



Cavarocchi-Ruscio-Dennis Associates

Health Policy Report

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- **SGIM CAPITOL HILL DAY BRINGS ADVOCATES TO WASHINGTON**
- **HEALTH REFORM MAY MOVE FOLLOWING BIPARTISAN SUMMIT - BUT MAYBE NOT BIPARTISANLY**
- **FY2011 BUDGET PROPOSAL FREEZES MOST DISCRETIONARY SPENDING; CONGRESS CONSIDERS ITS OPTIONS**

Overview

The month of February has continued a familiar pattern: Washington gets buried under still more snow and issues continue to move at an appropriately glacial pace for the surroundings.

Perhaps the fastest moving item in Washington in February was SGIM's Capitol Hill Day. Thirty seven general internists spent a full day holding nearly sixty meetings with senators, congressional representatives and their staffs, bringing the message of the critical nature of general internal medicine to DC. With an agenda that emphasized the critical needs of primary care in education, research, and clinical practice, SGIM advocates were met with great support.

This was the largest Capitol Hill Day SGIM has ever held and great thanks need to go out to those who took time out of their schedules to press for better policies from Washington.

With the Bipartisan Health Summit occurring the day after Capitol Hill Day, Congress continues to assess its options. While no final decisions have been made, it appears that Congress will pursue a so-called reconciliation bill that includes just enough reform to capture a simple majority in the House and Senate. Some will characterize this as a "parliamentary trick," but it simply restores the principal of "majority rules" to a largely undemocratic Senate.

If Congress pursues a budget reconciliation process for health care reform, the measure can include only those provisions that are considered "germane" i.e. have a direct impact on federal budget spending or taxes. A reconciliation bill could include new taxes, such as the Senate's excise tax on high-valued health plans, or offer tax credits for premium subsidies. But any provisions that go beyond those objectives would be subject to a point-or-order, meaning the provision would be stripped from the bill unless it garners 60 votes.

Among those provisions that would likely be considered non-germane are the creation of health insurance exchanges, some market reforms, a public option (if not dependent on federal spending), prevention and wellness programs, anti-abortion provisions, delivery system reforms and reporting and data collection activities. These could be considered under separate legislation.

Some rank-and-file members of Congress are pushing the idea of passing several scaled-back measures that would fall well short of universal coverage but would still include the most popular pieces of the overhaul. That group has outlined a series of bills that would include a patients' bill of rights, remove antitrust protections for insurers, close the "donut hole" in the Medicare prescription drug program and provide tax credits for buying insurance. Those bills would lack any mandates on employers to provide coverage or individuals to buy it.

Last month we noted that President Obama officially kicked off this year's budget season when sent Congress a \$3.8 trillion fiscal year 2011 budget proposal on February 1. In it he proposes a three-year freeze on domestic discretionary spending. A freeze would not put a big dent in overall deficits, but it is one of the easier targets in the federal budget and sends a symbolic message.

The freeze would last from fiscal years 2011 through 2013, and would apply to discretionary spending unrelated to the military, foreign operations, veterans' affairs and homeland security. It would not affect entitlement programs such

as Medicare, Medicaid and Social Security. If adopted, the freeze would hold spending levels at the affected federal departments to approximately \$447 billion, or about one-eighth of the entire 2010 federal budget, and save \$250 billion over the next 10 years.

The Budget Committees and the Appropriations Committees in both houses are just now beginning to hold hearings on the President's budget requests, in what promises to be a long and arduous process.

Education Subcommittee Issues

While the specific details behind the President's proposal for healthcare reform have not been released, it appears that his proposal follows the outlines of the workforce provisions contained in the reform bill passed by the Senate on Christmas Eve.

The President proposes to establish a multi-stakeholder Workforce Advisory Committee to develop a national workforce strategy, with appointments to be made by September 30, 2010. The plan would also increase the number of graduate medical education (GME) training slots by redistributing currently unused slots, with priorities given to primary care and general surgery and to states with the lowest resident physician-to-population ratios, effective July 1, 2011; increase flexibility in laws and regulations that govern GME funding to promote training in outpatient settings; and ensure the availability of residency programs in rural and underserved areas.

The plan would also establish Teaching Health Centers, defined as community-based, ambulatory patient care centers, including federally qualified health centers and other federally-funded health centers that are eligible for Medicare payments for the expenses associated with operating primary care residency programs.

The President's plan also would reauthorize and strengthen the current Title VII program. Among other things, his proposal would increase workforce supply and support training of health professionals through scholarships and loans; support primary care training and capacity building; provide state grants to providers in medically underserved areas; train and recruit providers to serve in rural areas; establish a public health workforce loan repayment program; provide medical residents with training in preventive medicine and public health; promote training of a diverse workforce; and promote cultural competence training of health care professionals. The plan encourages the development of training programs that focus on primary care models such as medical homes, team management of chronic disease, and those that integrate physical and mental health services.

Research Subcommittee Issues

The budget proposes \$611 million for AHRQ, an increase of \$214 million above FY2010. This includes \$286 million for patient-centered health research (the budget's new descriptor for comparative effectiveness

research), including support for 138 new and ongoing research grants to identify new and emerging issues, synthesize existing evidence and translate and disseminate new knowledge. The AHRQ budget also includes \$32 million, a \$4 million increase, for health IT research, enough to fund 44 research and training grants, and \$34 million to reduce and prevent healthcare-associated infections.

The President's budget proposes \$32.2 billion for NIH, an increase of \$1 billion, or 3.2 percent, over the FY2010 level. The request spreads the increase fairly evenly across the agency, with most institutes receiving an increase of about three percent. Within the total, the budget would support a two percent increase to help cover inflationary increases. The average cost of a new and competing grant will be \$443,000. Unlike last year, the President is not proposing to double funding for cancer and autism research over time. Instead, the budget highlights initiatives within those research programs, such as the start-up of 30 new cancer drug trials, cataloguing of the 20 most common malignancies and increased research to define the genetic and environmental factors contributing to autism spectrum disorders. The Clinical and Translational Science Award (CTSA) will be boosted so as to foster more collaborations among investigators in different fields. The budget calls for another \$20 million, bringing the program level to \$500 million, or \$200 million below what was originally promised for this program.

With regard to the healthcare reform bill, it appears that the President's proposal would follow the outlines of the bill passed by the Senate on Christmas Eve, specifically including an outside-of-government private research institute to implement comparative effectiveness research. That approach is problematic for reasons that have been discussed here before and SGIM continues to work diligently to improve the approach.

Clinical Practice Subcommittee Issues

The budget includes \$784.3 billion for CMS, to cover both mandatory and discretionary spending, a net increase of \$48.3 billion over FY2010. That includes \$110 million for a Health Care Data Improvement initiative to address aging information systems and to transform the agency's data environment. In addition, the budget includes \$78 million, an increase of \$17 million, for the Office of the National Coordinator for Health Information Technology, to advance health IT adoption and electronic health records utilization.

The budget also includes \$371 billion over 10 years to reflect the administration's best estimate of future congressional action to address the Medicare physician payment issue. However, a method for addressing this problem has not been identified at this point and the cut technically takes effect co-incident with the publication date of this report.

The Office of Management and Budget has ordered CMS to hold all payment claims for ten days to give Congress time to rectify this problem. Currently, Senator Jim Bunning of Kentucky has a "hold" on the legislation that would correct the problem and the entire medical establishment in Washington is working to address this. Further information will be available soon on this important matter.

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