Cavarocchi-Ruscio-Dennis Associates

Health Policy Report

April 1, 2010

- **COMPREHENSIVE HEALTH INSURANCE REFORM ENACTED; NOW THE HARD PART BEGINS!**
- **FY2011 BUDGET PROPOSALS EXPECTED TO MOVE TO THE FOREFRONT FOLLOWING COMPLETION OF HEALTH INSURANCE REFORM**

Overview

After fourteen months of debate, comprehensive health insurance reform legislation completed its tortuous path through five congressional committees, both houses of Congress, through a never-completed conference committee, to a bipartisan summit at the White House, to final passage, enactment by the President – and follow-up reconciliation legislation to clean up the bill that had been enacted.

As we reported last month, the President called a Bipartisan Health Summit (that occurred the day after SGIM's Capitol Hill Day). While this led to no breakthroughs, what it appeared to do was convince the majority Democrats that the White House had made every effort and that the Republicans were intent on providing no votes for the bill without regard to its content. This provided the will for the House to pass the Senate-passed bill and send it to the President. Both houses then passed the reconciliation bill to implement some compromises that had been agreed upon among the two houses and the White House. Some have characterized reconciliation as a "parliamentary

trick," but it simply restores the principal of "majority rules" to a largely undemocratic Senate, where otherwise 41 members can thwart the will of the majority.

As we have noted, President Obama officially kicked off this year's budget season when he sent Congress a $3.8 trillion fiscal year 2011 budget proposal on February 1. In it he proposed 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 continuing to hold hearings on the President's budget requests, in what promises to be a long and arduous process. We expect the Budget Committees in both houses to announce scheduling plans after the Easter recess.

Education Subcommittee Issues

The new health care reform law includes a five-year renewal of Title VII health professions training and development programs.

The new reform law authorizes the Training in Family Medicine, General Internal Medicine, General Pediatrics, and Physician Assistantship program, while repealing a section in the previous law that called for a "ratable reduction." This will help ensure the allocation of training funds on the basis of national need and merit. Provisions are also included that assign preferences that foster greater diversity in the workforce. Priority is assigned to programs that educate students in team-based approaches to care and innovative teaching models, such as the patient-centered medical home.

The new law also calls for creation of a 15-member national workforce commission, tasked with providing comprehensive, unbiased recommendations to Congress and the president on workforce goals, priorities and policies. An annual report must be submitted to Congress no later than October 1, beginning 2011. Congress will use this information

when determining appropriations to discretionary programs or in restructuring other Federal funding sources.

Beginning April 1 of 2011, and annually thereafter, the commission is to submit a review and recommendations addressing at least one high priority area set out in the legislation, including: integrated health care workforce planning; an analysis of the scopes of practice and demands for health care workers in an enhanced health IT and management workplace; the capacity, demands and integration of the workforce in nursing, oral health, mental and behavioral health, allied and public health, emergency medical service; and the geographic distribution of providers as compared to workforce needs of states and regions.

The reform also would 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. The measure also would 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.

Research Subcommittee Issues

The health insurance reform legislation that was signed into law by the President did not have research as a principal focus. However there are a couple of provisions that are worth noting. Of greatest significance, the legislation advances comparative effectiveness research (CER), although it does so through a mechanism that is less than ideal.

The bill establishes a non-profit Patient-Centered Outcomes Research Institute (PCORI) to identify research priorities and fund research comparing the clinical effectiveness of medical treatments. The Institute would be federally-chartered but outside the structure of the government. It would be controlled by a 17-member, multi-stakeholder Board of Governors that would include the Directors of AHRQ and NIH, as well as three industry representatives.

Findings from the research funded by the Institute would is prohibited statutorily from being construed as mandates, guidelines, or recommendations related to the existence or level of payment, coverage or treatment, or used to deny coverage.

In a separate provision, the legislation creates a Cures Action Network (CAN) within the Office of the Director of NIH. The purpose of this network is to

utilize NIH to assist start-up companies with moving developing products across the so-called "valley of death" between development and commercialization. The provision is based on legislation drafted by Senator Arlen Specter of Pennsylvania. It is not clear at this point what the relationship might be between CAN and CTSAs that currently are funded by the National Center for Research Resources at NIH.

The creation and implementation of both the PCORI and CAN will merit continued vigilance by SGIM to assure that they operate in a means to maximize the benefits to patients. The early establishment phases will be particularly important in defining the path these two new entities will follow.

Clinical Practice Subcommittee Issues

The health care reform legislation made important changes that will affect the way care is delivered. It included SGIM priority issues, including a 10 percent bonus for 5 years for the provision of primary care services and a directive for the Secretary of the Department of Health and Human Services to review misvalued services, which may benefit primary care service codes. The reconciliation package included a provision that Medicaid would pay at the same rate as Medicare for primary care services in 2013 and 2014.

The legislation also addresses the Patient-Centered Medical Home. The Secretary is required to establish a program to provide grants or contracts to establish health teams to support primary care practices. States or state-designated entities and Indian tribes or tribal organizations will be eligible to receive these grants or contracts if they submit a plan for achieving long-term financial sustainability within 3 years that incorporates prevention initiatives, patient education and care management resources. The health team must also include interdisciplinary, interprofessional teams of providers and agree to provide services to eligible individuals with chronic conditions. The legislation also creates a pilot program from Accountable Care Organizations (ACOs), which will impact how care is delivered.

Another important provision of the bill creates the Independent Medicare Advisory Board, charged with controlling costs in the Medicare program. CMS is required to determine if the projected per capita growth rate for the program is set to exceed the target growth rate for a given year. If it is, the Board is charged with developing a proposal with recommendations to reduce the growth in Medicare that must be implemented by the Secretary unless Congress enacts legislation that would alter the proposal.

The legislation did not address the flawed SGR formula. Prior to adjourning for a 2 week recess, the Senate did not pass legislation to avert a 21 percent cut in Medicare physician payment scheduled for April 1. The House passed

legislation that would freeze physician payments until May 1, but some Senators objected because the bill was not paid for. This is the second time in two months that Congress has allowed the sustainable growth rate cuts to take effect. However, the Senate can still act after recess. CMS has been instructed to hold the payment of claims submitted after April 1 for 10 business days to prevent providers from receiving a payment reduction.

Health Policy Executive Committee Contact Information

Bill Moran, HPC Chair	moranw@musc.edu
Laura Sessums, HPC Co-Chair	laura.sessums@us.army.mil
Lisa Rubenstein, Council Liaison	lisar@rand.org
Angela Jackson, Chair, Education Sub.	angela.jackson@bmc.org
Ira Wilson, Chair, Research Sub.	Iwilson@tuftsmedicalcenter.org
John Goodson, Chair, Clinical Practice Sub.	jgoodson1@partners.org
Patty Harris, Chair, Member Devel. Sub.	patricia.f.harris@medstar.net
Colleen Appleby-Carroll, SGIM Staff	applebycarrollc@sgim.org
Lyle Dennis, CRD Associates	ldennis@dc-crd.com
Dom Ruscio, CRD Associates	druscio@dc-crd.com
Erika Miller, CRD Associates	emiller@dc-crd.com

To volunteer to serve on the HPC and its subcommittees, please contact anyone listed above.