Debt Limit, Budget and Appropriations Debates Grind On

The complex – and critically important – Kabuki dance that is occurring among the White House, House Republicans and Democrats, and Senate Democrats and Republicans, on the debt limit, budget and on key appropriations bills continues.

At the time of this writing, the prospects for a debt limit increase are unclear. But, the situation is changing by the hour whether or not a deal can be struck before the August deadline is anyone’s guess. To some extent the world has turned upside down during the week of July 25. The House Republicans are asking for $850 billion in cuts over ten years; the Senate Democrats are seeking $2.2 trillion in deficit reduction; the “big spending” President wants nearly $4.0 trillion; and Sen. John McCain is calling Tea Party members “hobbits.”
While the exact impact of any deal on the FY12 budget and appropriations process is unclear at this point, it is not likely to be good. Cuts of the magnitude being discussed cannot help but impact both discretionary spending (i.e. AHRQ, NIH, health professions training, etc.) and entitlement spending (i.e. Medicare, Medicaid, GME, etc.). Work on appropriations bills has effectively stopped pending the outcome of the debt limit negotiations.

SGIM’s Health Policy Committee (HPC), and its subcommittees on Education, Clinical Practice and Research, are all actively engaged in these funding debates. As important issues arise, you can expect to hear from the HPC to ask that you reach out to your Representative and Senators to ask for their support for general internal medicine.

**Education Subcommittee Chair Meets with HRSA Leaders**

Education Subcommittee Chair Dr. Angela Jackson last month met with two key HRSA officials to discuss a wide range of issues and to offer SGIM’s help as the agency moves ahead with implementation of the Affordable Care Act (ACA). Dr. Jackson met with Edward Salsberg, Director of the National Center for Health Workforce Analysis, where Salsberg outlined the mission of his Center as being to improve the data available on all health professions as well as provide states with the tools to help determine their local needs. Ultimately, this information will be fed to the National Health Care Workforce Commission to aid in its work. Dr. Jackson offered SGIM’s resources to help inform the work of the National Center.

Dr. Jackson also met with Dr. Kathleen Klink, Director of the Division of Medicine and Dentistry and Dr. Shannon Bolon, Chief of the Primary Care Medical Education Branch. While on the staff of former Senator Hillary Clinton, Dr. Klink helped to develop the Title VII reauthorization legislation that eventually made its way into ACA. During the meeting, Dr. Klink said she hopes to widen the pipeline of Title VII funding by, among other things, broadening the definition of eligible institutions to include organizations such as SGIM. Other goals she has include developing new performance measures and broader dissemination of best practices. She also offered to participate in SGIM activities in the DC area.
CMS Issues Rule Setting Physician Fees for 2012

The Center for Medicare and Medicaid Services (CMS) recently published the proposed physician fee schedule rule. Most notably, CMS continues its efforts on misvalued codes. The agency recommends that the RUC revisit the entire family of evaluation and management codes over the next 2 years. CMS notes that while many of these codes were reviewed in 2006, during the intervening years there have been significant changes in the delivery system such as the development of the patient-centered medical home and the increased prevalence of chronic health conditions affecting the Medicare population (heart disease, diabetes, Alzheimer’s disease, etc.) has increased the work of primary care physicians.

CMS is also continuing to look at alternative methods to validate RVUs. While CMS received feedback opposed to a method other than the RUC, CMS would like comments on potential data sources and methodologies; specifically, CMS would like input on methods to validate physician time and intensity. The agency also proposed to add a health risk assessment to the new annual wellness visit. However, CMS does not propose increasing the payment for the visit.

Congress Continues to Scrutinize the IPAB

Secretary of Health and Human Services Kathleen Sebelius was called to defend the Independent Payment Advisory Board (IPAB) before the House Budget and Energy & Commerce committees this July, as the House escalated its efforts to repeal the Affordable Care Act provision creating the board.

Sebelius explained that the IPAB does not have the authority to ration care, as its critics argue; instead, the board would act as a backstop to ensure Medicare remains solvent. Republicans and Democrats on both committees argued that the board transfers Congress’ legislative authority to an unelected board. More than one member expressed concern that IPAB would exacerbate access problems if it was forced to cut provider payments to find the required savings.

Members advocated for consideration of Representative Phil Roe’s legislation to repeal the IPAB, the Medicare Decisions Accountability Act of 2011, after the August recess. At press time, this bill
had 186 co-sponsors, including 10 Democrats.

**CMMI, PCORI: Two Potential New Sources for Research Funding**

In a fiscal environment in which research advocates are calling flat funding a victory, it is worth noting that the Affordable Care Act included – and funded – two new research entities that have the potential to provide considerable support to health services researchers.

The Patient Centered Outcomes Research Institute (PCORI) is a federally-chartered non-governmental entity that has taken on the responsibility for supporting comparative effectiveness research (CER). It is funded by a tap on Medicare Part A funds and that will grow in the future with a tap on private insurance premiums as well.

The Center for Medicare and Medicaid Innovation (CMMI) is a new entity within CMS that is charged with transforming Medicare, Medicaid, and CHIP to deliver better healthcare, better health and reduced costs through program improvement for CMS beneficiaries, thus improving the overall healthcare system. CMMI has $10 billion available to fund it for ten years.

For both of these entities, the Research subcommittee has designated specific members to track and report on their progress. As with all new starts, there is a period of time during which they are getting organized – and that is the period we are currently in. More information will follow as these new agencies begin to implement their missions.

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