



September 15, 2005

CRD ASSOCIATES HEALTH POLICY UPDATE

Those of you with a little gray in your hair may remember a fellow named Ron Ziegler. Ziegler was the press secretary to President Richard Nixon. After months of deny, deny, deny, the Supreme Court finally ordered the President to release audiotapes that laid bare the massive conspiracy that was Watergate. After the courts ruled, Ziegler stepped up to the microphone in the White House briefing room and said, “All previous statements are hereby inoperative.”

The only difference between then and now is that the “inoperative” nature of previous statements results, not from political intrigue, but from a devastating natural disaster called Katrina.

In last month’s report, we indicated that when Congress returned after Labor Day, lawmakers would focus on finishing its work the appropriations bills and on the nomination of Judge John Roberts to the US Supreme Court. We suggested that it would be difficult for Congress to complete its appropriations work by September 30, and that lawmakers would likely adopt a stop-gap continuing resolution to keep government agencies operating into the new fiscal year that begins October 1.

The situation has gone from bad to worse very quickly.

Budget and Appropriations Update

Technically speaking, Congress is operating under a budget resolution that sets overall spending and revenue targets, and calls for reductions in entitlement programs and a new round of tax cuts. Specifically, the bill shaves nearly \$35 billion from entitlement spending through 2010, with nearly a third of that—\$10 billion—presumably coming from the Medicaid program. “Presumably” because while the budget resolution sets hard and fast spending limits, the responsibility for determining exactly how those limits are achieved is left to other congressional committees to decide.

The budget blueprint also clears the way for \$106 billion in tax cuts over the next five years, including the extension of tax cuts that would otherwise expire, like the cut in capital gains enacted in 2003.

Within the framework of the budget resolution, the task falls to the individual committees of Congress to determine how best to arrive at the savings called for in the resolution. For Medicare and Medicaid, responsibility rests with the House Ways & Means Committee, the House Energy & Commerce Committee and the Senate Finance Committee. In light of pressures to respond to Hurricane Katrina, however, the congressional leadership has now postponed action on coming up with savings from September 15 to October 26. The fundamental problem, of course, is: How do you cut Medicaid by \$10 billion at a time when so many families have been dislocated as a result of the hurricane?

On the discretionary side of the budget—that portion over which Congress has the most control—the budget resolution imposes a bottom-line spending freeze of \$404 billion on non-defense programs. The House has passed all eleven of its appropriations bills; the Senate has passed five of its twelve. (A reorganization of the appropriations committees has, for the first time in memory, left the two chambers with asymmetrical subcommittee structures.)

The House of Representatives has passed, and the Senate Appropriations Committee has completed its work on, the appropriations bill for FY06 that funds health services and health research programs. As we reported last month, under the Senate committee bill, the news is surprisingly good for SGIM and its members.

- While the House bill held AHRQ to \$318.7 million again this year, the Senate bill appropriates \$323.7, an *increase* of \$5.0 million over last year and over the President's request.
- The President's budget eliminated funding for most Title VII programs, including all money for "Training in Primary Care Medicine and Dentistry." While the House supported the President's position, the Senate bill appropriates \$454,393,000 for the HRSA health professions program. This is an *increase* of \$4,180,000 over last year's level and restores all the programs the President's budget eliminated. Of most direct impact for SGIM, the bill appropriates \$90,000,000 million to the "Training in Primary Care Medicine and Dentistry" programs, an *increase* of \$1,184,000 above last year and the precise figure that SGIM leadership requested on Capitol Hill Day.
- Finally, with regard to the National Institutes of Health, again, the Senate went far beyond the House funding levels. The House followed the President's lead and included a 0.5 percent increase for all of NIH in its appropriation bill. The Senate, on the other hand, stepped forward with an increase of 3.7 percent, or more than \$1.0 billion. This amount is roughly the rate of biomedical research inflation and would have the effect of not letting NIH fall any further behind in FY06.

All of these increases included in the Senate bill are at risk now as a result of Katrina. As tough as the pressures have been all year to hold down domestic discretionary spending, the appropriation of \$62.3 billion thus far for hurricane relief, with much more to come, will greatly exacerbate the situation. It will now be more important than ever for SGIM

to focus on retaining the key progress that we have achieved in the Senate bill and inspiring the House to concur in the Senate numbers.

Medicare Physician Payments; Pay for Performance

As we reported last month, legislation has been introduced in both the House and the Senate to create a “pay for performance” (P4P) or “value-based purchasing” (VBP) system (the terms are used interchangeably).

The Senate bill, introduced by Senators Grassley and Baucus, would create a P4P system that would be phased in over the next several years and would apply to physicians, hospitals and ESRD facilities. The bill would direct the Department of Health and Human Services to begin selecting quality measures in 2006. In 2007, physicians who do not report quality data would receive a 2 percent reduction in their reimbursement rates. In 2008, HHS would begin redistributing 1 percent of reporting physicians’ payments to top performers, based on the quality measures, with the figure increasing by 0.25 percent per year until it reaches the level of a 2 percent redistribution.

The House bill, introduced by Congresswoman Nancy Johnson (R-CT), would only apply to physicians. It would repeal the current Sustainable Growth Rate (SGR) formula, changing the system from one based on volume, to one that is based on the Medicare Economic Index (MEI), thus eliminating the planned 4.3 percent reimbursement reduction. Clinical measures will be developed by individual specialties, which will then be approved by a validating organization like the National Quality Forum, while structural measures will be developed by CMS via the rule-making process. For FY07 and FY08 physicians will report their claims data to the Centers for Medicare and Medicaid Services (CMS). In FY09 physicians will move to a reimbursement system based on quality. The bill adjusts for noncompliant patients and has an appeals process.

In the meantime, CMS has begun to move on its own to craft a “demonstration project” that would create a voluntary P4P system using very simple and generic measures of quality supplied by specialties. The un-validated measures would serve as a yardstick for CMS to begin to encourage physicians to think in new terms. SGIM, working with ACP and other organizations, is deeply involved in this topic to assure that any new standards that are developed do not work to the detriment of general internal medicine.

NIH Reauthorization

Jurisdiction over NIH rests with the House Energy and Commerce Committee and the Senate Health, Education, Labor and Pensions Committee. The latter has shown no interest in reauthorizing NIH, but the former has been aggressively pursuing the development of legislation.

In late August, House staff released a second draft of the measure, one that shifts even more power to the NIH director.

For example, the NIH Director currently is authorized to transfer up to one percent of appropriated funds to meet unanticipated research needs. The draft legislation suggests that the statutory limit will be increased, perhaps as high as three percent. The draft also proposes establishing a so-called “common fund” to support trans-NIH research activities. The fund would be financed at the beginning of each fiscal year by setting aside a pre-determined (but as yet undetermined) percentage of overall NIH funding.

Given that Congress is likely to have its hands full responding to demands for social services and rebuilding efforts in the Gulf Coast region, it is difficult to envision Congress taking time to debate an NIH reauthorization bill anytime soon.

The information concerning the other issues that has been included in past reports is reproduced below and remains current, as of the time of this writing.

NIH Public Access Policy

NIH’s much-lauded and much-criticized public access policy went into effect May 2, as pointed questions about its voluntary nature and long-term effects on the peer review system remain difficult to address. The agency announced its final public access policy Feb. 2 amid a flurry of criticisms that the rule is unenforceable and may violate copyright laws.

The House Labor-HHS-Education appropriations bill contained a paragraph of report language endorsing public access to NIH research results, but suggesting that the adopted policy may fall short. It requests a report from NIH by next year containing information to show the impact of the policy. It also directs NIH to create an education program to inform researchers about the new policy.

The comparable Senate bill has a less warm paragraph discussing the policy. It also calls for a report from the NIH to the Committee and includes in the report information on the cost of implementing the policy, something the House pointedly does not ask for.

Title VII Reauthorization Update

While we remain focused on obtaining funding for the Title VII health professions programs, there is a separate and equally important process occurring to reauthorize the underlying statute that governs these programs. Responsibility for reauthorization rests with the Senate Health, Education, Labor and Pensions (HELP) Committee and the House Energy and Commerce Committee.

Both committees seem poised to advance reauthorization bills this year, however the press of other legislative business could stall that process. Nevertheless, we recommend that SGIM play a more active role to ensure that relevant health professions programs are extended in a meaningful way. In line with that, we suggest that Title VII reauthorization be featured prominently during SGIM’s Capitol Hill Day visits.

Genetic Nondiscrimination Legislation Update

Legislation to outlaw genetic discrimination in health insurance and employment passed the Senate on February 17, 2005, by a vote of 98 – 0. The measure, which was sponsored by Senator Olympia Snowe (R-ME), is identical to legislation that passed last year, but died when Congress adjourned.

A companion measure, H.R. 1227, has been introduced in the House by Representative Judy Biggert (R-IL). However, because the legislation has been referred to three different committees—Education and the Workforce, Energy and Commerce, and Ways and Means—action is not likely to occur anytime soon. The House, in fact, has shown decidedly less enthusiasm for the bill than the Senate, with the GOP leadership essentially following the insurance industry’s mantra that they do not discriminate, will never discriminate and do not want to be told that they can not discriminate.

The Bush administration has issued a Statement of Administration Policy (SAP) endorsing the bill. However, it has not taken any overt steps to pressure the House to move the bill.

CMS Five-Year Review

Medicare statute requires that the Centers for Medicare and Medicaid Services (CMS) review the values it assigns to Current Procedural Terminology (CPT) codes on the physician fee schedule at least every five years. To do this, CMS works closely with the AMA’s Specialty Society Relative Value Update Committee (RUC) and specialty societies to revalue codes. The RUC is comprised of 28 members, including 23 representatives of major specialty societies. The remaining members represent the AMA, the American Osteopathic Association, a representative from the non-physician Health Care Professionals Advisory Committee, and the CPT Editorial Panel. The work of the RUC is supported by the RUC Advisory Committee, which is made up of representatives of 65 specialty societies in the AMA’s House of Delegates.

The timeline for this, the third five-year review process is as follows:

May 2005	Begin completing online surveys
July 2005	Due date for completing surveys
August 2005	Specialties present work RU recommendations to the RUC
October 2005	RUC sends recommendations to CMS
November 2005	CMS publishes final rule on five-year review
January 1, 2007	New work RVUs go into effect