principles however the AOA opted not to sign onto the principles because they potentially open the door to future mandates. Although the AOA has not sign on, it continues to participate on the Roundtable.

VII. Chronic Care Improvement Program

On April 23rd, the CMS released its notice on voluntary Chronic Care Improvement Programs (CCIP) under traditional Fee-for-Service Medicare. The CCIP can be run by disease management groups, insurers, integrated delivery systems, physician group practices, a consortium of entities or any other legal entity that meets CMS's requirements. The purpose of the voluntary program is to develop and test new strategies to improve the quality of patient care cost-effectively for chronically ill Fee-for-Service Medicare beneficiaries. AOA expressed concerns to CMS officials about the role physicians would have with their patients. CMS Administrator Mark McClellan testified before the House Ways and Means Subcommittee on Health that the agency wants to partner with organizations whose CCIPs support and improve the patient-physician relationship, not interfere with it.

VIII. Prescription Drugs

The AOA joined the Access to Benefits Coalition (ABC). The coalition was formed to ensure that low-income beneficiaries know about and use prescription drug savings programs, including the Medicare-approved discount cards and the \$600 per year credit as well as the Medicare prescription drug benefit that takes effect in January 2006 (Medicare Part D). ABC's goals: To help enroll 5.5 million beneficiaries in the drug discount card program by 2005; enroll 8 million in the Medicare Part D benefit by 2008; and enroll 12 million by 2012.

IX. Regulatory Reform

Earlier this year, the AOA sent a letter to HHS Secretary Tommy Thompson requesting an update on Regulatory Reform. Two years ago, an HHS advisory panel made 255 recommendations for reform. HHS has not responded to AOA's request. The AOA continues to press that regulatory reform is an essential part to improving care to patients.

X. EMTALA

As mandated by the Medicare Modernization Act (MMA), CMS is establishing the Emergency Medical Treatment and Labor Act (EMTALA) Technical Advisory Group (TAG). The AOA nominated six candidates for the EMTALA TAG. The purpose of TAG is to: Review the EMTALA regulations; provide advice and recommendations to the HHS Secretary concerning these regulations and their application to hospitals and physicians; solicit comments and recommendations from hospitals, physicians, and the public regarding implementation of such regulations; and disseminate information concerning the application of these regulations to hospitals, physicians, and the public.

XI. CMS Communications

CMS is working toward improving communications with the physician community. The agency implemented Medicare Issue of the Day and MedLearn Matters to help the physician and provider community to stay on top of the changes in the Medicare system. The AOA provides links to some of these articles on its web site.

XII. National Health Information Infrastructure

Dr. Beehler and Dr. Daniel Saylak, along with DGR staff, attended the National Health Information Infrastructure 2004 Conference in July in which HHS Secretary Tommy G. Thompson said the country must move more quickly to adopt information technology in the health care system. Thompson and David

Brailer, the National Coordinator for Health Information Technology, released the first outline of a 10-year plan to transform the delivery of health care by building a new health information infrastructure. The Centers for Medicare and Medicaid Services also plans to take action to advance health information technology. CMS is accelerating publication of a regulation laying out the first set of widely adopted e-prescribing standards in preparation for the implementation of the new Medicare drug benefit in 2006. CMS will publish the proposed regulation later this year. CMS will develop a Medicare Beneficiary Portal. The portal will enable authorized beneficiaries to have access to information off the Internet about the health care services they have received under Medicare. The pilot test for the portal will be conducted in Indiana, beginning this year.

XIII. Hospital Inpatient Prospective Payment System Final Rule

The Centers for Medicare and Medicaid Services (CMS) released on August 11, 2004 the final rule on changes to the Hospital Inpatient Prospective Payment Systems and fiscal 2005 rates. The effective date of the rule is October 1, 2004. The AOA submitted comments on the proposed changes to graduate medical education.

In our comments, we made the following recommendations to CMS:

- Recognize that, where supervising physicians agree to forego payment as faculty at a nonhospital site and the teaching hospital pays the residents' compensation and benefits and other training costs, if any, as determined by the parties by agreement, the hospital has incurred "all or substantially all" of the costs of the program and is entitled to count the residents for purposes for DGME and IME purposes.
- Or, failing the above, extend the moratorium pending the results of the Congressionally mandated study on alternative payment methodologies, making the moratorium applicable to all residency programs that utilize nonhospital settings to train interns and residents.
- Strike as ill conceived the proposed change in policy imposing payment of all nonhospital training costs by the end of the month following the month in which training occurs.
- Consider adding a look back step to the pool estimation process, ensuring that the number of unused positions lost does not exceed the number made available to applicants.

A preliminary analysis of the CMS response is noted below:

- Extension of the moratorium – CMS stated that the time frame of the moratorium is established in Section 713 of the Medicare Modernization Act. In addition, they also state that they have no discretion to expand the moratorium to other residency programs besides Family Practice.
- CMS states that the hospital must pay the cost of training residents at the nonhospital site in order to count FTE residents training at the site including teaching physician costs, as long as the teaching physician costs exist.
- Section 713 (b) of the Medicare Modernization Act requires the HHS Inspector General to conduct a study of the suitability of alternate methodologies for payment of resident training in nonhospital settings. This report will be submitted to Congress by December 8, 2004. CMS has stated that they will await release of this report and may consider further regulation and policy changes at

that time if necessary.

- CMS will now allow a hospital to choose how it will demonstrate that it will incur the nonhospital training cost in one of two ways: by executing a written agreement in accordance with existing regulations or by paying the costs of the training program in the nonhospital setting by the end of the third month following the month in which the training occurred.
- Redistribution - CMS states that the intent of Congress was not to delay implementation of the provision by waiting for cost reports, audits, etc. As such, CMS is adopting a policy which will require the fiscal intermediaries to use the latest available cost report or audit data at the time they make their determinations.

XIV. VA Chiropractic Advisory Committee

This Committee advises the Secretary of Veterans Affairs on VA chiropractic programs. Michael Murphy, D.O. represents the AOA on the committee. The panel advises the Secretary of Veterans Affairs in key areas such as direct access and scope of practice issues relating to chiropractors.

To date, the Committee has had seven meetings. The Committee's final recommendations were sent to the Secretary of Veterans Affairs in November 2003. In March 2004, the Secretary issued the VA response to the recommendations. Complete proceedings and recommendations of the Committee can be accessed at www.va.gov/primary.

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The American Osteopathic Association's (AOA) advocacy initiatives have increased to support the Association's expanding legislative priorities. The overall goal of the advocacy program is to inform, educate, and motivate AOA members to take part in the political process. The mission of the advocacy program is to establish a grassroots network of activists within the osteopathic community, to:

- Promote legislation which enhances osteopathic medicine and the delivery of quality care,
- Better understand issues affecting osteopathic medicine and explain organized osteopathic medicine's position to Members of Congress,
- Inform other D.O.s of the impact of proposed legislation and regulation on their professional and personal lives,
- Help Members of Congress understand the impact proposed legislation and regulation has on osteopathic physicians and their patients, and
- Motivate other D.O.s to become involved in the political process.

I. Grassroots Osteopathic Advocacy Link (GOAL) Program

The Grassroots Osteopathic Advocacy Link (GOAL) program offers an 'Inside the Beltway' look at legislation important to the practice and profession of osteopathic medicine.

The AOA's political needs require participation that is more than just an occasional, informal effort. What is required is a systematic approach embodied in an expanded advocacy program. The GOAL program involves taking an active role in the governmental process, getting to know our elected federal representatives, and making our views known to them. GOAL also helps to promote the interests of all D.O.s and their patients before Congress.

GOAL arms the osteopathic community with up-to-date health care policy information necessary to illuminate osteopathic perspectives to Washington policymakers.

Benefits of GOAL Membership:

- D.O. Washington Update
- GOAL Advocacy Alerts
- D.O. Day on Capitol Hill
- D.O. Advocacy Action Center

If you are not already a member, register now to become part of the AOA's Grassroots Osteopathic Advocacy Link (GOAL) program at <http://capwiz.com/aoa-aoia/mlm/>.

a. The D.O. Advocacy Action Center

Launched in October of 2003, the D.O. Advocacy Action Center provides D.O.s, students, and the osteopathic community with a central location to learn about the AOA's key legislative priorities, track bill votes and co-sponsorships, and provides a means for contacting federal legislators on key health care issues via email or fax. Upon entering the D.O. Advocacy Action Center, users are presented with 'Advocacy Alerts' on key federal issues requiring action by the osteopathic community. Users, after entering their zip code, are matched automatically with their federal legislators. Participants will then

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be directed to a sample letter on the issue needing action. After entering a name and address and clicking the 'send' button a message is sent to Congress.

Through the D.O. Advocacy Action Center, D.O.s, students, and the osteopathic community can:

- View and take action on federal Advocacy Alerts
- Send a letter to federal legislators
- Find contact information on federal legislators
- Read text, and track co-sponsorship and vote information on federal legislation
- Learn about candidates in election years
- Register to vote

1. **Current Messages Sent Via the D.O. Advocacy Action Center**

3,135 Active GOAL Members

35 GOAL Advocacy Action Alerts sent to GOAL members since October 2003

6,834 Emails/Faxes/Letters sent to Congress since October 2003

44 people have used the Action Center to register to vote in 2004

b. **D.O. Advocacy Handbook**

Created in June of 2003, the D.O. Advocacy Handbook aids D.O.s, students, and friends of osteopathic medicine in understanding and getting involved in the federal legislative and regulatory process. The D.O. Advocacy Handbook explains why grassroots involvement is necessary, how the legislative and regulatory processes work, and how to get involved in Washington and at home through letters, meetings, facility tours, fundraisers, etc. The D.O. Advocacy Handbook also gives an overview on the importance of political action committees (PACs), and why contributing to a PAC is essential to any government relations program.

II. **D.O. Day on Capitol Hill**

D.O. Day provides D.O.s and members of the osteopathic family the opportunity to come to Washington, be briefed on key healthcare legislation, and meet with their Senators and Representatives and/or their staff.

a. **D.O. Day on Capitol Hill - September 9, 2004**

The AOA hosted 46 D.O.s, students, and members of the osteopathic family for the fall D.O. Day on Capitol Hill. Participants, representing 16 states, visited 33 House and 32 Senate offices to discuss correcting the Medicare Physician Payment Formula, the preservation of volunteer faculty in graduate medical education and medical liability insurance reform.

b. **OGME Capitol Hill Day – June 9, 2004**

Eighteen Directors of Medical Education participated in the AOA's first OGME Day on Capitol Hill. Participants met with 8 Members of Congress, as well as staff from 20 congressional offices to advocate the preservation of the use of volunteer faculty in

graduate medical education. Specifically, participants requested that Members support a two year extension of the moratorium implemented by the Medicare Modernization Act (MMA) Section 713 and an extension of the moratorium to all residency programs, regardless of specialty.

Advocates participated in a breakfast briefing, featuring presentations by Priscilla Hanley, Legislative Assistant to Sen. Susan Collins (R-ME) and Karen Fisher, Vice-President, Division of Health Affairs at the Association of American Medical Colleges (AAMC).

c. Osteopathic Capitol Hill Day - April 15, 2004

The AOA hosted its largest Hill Day ever with approximately 1,100 D.O.s and osteopathic medical students participating. Members of the AOA visited over 264 House offices (out of 435) and 88 Senate offices. Representatives from 44 states and all 20 COMs met with Congressional staff to discuss Professional Liability Insurance Reform and the Higher Education Reauthorization Act.

d. Health Policy Fellows Weekend – March 7-9, 2004

The AOA hosted the Osteopathic Health Policy Fellowship Program retreat on the Legislative Branch: Federal Health Policy Role. Capitol Hill visits were arranged for the participants.

e. D.O. Day on Capitol Hill - April 10, 2003

The AOA hosted approximately 400 D.O.s and osteopathic medical students. Representatives from 38 states met with Congressional staff to discuss Professional Liability Insurance Reform.

f. Health Policy Fellows Weekend - March 9-11, 2003

The AOA hosted the Osteopathic Health Policy Fellowship Program retreat on the Legislative Branch: Federal Health Policy Role. Capitol Hill visits were arranged for the participants.

III. Advocacy Campaigns

a. Advocacy Over August

The Advocacy Over August campaign was launched at the House of Delegates meeting to encourage AOA members to take advantage of the six-week Congressional recess period in August. The launch was followed-up by a series of four email ‘messages of the week’ with suggestions for different ways to get involved in the process. Messages included ‘Meet with Your Legislators,’ ‘Host a Meet-N-Greet,’ ‘Conduct a Facility Tour,’ and ‘Register to Vote.’

b. EveryPatientCounts.org (EPC) Campaign

EveryPatientCounts.org is an AOA developed campaign to educate and inform patients about the growing medical liability crisis and its impact on their health care. The AOA

developed a number of resources for members and their patients to use to get information and get involved.

1. Current Messages Sent Via EveryPatientCounts.org

- 3,263 Active Members
- 4 Alerts Sent to EPC Advocates since October 2003
- 4,058 Emails/Faxes/Letters Sent to federal and state legislators since October 2003

2. Promotional Tools

- a) PR Toolkit for regional managers and state and specialty Executive Directors
- b) Member brochures for the campaign (to be launched at Convention)
- c) Series of EveryPatientCounts.org ads designed to be used in Washington and around the country.

3. Patient Materials

- a) Patient brochures for the campaign (to be launched at Convention)
- b) 'Patient Advocacy Kit' for members to educate their patients
- c) EveryPatientCounts.org website

4. Campaign Demonstrations/Speaking Events

- a) Washington
 - (1) Demonstrated EveryPatientCounts.org campaign site to annual meeting participants, handed out materials and participated in professional liability reform panel
- b) Illinois
 - (1) Presented EveryPatientCounts.org campaign during an advocacy panel
- c) Arizona
 - (1) Participated in the rally by all physician societies at the state capitol

5. EveryPatientCounts.org State Coordination

DGR staff work in conjunction with the state society Executive Directors and staff from the Departments of State and Socioeconomic Affairs and Component Societies to run campaigns and supplement their activities in the state. The following states initiated campaigns, rallies and ballot initiatives to promote medical liability reform in the state.

- a) Oklahoma
 - (1) Campaign materials
 - (2) Newspaper ads
- b) Iowa
 - (1) Campaign materials

- (2) Posters
- (3) Pins
- (4) Newspaper ads
- (5) Banners for rally
- (6) Promotion of rally through GOAL and students at DMU
- c) Ohio
 - (1) Campaign materials
 - (2) Posters
 - (3) Mobile billboards
- d) Nevada
 - (1) Campaign materials
 - (2) Posters
 - (3) Pins
 - (4) Mobile billboards
 - (5) Newspaper ads
- e) Arizona
 - (1) Rally
 - (2) Campaign materials
- f) Maine
 - (1) Campaign materials
 - (2) Pins

IV. Communications

a. D.O. Washington Update

The D.O. Washington Update began publishing in June 2003. The monthly federal and regulatory newsletter is provided as a benefit of membership in the Grassroots Osteopathic Advocacy Link (GOAL) program.

b. News Releases

1. Medicare

- a) “American Osteopathic Association Works to Support CMS’ Efforts to Provide Prescription Drug Support to Low-Income Americans”
 - (1) September 23, 2004
 - (2) Distribution
 - (a) AOA Media List
 - (b) Osteopathic Family
 - (c) Centers for Medicare and Medicaid Services
 - (d) Health and Human Services Press Conference
- b) “AOA Participates in Historic Medicare Modernization Bill Signing “
 - (1) December 8, 2003
 - (2) Distribution
 - (a) AOA Media List
 - (b) Osteopathic Family
- c) “Darryl Beehler, D.O. Celebrates Medicare 38th Birthday at White

House”

- (1) August 8, 2003
- (2) Distribution
 - (a) AOA Media List
 - (b) Osteopathic Family
- d) “American Osteopathic Association Praises Efforts to Enact a Medicare Prescription Drug Benefit”
 - (1) June 5, 2003
 - (2) Distribution
 - (a) Pharmaceutical Industry press conference
- e) “Osteopathic Physician Re-Appointed to Medicare Payment Advisory Committee”
 - (1) June 2, 2003
 - (2) Distribution
 - (a) AOA Media List
 - (b) Osteopathic Family

2. Professional Liability Reform

- a) “The American Osteopathic Association Calls on Both Chambers of Congress to Pass Meaningful Medical Liability Reforms”
 - (1) May 12, 2004
 - (2) Distribution
 - (a) Capitol Hill
 - (b) Osteopathic Family
- b) “The Senate Must Act to Ensure Patient Access to Health Care”
 - (1) April 7, 2004
 - (2) Distribution
 - (a) Capitol Hill
 - (b) Washington Media
 - (c) Osteopathic Family
- c) “D.O.s Rally on Capitol Hill for Professional Liability Insurance Reforms as Senate Cuts off Debate”
 - (1) July 9, 2003
 - (2) Distribution
 - (a) Capitol Hill
 - (b) Washington Media
 - (c) Osteopathic Family

3. Other

- a) “The AOA Calls On Senate to Support Omnibus Package”
 - (1) January 20, 2004
 - (2) Distribution
 - (a) Capitol Hill
 - (b) Osteopathic Family

c. Interviews

1. June 2004

- a) Credentialing and Peer Review Insider (Joseph Kuchinski, D.O.)

2. July 2004

- a) Family Practice News (Martin Levine, D.O.)
- b) Internal Medicine News (George Thomas, D.O.)

d. State and Specialty Colleges Sign-On Letters

1. Professional Liability Reform

- a) The AOA has sent four letters to Members of Congress with the majority of state and specialty colleges signed on in 2003 and 2004.

2. Medicare

- a) The AOA has sent five letters to Members of Congress with the majority of state and specialty colleges signed on in 2003 and 2004.

V. PR/Advertising

a. Ads

1. Osteopathic Medicine

- a) September 22, 2003; Roll Call, Washington DC

2. Medicare

- a) November 19, 2003; Roll Call, Washington DC

3. Professional Liability Reform

- a) January 20, 2004; Roll Call, Washington DC
- b) February 21, 2004; Congressional Quarterly Weekly, Washington, DC
- c) February 23-24, 2004; Congressional Quarterly Today, Washington, DC
- d) April 7, 2004; Roll Call, Washington, DC
- e) April 22, 2004; Daily Oklahoman, Oklahoma City, OK
- f) March 3-4; Des Moines Register, Des Moines, IA
- g) May 10-14, 2004; Congressional Quarterly Today, Washington, DC
- h) August 29, 2004; Las Vegas Review, Las Vegas, NV

b. Mobile Billboards

1. Nevada

- a) Las Vegas, Thursdays through Sundays from October 2 to November 2, 2004

2. Ohio

- a) Dayton, October 13-15, 2004
- b) Cincinnati, October 16-18, 2004
- c) Akron, October 19-21, 2004

- d) Cleveland, October 22-24, 2004
- e) Canton, October 25-27, 2004
- f) Columbus, October 28-30, 2004
- g) Toledo, October 31-November 2, 2004

VI. Legislative and Regulatory Association Operational Concerns

a. Blast Faxing

On July 3, 2003 the Federal Communications Commission (FCC) issued a report and order establishing the 'Do-Not-Call Registry' and updating provisions of the 'Telephone Consumer Protection Act of 1991' (TCPA), including junk faxes. The July 3rd ruling eliminated the 'Established Business Relationship (EBR)' exemption allowed since the implementation of TCPA and required businesses to obtain express invitation or permission in writing with a signature from the fax recipient prior to sending any information via fax. No exemptions were allowed for any business, including membership associations.

Public outcry from the business and association community caused the FCC to issue a moratorium until January 1, 2005. Legislation to reinstate the EBR and modify other provisions to accurately reflect Congressional intent has been passed by the House and is being considered by the Senate.

In light of this Congressional action, the FCC extended the moratorium until June 30, 2005 to allow Congress to take further action. Should Congress fail to act by this deadline, the FCC will have enough time to address the petitions for reconsideration on this issue. Several AOA staff members sent letters supporting the ability of an organization to send faxes to its members without express permission.

The AOA has and will continue to provide information to state and specialty Executive Directors as the rules and any related legislation progress.

b. CAN-SPAM Act (Email)

The Federal Trade Commission (FTC) has begun issuing rules in response to the 'CAN-SPAM Act of 2003' (PL 108-102), signed into law on December 16, 2003. The CAN-SPAM Act applies to commercial messages, a message whose sole purpose is to promote a product or service.

The FTC decided to begin its rulemaking in steps, addressing the overarching issue first, allowing more time for public comment on the details of implementation of those rules.

The AOA has and will continue to provide information to state and specialty Executive Directors as the rules and any related legislation progress.