



December 22, 2005

CRD ASSOCIATES HEALTH POLICY UPDATE

To paraphrase President Gerald Ford in 1974, “our long congressional nightmare is over...at least for the time being.”

With Santa’s reindeer prancing on the roof of the Capitol, Congress has finally finished its legislative year, reaching an adjournment that had been scheduled for the beginning of October. In so doing, lawmakers adopted drastic cuts in health professions; froze spending on direct health services, biomedical research and Medicare physician reimbursements; cut the President’s avian flu initiative; under-funded No Child Left Behind education programs; and reduced taxes yet again.

But it could have been worse!

Budget and Appropriations Update

On December 21, the Senate narrowly passed budget reconciliation legislation that includes significant reductions in important entitlement programs like food stamps, Medicaid and Medicare, and student aid. On a parallel track, lawmakers gave final legislative approval to the Labor-HHS-Education appropriations bill for fiscal year 2006, taking those programs \$1.4 billion below current funding levels, before a government-wide one percent across-the-board cut is factored in. (With the exception of veterans programs, all federal programs, projects and activities will be cut by one percent, a move that is expected to save \$8 billion in federal spending.)

The reconciliation bill cuts about \$40 billion from entitlement spending, or about \$5 billion more than was required by the spending blueprint Congress adopted in April 2005. Prior to passage, however, Democrats successfully raised points of order against three minor provisions of the bill. Those provisions were then removed, necessitating the bill going back to the House for concurrence in the revised bill. It seems likely that the House will vote on this when it returns to work January 31.

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. Nowhere has that squeeze more apparent than in the House-Senate conference report on the Labor-HHS-Education appropriations bill.

Last month, we reported on the significant cuts to programs that matter most to SGIM members, and urged opposition to that bill when it came before the House. The legislation subsequently lost in the House by a vote of 209-224. This then sent the bill back to the conference committee where some of the funding was restored. For example:

- We had reported that the conference agreement devastated Title VII health professions training programs, with the Primary Care Medicine and Dentistry Training program is slashed by 68 percent, from \$89 million down to \$28 million. The new conference report increased that program to \$41 million. HETCs, geriatric, rural training, workforce information and analysis and the health administration programs were all eliminated in the original bill and those cuts stuck through the revised conference.
- We also told you the legislation would fund the National Institutes of Health at \$28.5 billion, an increase of \$253 million, or less than one percent over FY2005 funding, the smallest increase for that agency in three decades. With the rate of biomedical research inflation running at more than 3.5 percent, this represents a real reduction in the number of R-01s and other grant mechanisms that can be funded in FY06. This was unchanged in the final bill.
- The Agency for Healthcare Research and Quality (AHRQ) was held to \$318.7 million again this year, wiping out an increase of \$5.0 million over last year and over the President's request that had been included in the Senate bill. Again, the new conference report did not change this.

Medicare Physician Payments; Pay for Performance

Somewhat surprisingly, the Budget Reconciliation legislation blocked the planned 4.4 percent reduction in physician reimbursements that was scheduled to take effect on January 1, 2006. The final version of the bill freezes physician payments at current levels.

On the issue of pay-for-performance, while the Senate bill originally included the creation of a new payment system, the House bill did not. In the final legislation, this provision was dropped.

In the meantime, CMS has continued to move forward 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. These 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, remains deeply involved in this topic to assure that any new standards that are developed do not work to the detriment of general internal medicine.

The Health Policy Committee is continuing to follow this issue that could ultimately determine the means of physician reimbursement for the next 15-20 years, and will keep the membership advised on important developments, including asking for members to

contact their representatives in Congress at appropriate times. Please respond affirmatively and quickly when those requests are made.

NIH Reauthorization

As Congress winds up its work for the year, any efforts to restructure and reauthorize NIH will have to wait until 2006.

Jurisdiction over NIH rests with the House Energy and Commerce Committee and the Senate Health, Education, Labor and Pensions Committee. Thus far, the Senate 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.

No further action was taken on this legislation in the year-end rush and it is not clear whether this will become a priority for consideration in 2006. However, given the potential of the legislation to either benefit or hurt health services researchers, it will merit continued close scrutiny.

GME Volunteer Preceptor Issue

Since the late 1980s, CMS has permitted hospitals to count the time residents spent in non-hospital settings for the purpose of GME payments, as long as two requirements were met. A written agreement between the hospital and non-hospital site must be in place, and it must stipulate that the hospital would cover “all or substantially all” of the costs associated with the resident. Since 2002, CMS intermediaries have begun denying, retroactively through audits, the time residents spend in these non-hospital sites where physicians are volunteering their services, reducing the GME payments a hospital or teaching program receives for residents training in non-hospital sites. These actions conflict with the Congressional intent expressed in the 1997 and 1999 balanced budget acts, which were designed to encourage rural and out-of-hospital experiences.

To preserve the opportunity for residents to train in diverse settings and to ensure that programs in rural and underserved areas remain in operation, legislation has been introduced in both the House and the Senate. The Community and Rural Medical Residency Preservation Act of 2005 (S. 2071/ H.R. 4473) was introduced by Senators Snowe (R-ME), Bingaman (D-NM), Collins (R-ME), Dorgan (D-ND), Rockefeller (D-WV) and Representatives Hulshof (R-MO) and Tanner (D-TN). This legislation provides that CMS regulations will allow supervising physicians to volunteer their teaching time,

while ensuring that any teaching costs associated with supervising physicians who are not volunteers would be based on negotiations between the hospital and non-hospital setting.

When Congress returns and takes action on this legislation, we will ask members to contact their representatives.

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