Washington Report

Academic and Subspecialty Advocacy

Executive Summary

The Senate is considering its own health reform bill after the House passed the American Health Care Act (AHCA) by a narrow margin. The AAP is actively opposing changes to the ACA that would erode the recent historic gains in child health coverage. The AAP is speaking out about large proposed Medicaid cuts that would lead to decreased enrollment and provider payment, jeopardizing child access to pediatricians and pediatric subspecialists.

Funding for the Children’s Health Insurance Program (CHIP) expires in September. The AAP is working to secure a timely renewal of funding to make sure children do not lose their coverage.

The AAP-championed Ensuring Children’s Access to Specialty Care Act has been reintroduced in the Senate. It would allow pediatric subspecialists to benefit from the National Health Service Corps (NHSC) loan repayment program. The AAP helped develop the legislation and is working with a broad coalition of stakeholders to advance it as a key policy to strengthen the pediatric subspecialty workforce, particularly in underserved areas.

The Supreme Court will review President Trump’s immigration ban executive orders this fall. In the meantime, they remain partially in effect. The AAP has joined several amicus court briefs arguing against these actions for their negative impact on children and their negative implications for maintaining an adequate medical workforce.

The AAP successfully lobbied to preserve military pediatric subspecialty training programs after legislation was proposed that would have required the Department of Defense to cut them way back.

The 21st Century Cures Act was signed into law in December 2016. The legislation makes major investments in biomedical research and includes several key child-specific provisions, including a new AAP-championed requirement that NIH improve its tracking of children enrolled in National Institutes of Health (NIH)-funded studies.

Congress must reauthorize the Food and Drug Administration (FDA) drug and device user fee programs. The AAP is working to ensure the inclusion of provisions to improve drugs and devices for children by strengthening the Best Pharmaceuticals for Children Act, the Pediatric Research Equity Act, and the Pediatric Medical Device Safety and Improvement Act.

The AAP continues to advocate for FDA’s Pediatric Device Consortia (PDC) program. It was funded at $3 million in Fiscal Year (FY) 2017. The AAP continues to advocate for this program to promote the development of pediatric medical and surgical devices.

President Trump signed the final omnibus spending bill for FY 2017 in to law on Friday, May 5. The bill passed with wide bipartisan support and secured increased funding for biomedical research priorities.

The National Institutes of Health (NIH) received a $2 billion funding boost, putting total appropriations at $34.1 billion for FY 2017. The AAP engaged with Congressional appropriators throughout the appropriations process to ensure that the needs of pediatric academic researchers were a part of Congress’s deliberations.

The Children’s Hospital Graduate Medical Education Program (CHGME) was funded at $300 million, its fully authorized level.

President Trump released his full FY 2018 budget proposal on May 23, calling for massive cuts to domestic spending. The Academy immediately issued a statement opposing the budget and its drastic cuts to child health programs and continues to advocate the passage of a budget that funds the full spectrum of programs critical to child health and well-being.

The Trump budget called for a $7 billion (25%) cut to NIH in FY 2018, including large cuts to facilities and administration (or indirect) costs. It also proposes eliminating the Emergency Medical Services for Children (EMSC) program, the Title VII Primary Care Training program, and the Public Service Loan Forgiveness Program.
Letter from the CEO

Colleagues:

The first half of 2017 has been an eventful one in Washington, DC, to say the least. Amid all the partisan rancor, the AAP has been working to keep the needs of children—and the pediatricians and pediatric medical and surgical subspecialists who care for them—at the forefront of the debate.

I’m delighted to share with you our latest AAP Academic and Subspecialty Advocacy Washington Report. This report details the important advocacy work that the Academy is engaging in and highlights issues of particular importance to our medical and surgical subspecialty members who include many academicians and researchers. It includes updates on AAP advocacy efforts to protect Medicaid from cuts, extend the Children’s Health Insurance Program, promote pediatric subspecialty workforce issues, increase funding for pediatric research, and improve drugs and medical devices for children, among many other issues.

Our Board of Directors recently approved a plan to continue and expand our work to improve value for our subspecialty members. Advocacy is a key element of this plan, and I know that the Academy’s advocacy work is a crucial part of why you are an AAP member. In the coming months, we’ll be unveiling new tools to help our subspecialty members engage in advocacy. Stay tuned.

If you have questions or comments about the AAP’s advocacy work for subspecialists, please be in touch. And thank you for all you are doing for children and families. The vitality of the Academy depends on your hard work and engagement.

Sincerely,

Karen

Karen Remley, MD, MBA, MPH, FAAP
CEO/Executive Vice President

AAP Advocacy for Academic and Subspecialty Pediatrics

The American Academy of Pediatrics is actively engaged in federal advocacy for the needs of academic and subspecialist pediatricians and the children for whom they provide care. Through its Department of Federal Affairs and dedicated staff for academic and subspecialty issues, the Academy works to promote medical research for children, funding for medical education, child access to needed providers through appropriate payment, and a pediatric workforce able to meet the needs of children across the country.

The AAP has helped lead coalition efforts to pursue this agenda and partners with many pediatric subspecialty organizations. The Academy also works closely with the Pediatric Policy Council, which represents academic pediatric organizations: the Academic Pediatric Association, the American Pediatric Society, the Association of Medical School Pediatric Department Chairs, and the Society for Pediatric Research.

If you have questions, please contact the AAP Department of Federal Affairs: James Baumberger (jbaumberger@aap.org) or Matt Mariani (mmariani@aap.org).

Advocacy Training for Pediatric Subspecialists

The 2018 AAP Legislative Conference will take place April 8-10 in Washington, DC. Each year, the conference brings together pediatricians from across the country who share a passion for child health advocacy. Participants attend skills-building workshops, hear from guest speakers, learn about policy priorities impacting children and pediatricians and go to Capitol Hill to urge Congress to support strong child health policies.

For the third consecutive year, the conference will include a Pediatric Subspecialty Advocacy Track. The track will feature specific workshops, advocacy and educational opportunities for specialists, including a skills-building workshop on how to frame specialty expertise to legislators and build relationships with congressional staff, advocacy on legislative priorities especially relevant to pediatric subspecialists and the patients they treat, networking opportunities and more.

AAP subspecialty sections are encouraged to send individuals to the Legislative Conference. For more information, please contact Katy Matthews at kmatthews@aap.org.
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Access to Care

Medicaid and the Children’s Health Insurance Program (CHIP) together provide coverage for approximately 46 million children and are a crucial source of coverage for children with special health care needs and other children cared for by academic and subspecialty pediatricians. The AAP is actively working to prevent harmful cuts to Medicaid and to renew CHIP as soon as possible. The Academy is also working to preserve the crucial insurance market reforms included in the Affordable Care Act.

Current Health Reform Proposals

Senate leadership backed away from planned efforts to vote on the Senate’s health reform bill prior to the July 4 recess. On June 27, Majority Leader Mitch McConnell abruptly canceled a planned vote on a motion to proceed due to lack of support, a vote that would have opened debate on the legislation. Just one week prior, the Senate had unveiled its health reform bill, known as the Better Care Reconciliation Act (BCRA).

The Senate chose to write its own health reform bill, rather than take up legislation passed by the House of Representatives; the House passed its own version of health reform—the American Health Care Act (AHCA)—on May 4, by a vote of 217 – 213. BCRA was negotiated entirely behind closed doors by a “working group” of 13 Republican senators. Lacking a filibuster-proof 60-vote majority in the Senate, Republicans are using a process known as budget reconciliation to enact health care reform, a process that allows for the passage of policies with significant budget implications with only a simple majority.

The Academy continues to oppose health reform legislation that harms children’s coverage and sent a letter in March outlining how the legislation falls short for children by making health care coverage less affordable and less comprehensive. The Academy has weighed in with key senators as well with the message that any health care legislation must build on the historic gains to children’s health insurance coverage in recent years. The AAP also strongly opposed the BCRA.

BCRA and AHCA have substantially similar frameworks and contain many harmful provisions and would:

- **Drastically alter Medicaid, jeopardizing children’s health and access to pediatric subspecialists.** Both bills would transform Medicaid from an entitlement to a capped funding stream, shifting costs to states and likely leading to enrollment and provider payment cuts. This means less coverage for those who need it most: children with special health care needs and low-income families. It also jeopardizes Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits, which cover a wide array of medically necessary services for children, including developmental, vision, and hearing screenings.

- **Make coverage less affordable.** The bills reduce tax credits and eliminate cost-sharing subsidies that help families afford insurance that meets their needs.

- **Compromise care for low-income families.** AHCA and BCRA would phase out the ACA’s Medicaid expansion, which increased parental coverage and helped keep families healthier. They also phase out another ACA provision that moved more than half a million children from low-income families into Medicaid from a patchwork of different programs. Kicking those children out of Medicaid not only disrupts their coverage, but is unnecessarily confusing and burdensome for their families.

- **Undermine patient protections.** Both bills would allow states to waive certain ACA patient protections. For instance, BCRA and AHCA allow waivers of ACA’s 10 “essential health benefits” (EHBs), which require insurers to cover a set of benefits including pediatric services. Allowing states to do away with EHBs would diminish the quality of coverage individuals can access. It would also drive up the cost of coverage for the sickest individuals, as insurers would in effect be able to screen individuals with preexisting conditions into more expensive plans with more generous benefits packages. AHCA would also allow for waivers of community rating, a practice that requires insurers to charge all customers the same rate with only minor variability for age and other factors.

The non-partisan Congressional Budget Office (CBO) released a cost estimate, referred to as a “score,” for both AHCA and BCRA. According to the CBO, both bills would lead to massive coverage losses and cuts to Medicaid. AHCA would leave 14 million more people uninsured by 2018 compared with current law. That figure jumps to 19 million in 2020 and to 23 million by 2026. The total uninsured under BCRA are largely the same, with 15 million more uninsured in 2018, 19 million more in 2020, and 22 million more in 2026.

Both bills slash Medicaid funding, decreasing the federal contribution for state Medicaid programs by $834 billion (AHCA) and $772 billion (BCRA) over 10 years, resulting in roughly 15 million fewer Medicaid enrollees by 2026. In the absence of these federal funds, states would likely have to cut enrollment and benefits, which would have a disproportionate effect on children. Both bills would cause millions on individual market and employer sponsored insurance coverage to become uninsured. It is unclear how many of these newly-uninsured would have been children, but it is clear that many low-income children would have been negatively impacted.
either by becoming uninsured themselves or by a loss of coverage for their parents.

Throughout the process, the AAP has joined with other physician groups to advocate for preserving children’s coverage gains. AAP leadership has repeatedly joined leaders from the American Academy of Family Physicians, the American Congress of Obstetricians and Gynecologists, the American College of Physicians, the American Osteopathic Association, and the American Psychiatric Association on Capitol Hill. Together, they visited with key members of the U.S. House and Senate to discuss their priorities for coverage, benefits and consumer protections as they consider health reform.

The Academy’s opposition to both bills and the consequences for children and families have been covered extensively by local and national print, online, television and radio news networks. Most recently, the AAP’s opposition to the Senate bill was picked up by numerous news outlets, ranging from NBC News to the Washington Post to the New York Times. In addition, the AAP mobilized its 66,000 members for two days of action to protect Medicaid on June 15 and June 22. The efforts concentrated on those two days led to hundreds of phone calls and emails to U.S. senators urging them to oppose funding cuts or caps to Medicaid, thousands of tweets using #DontCapMyCare and #KeepKidsCovered and nearly two dozen pediatrician op-eds and letters to the editor. Also, pediatricians have posted 50 video testimonials on social media speaking out about the bill and the harms it would do to children and families on Medicaid. The Day of Action efforts were also coordinated directly with other child health groups and residency programs across the country. In addition, the Academy has been working closely with AAP chapters on targeted advocacy efforts.

Over the July 4 recess, the AAP is undertaking a robust grassroots mobilization strategy to continue to drive momentum around the need to urge senators to oppose the BCRA and protect Medicaid. These efforts were kicked off with a communication to all members after the Senate announced it would delay its vote on the bill until after the July recess. Throughout the health care debate, the Academy and its members will continue to serve as the voice for children and their unique needs at every step of the way.

Children’s Health Insurance Program
The Children’s Health Insurance Program (CHIP) is currently authorized through 2019, but funding expires September 30, 2017. Legislative action will be needed to extend federal funding past that date. CHIP was first enacted by a bipartisan group of lawmakers in 1997. The Affordable Care Act (ACA) included a maintenance of effort (MOE) provision requiring states to keep children currently enrolled in Medicaid and CHIP in the program through 2019—and also implemented an increase of the federal matching funds rate of 23 percentage points. Even with attention still on the AHCA, the AAP has ramped up its efforts to lobby Congress to urge them to protect children’s health care coverage by extending CHIP for at least five years and to maintain the MOE and 23 percentage point bump in federal financial participation. In addition, the AAP is underscoring the need for immediate action as states are currently crafting their FY 2018 budgets and negotiating contracts with insurers and providers. For states to continue their CHIP programs without interruption, they must know as soon as possible that federal support for CHIP will exist beyond September 30, 2017, with no reductions.

CHIP reauthorization may move with other extenders that were included in MACRA, such as the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV), and funding for community health centers. The AAP has been clear that the reauthorization of CHIP should not be used as a bargaining chip at the expense of other programs that play a key role in serving vulnerable children.

ACE Kids Act
The Advancing Care for Exceptional Kids (ACE Kids) Act of 2017 (S. 428) was reintroduced in the Senate on February 16 by Senator Chuck Grassley (R-IA). The bill was introduced originally during the last Congress in both chambers and has strong bipartisan support. The bill would allow states the option of creating a Medicaid Children’s Coordinated Care (MCCC) Program for children with medical complexity. The bill has 12 co-sponsors in the Senate. The AAP, the American Board of Pediatrics, and the Association of Medical School Pediatric Department Chairs support the legislation.

Under the bill, eligible children with complex medical conditions in participating states would be prospectively enrolled in an MCCC program through initial assignment to a nationally designated children’s hospital network. Enrolled children would receive coordinated care through this network.

While the bill may ease the delivery of care across state lines, questions have been raised about the bill’s potential impact on the primary care medical home, particularly given the automatic assignment of children to MCCC networks.

Medicaid Health Plans of America, a trade group representing for-profit Medicaid health plans, has raised concerns about the legislation and released a report arguing that the program would increase, rather than decrease, Medicaid costs.

Medical Foods Coverage
The AAP actively advocated for a provision in the National Defense Authorization Act (NDAA) that would correct the
current ambiguous TRICARE coverage policy for nutrition therapy that often results in delayed or denied care for the treatment of children and adults afflicted by digestive and inherited metabolic disorders. TRICARE had routinely been denying coverage of these foods, and families reported being subject to arduous paperwork to get the foods that they needed. As a result of this advocacy, the final NDAA legislation contains language requiring TRICARE to cover medically necessary foods.

On May 22, Senators Chuck Grassley (R-IA) and Bob Casey (D-PA) and Representatives John Delaney (D-Md.) and Jaime Herrera Beutler (R-Wash.) introduced the Medical Nutrition Equity Act (S. 1194/H.R. 2587), which would provide public and private insurance coverage for medically necessary foods for digestive and inherited metabolic disorders. The legislation closely resembles the TRICARE provision and applies to both federal health programs and private health insurance. The AAP supports this legislation and is working with members of Congress to advance the bill.

**Academic and Subspecialty Workforce**

Shortages and misdistribution among pediatric subspecialists create access problems for children with special healthcare needs. The Academy strongly advocates for funding programs to improve the subspecialty workforce, including the Children's Hospital Graduate Medical Education Program (CHGME) and the Ensuring Children's Access to Specialty Care Act.

**Support for Pediatric Subspecialists**
The *Ensuring Children’s Access to Specialty Care Act of 2017* (S. 989) was reintroduced in the Senate on April 28 by Sens. Roy Blunt (R-Mo.) and Jack Reed (D-R.I.). The legislation would amend the Public Health Service Act to include pediatric subspecialists in the National Health Service Corps (NHSC) loan repayment program. Currently, the NHSC is unable under existing law to meaningfully fund pediatric subspecialty loan repayment. The legislation was introduced during the previous Congress in both chambers and enjoyed bipartisan support. This legislation was the product of work by the AAP along with a coalition of stakeholders to explore new ways to fund training for subspecialists. Last year, the AAP and 71 other public health and medical organizations endorsed the legislation.

Previously, the Affordable Care Act authorized a Pediatric Subspecialty Loan Repayment Program (PSLRP) as part of Title VII of the Public Health Service Act (PHSA). It would have allowed for up to $35,000 in loan repayment per year for up to three years for pediatric subspecialists or child mental health providers who agree to practice in underserved areas. The program’s authorization expired in 2014 and has not since been reauthorized. Congress is expected to reauthorize Title VII programs this year, which may provide an opening for the reauthorization of PSLRP. The AAP will continue to strongly fund for PSLRP.

**Children’s Hospital GME Funding and Reauthorization**

On May 5, President Trump signed the final Fiscal Year (FY) 2017 omnibus spending bill, which will fund the government through September 30. The spending bill funds the Children’s Hospital Graduate Medical Education (CHGME) at $300 million. This represents a $5 million increase in funding over the FY 2016 enacted level and brings the program to its fully authorized funding level. The CHGME program was last reauthorized in April of 2014 at $300 million through FY 2018.

CHGME provides funding to free-standing children’s hospitals to support pediatric residency and fellowship positions. The AAP has worked to maintain this invaluable funding stream for pediatric residents and fellows, more than half of whom train at CHGME-eligible children’s hospitals.

**Defense Department Subspecialty Training**
The National Defense Authorization Act (NDAA) is an annual piece of legislation that authorizes all defense programs in the United States. The final conference report for the 2016 bill— which came when the House and Senate Armed Services Committees reconciled the versions of the bill they had passed— contained several provisions that benefit children. These include language directing TRICARE to cover medically necessary foods, increasing child abuse reporting requirements in the military, authorizing TRICARE to make payments to State Vaccine Purchasing Programs for the cost of providing vaccines to covered beneficiaries, and directing the Comptroller General to conduct a study on the Exceptional Family Member Program, a program that provides resources for military families who have a child with special health care needs.

Unfortunately, the conferees removed language that had been included in both the House and Senate bills that would direct the Department of Defense (DoD) to report on actions it has taken to improve pediatric care in the Military Health System. In addition to these provisions, the AAP was concerned about three sections included in the Senate bill that sought to reduce or eliminate medical specialists and graduate medical education (GME) slots that were deemed to not “directly support military readiness.” Pediatricians and obstetrician-gynecologists were specifically listed in Senate report language as overstuffed specialties slated for elimination or reduction. AAP, ACOG, and other specialty and subspecialty groups worked over the summer to urge conferees to strip these provisions from the bill. While the provisions were not stripped in their entirety, AAP was successful in altering the
language significantly. Whereas the original bill would have reduced the number of practicing pediatricians in military treatment facilities (MTFs), the new language will direct the Secretary of Defense to establish best practices for care delivery at MTFs, and to ensure that critical wartime readiness and core competencies of health care providers in the Armed Forces are maintained at high levels.

While the previous Senate language proposed to eliminate numerous GME slots within the DoD, the new language instead instructs the Secretary to conduct oversight of the program to ensure that the current numbers of GME slots are appropriate for the readiness of the military. The new language also instructs the Department to issue two reports, one by the Secretary and one by the Comptroller General, that detail these GME programs and how they provide direct and indirect support to readiness, as well as other medical support to the Armed Forces. President Obama signed the NDAA into law on December 23, 2016.

Public Service Loan Forgiveness
President Trump’s Fiscal Year (FY) 2018 budget proposes the elimination of the Department of Education’s Public Service Loan Forgiveness (PSLF) program for new (but not existing) participants. This mandatory program forgives loans after 10 years of making payments for those working in government or non-profits and is a critical tool to ensure the long-term viability of the pediatric workforce. It is important to note that the president cannot unilaterally end PSLF. Because PSLF is mandatory spending, Congress would need to pass separate legislation, outside of the annual appropriating legislation that funds discretionary (non-mandatory) programs, to eliminate it. The AAP will continue to advocate for PSLF.

International Physician Legislation
The Conrad State 30 and Physician Access Act was reintroduced in the House (H.R. 2141) and the Senate (S. 898) by Reps. Bradley Schneider (D-III.) and Darrell Issa (R-Calif.) and Sens. Amy Klobuchar (D-Minn.), Susan Collins (R-Maine), Heidi Heitkamp (D-N.D.), and Jerry Moran (R-Kan.). The Conrad State 30 J-1 visa program expired on April 28, and a bipartisan group of legislators has been working to reauthorize the program. Specifically, the legislation would reauthorize and make permanent the Conrad State 30 J-1 visa waiver program and would allow waivers to be used by physicians whose specialties require them to practice at facilities that serve a medically underserved community. The AAP has endorsed the previous version of this legislation.

Immigration Policy
During his first few weeks in office, President Trump issued several immigrant and refugee-focused executive orders (EOs). The president’s executive orders ban U.S. travel for refugees and immigrants from certain countries, mandate the construction of a wall along the U.S.-Mexico border, call for increased detention and deportation, and eliminate federal funding to sanctuary cities. The AAP immediately responded to these actions with a press statement.

The “refugee and immigrant ban” EO that was signed by President Trump on January 27 has since been halted by the courts. The 9th Circuit Court of Appeals unanimously agreed with the lower court’s ruling to temporarily halt the EO. The AAP joined several other medical organizations and individual physicians in submitting an amicus brief to the U.S. Eastern District of New York for the case of Darweesh v. Trump. The plaintiffs in this case were detained by the U.S. government and threatened with deportation even though they possessed valid visas to enter the country. The brief discusses the important contributions of foreign-born healthcare providers to the care of U.S. patients as well as to the advancement of medical science.

On March 6, the Trump Administration issued a revised version of the executive order on the immigrant and refugee travel ban, which the AAP previously opposed. In response to the revised executive order, the AAP issued a press statement, expressing pediatricians’ concern of the harm its implementation will have on immigrant and refugee children and families.

On March 15, a federal judge in Hawaii issued a nationwide restraining order against enforcement of key parts of President Trump’s revised travel ban executive order just hours before it was supposed to take effect. Similarly, a federal judge in Maryland held that the order appeared to violate federal law. The AAP worked with the Association of American Medical Colleges (AAMC) to submit an amicus brief in the Hawaii case explaining the negative implications of the executive order for maintaining an adequate medical workforce.

On June 26, the Supreme Court announced that it will hear the travel ban case in October and will allow the administration to enforce certain aspects of the executive order until the justices issue their ruling. The court said the travel ban could not be imposed on anyone who has a “credible claim of a bona fide relationship with a person or entity in the United States.” The AAP issued a statement on the ruling once it was announced and will continue to advocate to ensure that immigration
policy supports the pediatric academic and subspecialty workforce.

**Physician Payment**

*Appropriate payment for services provided by all pediatricians is essential to ensuring that all children have access to care. The Academy is continuing to advocate for increased Medicaid payment for pediatrics with the broadest possible applicability to pediatricians and pediatric subspecialists.*

**Medicaid Payment Equity**

The Medicaid payment equity (MPE) provision authorized under the Affordable Care Act (ACA) increased Medicaid payment rates for vaccines and evaluation and management services to at least those paid by Medicare. Currently, Medicaid payment rates are about 70% of Medicare payment rates. However, the ACA provision only applied to calendar years 2013 and 2014 and expired at the end of calendar year 2014. Several efforts were made by legislators during the previous Congress to extend MPE, but those efforts were not successful. Given broader questions surrounding health reform and the structure and financing of Medicaid, legislation has not yet been introduced in the 115th Congress addressing MPE. Although there has been a great deal of anecdotal evidence on the importance of MPE, several new studies help quantify the MPE’s impact on access to care. The Urban Institute released its finding from a *study of Medicaid physician fees* in December 2014. The study concluded once the MPE expires, that Medicaid payments for primary care services would decrease by 42.8% on average. This figure varies from state to state with payments cut by over 50% in seven states and no payment reduction in four states.

In February 2015, the New England Journal of Medicine *released a study* on the impact MPE made on appointment availability. Although the study did not include pediatricians, the results were encouraging. The researchers posed as new Medicaid enrollees and privately insured patients seeking new patient primary care appointments. The study found that the availability of primary care appointments for Medicaid patients increased by 7.7 percentage points from the time period at the beginning of the MPE program in late 2012/early 2013 to May-July 2014 after payments were consistently made at the higher rate.

**Pediatric Drugs and Devices**

*The Academy is continuing efforts to advocate for policies that promote access to safe and effective drugs and medical and surgical devices for children. The AAP is advocating for policies to strengthen three pediatric drug and device laws.*

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**21st Century Cures Act**

On Dec. 13, 2016, President Obama signed the 21st Century Cures Act into law, a sweeping piece of legislation that includes several strong protections for children across a range of issues. Prior to consideration by President Obama, the legislation overwhelmingly passed the House and Senate respectively by votes of 392-26 and 94-5. The Academy released a *press statement* following House passage of the bill.

The following are key takeaways from the legislation:

- New funding for initiatives at both the National Institutes of Health (NIH) and the Food and Drug Administration (FDA) that goes above any annual appropriations funding:
  - A total of $4.8 billion to the NIH Office of the Director for fiscal years 2018 - 2026. This includes $1.4 billion for the Precision Medicine Initiative, $1.6 billion for the BRAIN Initiative, $1.8 billion for cancer research, and $30 million for clinical research to further the field of regenerative medicine using adult stem cells.
  - $500 million for the FDA.

- An AAP-championed requirement that the NIH track and report on the number of children enrolled in clinical trials. Although the NIH has had a formal policy since 1998 requiring this, it has failed to track and publish data on the numbers of children actually enrolled. The AAP has fought for years for such a provision to better understand diseases impacting children and their treatments.

- The AAP-supported Next Generation Researchers Act, which creates a “Next Generation of Researchers Initiative” in the Office of the Director at the NIH to coordinate, develop, modify, and prioritize policies and programs to improve opportunities for new researchers. The provision also requires the NIH to report to Congress on any actions taken in response to recommendations from the National Academy of Sciences as part of a study on policies affecting the next generation of researchers.

- $1 billion over two years to expand access to opioid treatment, training, and prevention. The AAP supported the Comprehensive Addiction and Recovery Act (CARA), which was recently signed into law and authorizes numerous programs to help combat the opioid epidemic. Since CARA did not include supplemental funding, this additional funding is a major step forward in providing the resources necessary to combat the epidemic.
• Reauthorization of the AAP-supported Sober Truth on Preventing (STOP) Underage Drinking Act. The STOP Act reauthorization creates a new grant program to train child healthcare providers about screening, brief intervention, and referral to treatment, which is strongly supported by the AAP and has been shown to help identify alcohol and other substance use disorders early on.

• A provision similar to the AAP-supported Promise for Antibiotics and Therapeutics for Health Act (PATH), which would establish a new approval pathway at FDA for antibiotics to treat serious infections with unmet medical needs.

• The establishment of a Task Force on Research Specific to Pregnant and Lactating Women to provide advice and guidance to the Department of Health and Human Services (HHS) Secretary. The goal is to address gaps in knowledge and research regarding safe and effective therapies for pregnant and lactating women, and the Secretary is required to update regulations and guidance after considering the task force’s recommendations.

• A provision that directs the HHS Secretary, within two years, to make recommendations for the voluntary certification of health information technology for use by pediatric health providers to support the health care of children.

Pediatric Drug Laws

Every five years, Congress must reauthorize the Food and Drug Administration (FDA) drug and device user fee programs. The user fee programs allow FDA to continue to collect money from drug and medical device companies in order to contribute to the cost of reviewing new products.

Since 1997 Congress has included modifications in the user fee legislation that have strengthened and improved the efficiency of the Best Pharmaceuticals for Children Act (BPCA) and the Pediatric Research Equity Act (PREA). Because of Congress’s work on BPCA and PREA, today, more than 675 drug labels have been updated with important pediatric information. AAP joined with over 20 other organizations in outlining seven priorities that should be included in FDA user fee legislation in order to strengthen BPCA and PREA. For more information about these priorities, please see our one pager.

Unfortunately, the current version of the FDA Reauthorization Act of 2017 fails to address a provision in law that prevents FDA from being able to require pediatric studies of drugs for rare diseases. Further, the legislation does not empower FDA to apply PREA to molecularly targeted drugs, failing to adapt the law to continued advances in how drugs are being developed. These drugs are now mainstay of new drug development for cancer, including in children. FDA should be allowed to use PREA to require pediatric studies for a drug when it affects specific molecular targets that are shared between the adult and pediatric disease.

The AAP issued a statement upon the Senate Health, Education, Labor, and Pensions Committee passage of the FDA Reauthorization Act, urging legislators to prioritize children and advance policies to strengthen BPCA and PREA. AAP issued a similar statement upon the House Energy and Commerce Committee’s subcommittee on Health’s passage of the legislation. As this legislation moves forward, the AAP will continue to serve as a vocal advocate for the need to improve these programs in order to ensure safe and effective drugs are available for children.

Pediatric Device Consortia Program Appropriations

The Pediatric Device Consortia (PDC) program was funded at $3 million in FY 2017. The PDC grant program, established in 2009 and reauthorized under the Food and Drug Administration Safety and Improvement Act (FDASIA) in 2012, supports nonprofit consortia that promote the development of pediatric medical devices. Since their inception in 2009, the PDC have been remarkably successful — nine consortia have assisted in advancing the development of more than 440 proposed pediatric medical devices. Most of the devices supported by the consortia are in the early stages of development, including concept formation, prototyping, and preclinical (animal and bench testing) stages, though several devices are now available to patients.

Opioids and Children

President Trump made tackling the opioid epidemic a key part of his campaign. As such, the White House issued an executive order on March 29 instructing four federal agencies to conduct a review of the opioid crisis and recommend new action within 90 days. The order establishes a high-level commission for combating opioid abuse, addiction, and overdose to be comprised of relevant federal employees and non-government stakeholders. New Jersey Governor Chris Christie will chair the commission. The AAP, American Congress of Obstetricians and Gynecologists, and March of Dimes wrote a letter to the commission focusing on the challenges surrounding opioid use during pregnancy and the resulting neonatal abstinence syndrome (NAS), and the impact of parental opioid use on child welfare. Public health advocates worry that these efforts may be duplicative of efforts made under the Obama White House, efforts which include a report issued just last November by Surgeon General Vivek Murthy. In addition, Rich Baum, a longtime civil servant and Republican Hill staffer, has been named head of the White House’s Office of National
Drug Control Policy, a position widely known as the “drug czar.”

Under President Obama, the Comprehensive Addiction and Recovery Act (CARA) was signed into law. The sweeping legislation, which authorizes numerous programs to help combat the opioid epidemic, included provisions to improve treatment for pregnant and postpartum women, reauthorize state prescription drug monitoring programs and increase access to medication assisted treatment and naloxone. In total, the FY 2017 spending bill provides $157.93 million for CARA programs and $5.43 billion in aggregate funding for programs needed to provide a comprehensive response to addiction. The FY 2017 spending bill includes $19.93 million for programs to improve treatment for pregnant and postpartum women and $56 million for medication-assisted treatment.

CARA also includes an update to the Child Abuse Prevention and Treatment Act (CAPTA) related to infants prenatally exposed to certain substances. CAPTA previously required medical professionals to notify child welfare agencies of infants born exposed to illegal drugs or with fetal alcohol spectrum disorder. Child welfare agencies in turn must then develop a plan of safe care (POSC) for ensuring the safety of the infant following hospital discharge. CARA updated this policy to include exposure to any substance, legal or illegal, that causes neonatal withdrawal. In addition, CARA requires states to provide greater data to HHS on its adherence to these requirements. The AAP is engaged in advocacy efforts to ensure CAPTA is appropriately funded to support effective implementation of these provisions.

On June 8, the Food and Drug Administration (FDA) requested that Endo Pharmaceuticals remove its opioid pain medication, Opana ER, from the market. This decision is in line with a recent recommendation by a panel of FDA advisers. The panel determined that the risks of an updated formulation of the drug outweighed the benefits. The updated formulation was intended to reduce the risk of abuse, but the panel determined that some forms of abuse were exacerbated by the reformulation.

FDA Approves Label Changes for Use of General Anesthetic and Sedation in Young Children

The U.S. Food and Drug Administration (FDA) has updated a Drug Safety Communication notifying the public of label changes regarding the use of general anesthetic and sedation medicines in children younger than 3 years. These changes include:

- A new warning stating that exposure to these medicines for lengthy periods of time or over multiple surgeries or procedures may negatively affect brain development in children younger than 3 years.
- Addition of information to the sections of the labels about pregnancy and pediatric use to describe studies in young animals and pregnant animals that showed exposure to general anesthetic and sedation drugs for more than 3 hours can cause widespread loss of nerve cells in the developing brain; and studies in young animals suggested these changes resulted in long-term negative effects on the animals’ behavior or learning.
- FDA reiterates that surgeries or procedures in children younger than 3 years should not be delayed or avoided when medically necessary. They recommend that consideration should be given to delaying potentially elective surgery in young children where medically appropriate.

Restricted Use of Codeine and Tramadol

In April, FDA announced that they are restricting the use of codeine and tramadol medicines in children. In their announcement, FDA noted that these medicines carry serious risks, including slowed or difficult breathing and death, and there appears to be a greater risk in children younger than 12 years, as such they say these medications should not be used in these children. These medicines should also be limited in some older children. Single-ingredient codeine and all tramadol-containing products are FDA-approved only for use in adults. They also recommend against the use of codeine and tramadol medicines in breastfeeding mothers due to possible harm to their infants.

Because of this, FDA is requiring several changes to the labels of all prescription medicines containing these drugs. FDA is now adding:

- FDA’s strongest warning, called a Contraindication, to the drug labels of codeine and tramadol alerting that codeine should not be used to treat pain or cough and tramadol should not be used to treat pain in children younger than 12 years.
- A new Contraindication to the tramadol label warning against its use in children younger than 18 years to treat pain after surgery to remove the tonsils and/or adenoids.
- A new Warning to the drug labels of codeine and tramadol to recommend against their use in adolescents between 12 and 18 years who are obese or have conditions such as obstructive sleep apnea or severe lung disease, which may increase the risk of serious breathing problems.
- A strengthened Warning to mothers that breastfeeding is not recommended when taking codeine or tramadol medicines due to the risk of serious adverse reactions in breastfed infants. These can include excess sleepiness,
difficulty breastfeeding, or serious breathing problems that could result in death.

FDA is urging patients and health care professionals to report side effects involving codeine-and tramadol-containing medicines to the FDA MedWatch program.

Pediatric Research

The Academy continues to advocate for basic and translational pediatric research funding, as well as the importance of including children in clinical research. The AAP closely tracks the Environmental influences on Child Health Outcomes (ECHO) program and the basic and translational research activities at the National Institutes of Health.

National Institutes of Health Appropriations

On May 5, President Trump signed the final fiscal year (FY) 2017 omnibus spending bill, which will fund the government through September 30. The spending bill funds the National Institutes of Health (NIH) at $34.1 billion through the end of FY 2017, a $2 billion increase over the FY 2016 enacted level.

The omnibus also includes $1.38 billion for the Eunice K. Shriver National Institute of Child Health and Human Development (NICHD), a $41 million increase over the FY 2016 level. Additionally, $165 million has been appropriated for the Environmental influences on Child Health Outcomes (ECHO) program and $320 million for the Precision Medicine Initiative, a $120 million increase over FY 2016.

The President’s FY 2018 budget request, which was released May 23, calls for dramatic cuts to the NIH, decreasing funding by nearly $7.2 billion or 21 percent. The budget also cuts funding for the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) to $1.032 billion, a $348 million, a 25 percent decrease as compared to the FY 2017 enacted level. The budget proposes that ECHO will be continued, albeit with a $34 million, 25 percent cut.

Precision Medicine Initiative

The 21st Century Cures Act (Public Law 114-255), which was signed into law by President Obama on Dec. 13, 2016, included an additional $1.5 billion for the Precision Medicine Initiative (PMI) for FYs 2018 – 2026. This funding is supplemental to any funding provided for the PMI through the regular appropriations process. The final FY 17 omnibus appropriations bills included $320 million for the PMI. This represents a $120 million increase over the Fiscal Year (FY) 2016 levels. The President’s FY 2018 budget proposal calls for funding the Precision Medicine Initiative at its FY 2018 authorized level of $100 million, which would represent a cut of 68 percent as compared to current funding.

On Sept. 17, 2015, the Precision Medicine Initiative (PMI) Working Group of the National Institutes of Health (NIH), the advisory group tasked with providing recommendations on the design and implementation of the PMI, released its final report. In the report, the working group took up the AAP’s recommendation that the PMI national cohort include all life stages, including children. The NIH announced in 2016 that the PMI Cohort Program would be renamed the All of Us Research Program.

The NIH report also recommended that the NIH carefully examine issues related to the inclusion of children among other populations, and that the agency should develop “specific approaches to address the needs of these individuals so that they may be included and retained in the cohort.” While the NIH has said that children will not be included in the first phase of the study, it has created the Child Enrollment Scientific Vision Working Group to inform NIH on pediatric issues. Cliff Bogue, MD, FAAP, chair of AAP’s Committee on Pediatric Research, will serve on the working group.

Environmental influences on Child Health Outcomes (ECHO)

On Sept. 21, the National Institutes of Health (NIH) announced awards totaling $157 million to launch the seven-year Environmental influences on Child Health Outcomes (ECHO) program. The awards were given in response to several FOAs published earlier this year for the pediatric cohorts, and clinical sites for the IDEa States Clinical Pediatric Trials Network, which aims to provide medically underserved and rural populations with access to clinical trials.

The final FY 17 omnibus appropriations bills included $165 million for ECHO program. This represents level funding from Fiscal Years (FYS) 2015 and 2016. In addition, the House Labor-HHS appropriations bill included report language urging the NIH to ensure that ECHO grantees and other ECHO-related activities collect data on the impacts of the environment on children’s health as well as requesting a report to Congress on the establishment of a federal advisory committee to oversee the project. President Trump’s FY 2018 budget proposal indicates that ECHO will be continued, albeit with a $34 million, 25 percent cut. Specifically, the Children’s Health Exposure Analysis Resource (CHEAR), composed of a laboratory network to analyze exposures in bio and environmental specimens, would be eliminated. Reductions would also occur to the program’s Data Analysis Centers and Coordinating Centers as well as Cohort grants.

On April 24, 2016, NIH Director Francis Collins, MD, PhD, announced that the agency selected Matthew Gillman, MD as program director of the ECHO program, the follow-on to the now-shuttered National Children’s Study. Dr. Gillman has
experience in epidemiology, pediatrics, and internal medicine, and has been affiliated with a number of large research studies including Project Viva, the Framingham Heart Study, and the aforementioned National Children’s Study. Dr. Gillman also serves as a member of the U.S. Preventive Services Task Force.

Inclusion of Children in NIH-Funded Research

On June 1 and 2, NIH held a workshop to examine policy and science regarding the inclusion of children and older populations in clinical trials and studies. The workshop was held in response to the 21st Century Cures Act, which required NIH to begin to collect and report on the numbers of children including in NIH studies. AAP Immediate Past President Benard P. Dreyer, MD, FAAP, and Scott Denne, MD, FAAP, former chair of AAP’s Committee on Pediatric Research, attended the workshop.

On Dec. 13, 2016, President Obama signed the 21st Century Cures Act into law. The law included AAP-championed provisions that require the National Institutes of Health (NIH) to collect and publish data on the numbers of children included in its clinical research. More specifically, the law requires the NIH to publish data on the “relevant age categories, including pediatric subgroups” included in its clinical research and to hold a workshop of experts in pediatrics and older populations in June to provide input on criteria for appropriate age groups to be included in NIH research studies. The AAP will work with the NIH concerning the implementation of the provisions as well as providing pediatric expertise as the NIH holds its June workshop. Although the NIH has had a formal policy since 1998 requiring the appropriate inclusion of children in its research, the agency has failed to track and publish data on the numbers of children actually enrolled. This data is needed to inform NIH officials and the public about possible gaps in pediatric research. Enactment of these inclusion provisions comes after years of engagement with NIH and Congress on this issue.

Cancer “Moonshot” Initiative

On Sept. 7, the National Cancer Advisory Board approved a draft report developed by the Cancer “Moonshot” Blue Ribbon Panel and its seven working groups that describes a series of recommendations for accelerating cancer research to achieve “a decade’s worth of cancer research progress in five years” and to increase access to promising clinical developments for those currently diagnosed with cancer. The panel had several recommendations related to children, including developing a cancer immunotherapy clinical trials network, developing preclinical models to improve understanding of fusion oncoproteins in pediatric cancer, and developing threedimensional human tumor atlases to improve understanding of various cancers. President Trump’s FY 2018 budget request included $300 million for the cancer moonshot initiative.

Indirect Costs in NIH Grants

President Trump’s Fiscal Year (FY) 2018 budget proposal has targeted indirect cost reimbursements in NIH grants. The overarching budget document released by the White House calls for instituting “policies to ensure that Federal resources maximally support the highest priority biomedical science by reducing reimbursement of indirect costs (and thus focusing a higher percentage of spending on direct research costs).” While the administration’s ideas for reducing spend on indirect costs is unclear, it appears they want to move toward one “uniform indirect cost rate” of between 11 and 15 percent.

On May 24, the Research and Technology and the Oversight Subcommittees of the House Committee on Science, Space, and Technology held a hearing to examine the overhead costs of research. The subcommittees heard testimony from representatives of the National Science Foundation, the Government Accountability Office, Duke University, and Ohio University. The testimony offered contrasting opinions on the current system of reimbursing institutions for indirect research costs in government-funded grants. Members of the subcommittee were generally supportive of indirect cost reimbursements in theory, though some expressed concern that the current system leads to institutional inefficiencies and the potential for fraud. The AAP will continue to monitor developments on this front and advocate for necessary funding for the indirect costs of research.

Budget and Appropriations

The AAP is working hard to support funding for important child health programs that are particularly vulnerable to cuts as a result of the strict discretionary budget caps set forth in the Budget Control Act of 2011, which continue to constrain federal funding on non-entitlement spending.

Fiscal Year 2017 and 2018 Appropriations

President Trump signed the final omnibus spending bill for Fiscal Year (FY) 2017 in to law on Friday, May 5, finishing the appropriations process for FY 2017. The omnibus bill was passed by wide bipartisan majorities in the House and Senate just days before. President Trump had stated he wanted $18 billion in increased spending for defense, a Mexican border wall, and other priorities. Despite that, Congress was wary of that proposal and was also debating whether to cut federal funding for Planned Parenthood. Ultimately, President Trump decided not to push for his priorities.

The omnibus funds the federal government through September 30, 2017, and allocates $1.07 trillion in discretionary funding for the fiscal year, which lines up with the budget cap set by the Bipartisan Budget Act of 2015. Notably, the final omnibus did not include an $18 billion cut to
non-defense discretionary spending proposed by President Trump to pay for increased defense spending and a wall along the Mexican border. The omnibus also contained neither cuts in funding for Planned Parenthood nor reduced funding for "sanctuary cities."

In the Labor-Health and Humans Services-Education portion, where most cuts to discretionary federal funding for health care programs occurred, the Department of Health and Human Services (HHS) received $77.7 billion, an increase of $2.7 billion from FY 2016. Included in this funding was $34.1 billion for the National Institutes of Health (NIH), an increase of $2 billion from the previous fiscal year.

Although the Centers for Disease Control (CDC) saw a $13 million decrease in funding compared to the previous fiscal year, the omnibus retained $286 million in funding for the Title X family planning program, even though the House bill had proposed its elimination. The omnibus also included increases in the following programs important to research and child health:

- $34.1 billion for the National Institutes of Health (NIH), an increase of $2 billion over the FY 2016 enacted level.
- $165 million for a “follow-on” to the National Children’s Study, also known as the Environmental influences on Child Health Outcomes (ECHO).
- $320 million for the Precision Medicine Initiative, a $120 million increase over the FY 2016 enacted level.
- $1.38 billion for the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), a $41 million increase from the FY 2016 enacted level.
- $300 million for the Children’s Hospital Graduate Medical Education (CHGME) program, a $5 million increase over the FY 2016 enacted level.

However, several programs were level-funded or cut:

- $324 million for the Agency for Healthcare Research and Quality (AHRQ), a $10 million decrease from the FY 2016 enacted level.
- $7.255 billion for the Centers for Disease Control and Prevention (CDC), which is a reduction from the FY 2016 enacted level.
- $39 million for Title VII primary care funding under the Health Resources and Services Administration (HRSA), level funding from FY 2016.

Also of note, the omnibus contained $802 million to combat opioid abuse, an increase of $650 million from FY 2016, as well as $296 million for Puerto Rico to help fund the island’s Medicaid program and alleviate the territory’s fiscal crisis.

**President’s Fiscal Year 2018 Budget**

On May 23, President Trump released his full FY 2018 budget proposal. The Academy immediately issued a statement opposing the budget and its drastic cuts to child health programs. The budget proposed by the president contained devastating cuts to child health programs, both domestic and global, and drastically reduced both mandatory and discretionary spending.

On the mandatory spending side, the president has proposed the following:

- Deep cuts to Medicaid totaling about $610 billion. These cuts are proposed on top of the nearly $834 billion that the House has proposed through the AHCA. Combined, if these proposals were enacted, they would cut over $1.6 trillion from the Medicaid program in the next 10 years;
- A two-year extension of the Children’s Health Insurance Program (CHIP), which amounts to a program reduction;
- Reductions to the Supplemental Nutrition Assistance Program and Temporary Assistance for Needy Families;
- A sliding scale on Supplemental Security Income beneficiaries in multi-beneficiary households, which would amount to benefits cuts for children in those homes;
- Eligibility changes to the Earned Income Tax Credit and the Child Care Tax Credit, that effectively cut these poverty-fighting tax credits by $40 billion.

On the discretionary side, the president proposed egregious cuts and full scale eliminations to critical child health programs. Some critical programs that were fully eliminated include: the Public Service Loan Forgiveness Program, Emergency Medical Services for Children, Universal Newborn Hearing Screening, and the Autism and Other Developmental Disabilities program at the Health Resources and Services Administration.

Programs proposed for extreme cuts include global health programs at USAID and the Centers for Disease Control and Prevention, pediatric environmental health programs, especially the Environmental Protection Agency (EPA) Office of Children’s Health Protection, the National Center for Birth Defects and Developmental Disabilities, Head Start, and the Eunice K. Shriver National Institute of Child Health and Human Development.

A full breakdown of children’s health programs in the budget is available here. Going forward, the AAP will continue to urge
Congress to reject the president's budget and to put children first in federal spending.

Emergency Medical Services for Children

Federal Aviation Administration Emergency Medical Kits

The bipartisan, bicameral Airplane KiTS Act (S.1167/H.R. 2485) was introduced in May by Senators Brian Schatz (D-Hawaii) and Jerry Moran (R-Kansas) and Representatives Sean Patrick Maloney (D-N.Y.) and John Faso (R-N.Y.). The legislation requires the Federal Aviation Administration (FAA) to begin the process of updating the contents of the emergency medical kits on commercial flights. The kits currently do not require appropriate medication and devices for the treatment of children.

Brian Moore, MD, FAAP, member of the AAP Committee on Pediatric Emergency Medicine, joined Rep. Maloney and Rep. Faso on a press call to share the importance of the legislation. The bill introduction was covered by the Hudson Valley News Network.

The legislation was previously included in the Senate’s FAA reauthorization bill last year, but unfortunately, Congress ultimately passed a pared-back, short-term extension of the FAA that did not include a requirement to review and update the contents of EMKs on airplanes. The AAP will continue advocating for the provision to be included in the larger FAA reauthorization package that must be passed by September 2017.

Protecting Patient Access to Emergency Medications Act

Recently, the DEA began notifying emergency medical services (EMS) agencies that it believed they were in violation of the Controlled Substances Act by allowing EMS providers to receive, store, transport and administer controlled substances to patients pursuant to standing orders issued by the EMS agency’s medical director. In the absence of a change in law or change in DEA interpretation, an individual patient prescription would have to be provided by a properly licensed and credentialed medical provider prior to dispensing a controlled substance.

AAP supports the bipartisan Protecting Patient Access to Emergency Medications Act of 2017 (H.R. 304) introduced by Reps. Richard Hudson (R-N.C.) and G.K. Butterfield (D-N.C.) that passed the House in January. Previously, the bill was unanimously passed by the House in December, but the Senate was unable to pass a companion measure before the end of the 114th Congress. Following the bill’s passage through subcommittee, the Academy issued a statement thanking its sponsors Rep. Richard Hudson (R-N.C.) and Rep. G.K. Butterfield (D-N.C.) for their work on the issue. AAP has endorsed the bill and will continue to work with partner organizations to advocate for the passage of this important legislation through the Senate.

AAP Blueprint for Children

![AAP Blueprint for Children](image)

The AAP is leveraging the Blueprint for Children as a tool to educate newly appointed cabinet secretaries and administration officials on the work their agencies can do to improve the health of children. As officials join the administration, the AAP is reaching out to share the Blueprint and highlight relevant recommendations.

Originally unveiled by the AAP on September 19, 2016, Blueprint for Children: How the Next President Can Build a Foundation for a Healthy Future is a transition plan for the new administration. The Blueprint includes a comprehensive overview of specific federal policy recommendations to promote healthy children, support secure families, build strong communities, and ensure that the United States is a leading nation for children. In addition, the transition plan offers agency-by-agency recommendations with detailed actions federal agencies and departments can take to improve the lives of children.

As of October 1, the document has been endorsed by 11 leading medical and health organizations. For more information on the Blueprint and to read the full document, please visit aap.org/blueprint. On the same day as the plan’s release, the Academy hosted an expert panel discussion in Washington, DC, Speaking Up for Children: A Conversation About Child Health in the Next Administration. The archived video from the event can be found here.

Grassroots Advocacy: AAP Key Contact Program

Key Contacts are AAP members who are interested in receiving advocacy opportunities and timely policy updates from the AAP Department of Federal Affairs on federal legislation and other issues important to the Academy.

Through regular e-mail communication with specific requests for action, the Department of Federal Affairs keeps Key Contacts informed of the latest legislative developments affecting children and pediatricians.
How to Become a Key Contact

E-mail kids1st@aap.org with your name, AAP ID if known, and your preferred e-mail address. If you have questions about federal advocacy, contact AAP Department of Federal Affairs at 800-347-8600.

FederalAdvocacy.aap.org: Dept. of Federal Affairs Online Resource Center

Visit the AAP Department of Federal Affairs website at FederalAdvocacy.aap.org to find federal advocacy resources and tools, including:

- Contact and biographical information for your federal legislators
- An Action Center where you can call and e-mail federal legislators directly on current federal child health policy priorities
- A media center where you can read recent opinion pieces written by pediatricians
- Background information on current AAP federal child health issues advancing in Congress
- Highlight the importance of pediatric research with a thank you note to your members of Congress each time you are awarded a federal grant.

Engage with AAP on Social Media

Twitter is a powerful tool that allows individuals and organizations to amplify messages, connect with new and diverse networks, and gain access to local-, state- and federal-level decision-makers. As a pediatrician, Twitter also offers you the opportunity to be part of a community that encourages the exchanging of ideas around child health, while not being constrained by time or geography.

To stay up-to-date on child health news, follow and engage with AAP on social media via @AmerAcadPeds, @AAPPres, @AAPNews and @healthychildren. You also can subscribe to AAP’s official #tweetiatrician list on Twitter by visiting https://twitter.com/AmerAcadPeds/lists/tweetiatricians.

Request to be added to the list by emailing AAP’s social media community manager, Helene Holstein, at hholstein@aap.org.
AAP Washington Office

Mark Del Monte, JD  Chief Deputy
          Senior Vice President, Advocacy and External Affairs

Department of Federal Affairs

James D. Baumberger, MPP  Associate Director
Tamar Magarik Haro  Associate Director
Ami Gadha, JD  Assistant Director
Patrick Johnson, MA  Assistant Director
Marielle Kress, MPP  Assistant Director
Aaron Emmel, MA  Manager, Global Health Advocacy Initiatives
Zach Laris, MPH  Policy Associate
Allyson Perleoni, MA  Policy Associate
Madeline Curtis  Legislative Assistant
Matt Mariani  Legislative Assistant

Department of Public Affairs

Division of Advocacy Communications

Jamie Poslosky  Director
Helene Holstein  Manager, Social Media Community
Devin Miller  Advocacy and Public Affairs Assistant