THE CRD ASSOCIATES'

HEALTH POLICY REPORT

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Let the Games Begin!

On February 2, President Obama sent his next-to-last budget request to Congress, a $4.066 trillion blueprint that critics will surely declare DoA, but will nonetheless set parameters for negotiations with the GOP-controlled Congress.

Not surprisingly, the president's fiscal year 2016 budget proposal sounds a populist theme and leverages a strengthening economy and a declining federal deficit to propose increasing federal spending and higher taxes on the wealthy.

The president's plan also calls for rolling back $74 billion in across-the-board sequestration cuts to government programs, and asks Congress to lift the caps on discretionary spending by seven percent in fiscal 2016. The increases would total about $74 billion in spending above the limits set in 2011, increasing defense spending by $38 billion, to $561 billion, and non-defense programs by $37 billion, to $530 billion.

Overall, the budget proposes to narrow the nation's income inequality through new taxes, including one on the nation's 50 largest financial firms and others aimed at inheritance and trust funds, to help pay for tax breaks for middle-class households, such as a $500 second-earner tax credit, expansions of both the college tuition credit and the Earned Income Tax Credit, and additional tax credits of up to $3,000 per child.

Highlights of the President's Budget

While specific details are still emerging, following are the highlights of what's included in the president's budget blueprint.

- The budget includes $2.6 billion in mandatory resources for the National Health Service Corps for FY 2016 through FY 2020, which is in addition to $287 million in discretionary funding requested for the program. The proposed investment by the Health Resources and Services Administration (HRSA) is projected to support an historically high field strength of over 15,000 providers and to serve the primary care needs of nearly 16 million patients.
- For HRSA's Primary Care Training program, the budget proposes $38.9 million, the same as the fiscal year 2015 funding level. Centers of Excellence would be funded at $25 million, a 15 percent increase over current funding, while the administration once again calls for the elimination of the Health Careers Opportunity Program and the Area Health Education Centers programs, which are currently funded at $14.2 million and $30.2 million, respectively. In their place, the budget proposes a new "Health Workforce Diversity Program," funded at $14 million. According to the budget, the new program will "fund activities that create a career pipeline for health professions students that lead directly to service in underserved

communities." The goal of the program is to increase the diversity and cultural competence of the health professions workforce providing care in underserved communities. This new program is expected to leverage or establish partnerships, including public-private partnerships, in academic training and workforce development to serve in underserved rural or urban communities. Grant activities and partnerships will be focused on supporting the education, training, licensure, and career placement of health professions students from disadvantaged backgrounds, including racial and ethnic minorities underrepresented among health professionals."

- Noting that MedPAC has found that existing Medicare add-on payments to teaching hospitals for the indirect costs of medical education significantly exceed the actual added patient care costs these hospitals incur, the budget proposes to partially correct the imbalance by reducing these payments by 10 percent, beginning in 2016. In addition, the Secretary would be granted the authority to set standards for teaching hospitals receiving GME payments to encourage training of primary care residents and emphasize skills that promote high-quality and high-value health care. If enacted, this proposal would generate $16.3 billion in savings over 10 years
- As part of a $146 billion government wide R&D initiative, the budget includes $31.3 billion for the National Institutes of Health, to support 35,000-plus research project grants, including roughly 10,000 new and competing awards. Included in that total is $215 million for a Precision Medicine initiative; $461 million in support of a national strategy to combat antibiotic resistant bacteria (CARB); and $638 million for Alzheimer's research.

The Clock's Ticking for the New Congress to Address the SGR

The last Congress was the first ever to reach a bipartisan agreement on policy to replace the flawed sustainable growth rate (SGR) formula; however, their inability to agree on how to pay for permanent repeal put the issue on the top of the to do list for the newly elected 114th Congress. With both the House of Representatives and Senate now controlled by Republicans, there is agreement on both sides of

the Capitol that the SGR repeal must be paid for, but time is limited for them to reach an agreement on offsets. The current patch expires on April 1, and without Congressional intervention, it will dictate a 20.9 percent cut in Medicare reimbursement.

The new Congress includes new chairmen for two of the committees with jurisdiction over the SGR; Senator Orrin Hatch and Representative Paul Ryan assumed the chairmanships of the Senate Finance Committee and House Ways & Means Committee, respectively. Both will now have to wrestle with this issue that has plagued Congress since the SGR dictated the first cut in physician reimbursement in 2002. To date, Congress has passed 17 patches that have cost $170 billion. In November, the Congressional Budget Office estimated that the bipartisan repeal legislation would cost $144 billion.

To date, all statements from the committees of jurisdiction indicate they plan to build upon the policy agreement reached last year. However, no specifics have been provided. Chairman Hatch was a co-sponsor of the bipartisan repeal legislation introduced last year and has stated that permanent SGR repeal is one of his top priorities this year. His statements indicate that SGR repeal may be tied to broader Medicare reforms designed to put the program on a more sustainable path.

The House Energy & Commerce Committee held a two day hearing on the SGR that focused on how to pay for the permanent repeal. Former Senator Joe Lieberman (I-CT) stressed to the committee that permanent repeal should be offset and should not add to the country's debt. He urged the committee to look at potential offsets that were included in a Medicare reform bill that he introduced in 2011 with former Senator Tom Coburn (R-OK), including combining the deductible's for Medicare Part A and B and raising the Medicare eligibility age from 65 to 67. Alice Rivlin, Director of the Engleberg Center for Health Reform at the Brookings Institution, echoed Senator Lieberman's points about the need to offset the SGR repeal and some of the potential offsets. She also noted that if agreement cannot be reached on a full package of offsets Congress should

consider passing a "semi-permanent fix." This would include 5 years of payment stability with structural reforms, moving physicians into payment models that reward value rather than volume; she estimated the cost to be between $50 and $60 billion.

Representatives from provider groups remain united and urge Congress to pass permanent repeal in advance of the April 1 deadline. It appears that stakeholders and members of Congress continue to agree on the policy to replace to SGR, but there has not been any clear signal from legislators on how they intend to pay for it.

CMS Moving to Value-Based Payment

The Centers for Medicare and Medicaid Services (CMS) announced that Medicare reimbursement will be moving from volume-based payments to rewarding value, care coordination, and quality. The goal is to tie 30 percent of Medicare payment to quality or value through alternative payment models, like accountable care organizations (ACOs), by the end of 2016. By 2018, the agency plans to have 50 percent of payments tied to quality and value.

To support these goals, the Department of Health and Human Services is creating a Helath Care Payment Learning and Action Network that will meet for the first time this March. The network is charged to work with payors, providers, Medicaid programs and others to expand the use of alternative payment models. CMS has stressed that the participation of private payors is critical to meet these goals.

Claims Data Restrictions Negatively Impact Research

A change in federal policy – of murky origin – is creating a data access challenge to researchers throughout academia, including those in general internal medicine.

The Centers for Medicare and Medicaid Services (CMS) has been directed by the Substance Abuse and Mental Health Services Administration (SAMHSA) to exclude identifiable data on claims related to substance abuse disorder diagnoses and treatments from it Medicare and Medicaid datasets. This has significant implications for researchers from health services, behavioral, comparative

effectiveness and biomedical spheres. The problem was first reported in the blog *The Incidental Economist*.

SAMHSA has issued a response to concerns about the issue, citing the letter of the federal law (42 USC 290dd-2) and the regulation to implement it (42 CFR Part 2 (Part 2), which guarantee the confidentiality of patient records of individuals receiving substance abuse services from federally-assisted alcohol and drug abuse programs.

While SAMHSA has indicated it is reviewing the issue to determine if they have the authority to change it that could be a time-consuming process. And, if they determine that they do not the authority, then the law would have to be changed – and even more time-consuming process. In the meantime, the withholding of data from Medicare and Medicaid data sets threatens the integrity of some funded research.

SGIM representatives have begun discussions about next steps to address this issue with a variety of stakeholders interested in HSR, biomedical and related fields. Researchers who have encountered this problem might consider sharing their experience via GIM Connect.

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