



**Cavarocchi-Ruscio-Dennis Associates**

# **Health Policy Report**

**August 31, 2010**

- **A QUITE AUGUST - THE CALM BEFORE THE STORM?**

## **Overview**

The Senate and the House of Representatives are now continuing their annual August recess. As we reported in July, both houses have made significant progress in moving their appropriations bills forward, while the Obama administration continues to move ahead with activity related to appointments to board and commissions and the proposal of regulations.

As of this writing, all twelve appropriations bills have been reported out of their subcommittees in the House. Two of those have been released from full committee and passed the House.

In the Senate, nine bills have been released from both their subcommittees and from the full Appropriations Committee, but none of those bills has yet been brought to the Senate floor for consideration.

We continue to expect that when Congress recesses for the election season in early October, most of these bills will not be finalized and that a significant portion of the government will be funded by a Continuing Resolution (CR).

Implementing the healthcare reform legislation will also be a major focus for the rest of year – in fact, for the next four years. As we have mentioned in the past, some of the Boards and Commissions that are created in the statute need to be populated; there are a wide variety of regulations that need to be

promulgated and opportunities to comment on those draft regulations will be plentiful.

There is a lot of work to in general and on these topics in particular. SGIM is well-positioned to continue to expand its role in health advocacy, but it continues to need a lot of help from the membership to do it.

The leadership of the committee is listed at the end of this report. SGIM members should not hesitate to contact the HPC Chair, Dr. Bill Moran or any of the subcommittee chairs and offer their help. The decisions that are made in the near future will be crucial to the future course of primary care.

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### **Education Subcommittee Issues**

While SGIM awaits action on the FY2011 spending bills, the Education Subcommittee is using this time to closely monitor implementation of the new health reform law, the Affordable Care Act (ACA).

Recently, the Subcommittee sought input from SGIM members on the topic of teaching health centers, a new program authorized by ACA, the goal of which is to expand or create new primary care residency programs, including programs in internal medicine, family medicine, pediatrics, psychiatry, dentistry and geriatrics.

The new law defines a teaching health center as a community-based, ambulatory patient care center that operates a primary care residency program. Examples include federally-qualified health centers, community mental health centers, rural health clinics, health centers operated by the Indian Health Service, a tribal organization, or an urban Indian organization and Title X family planning programs.

Centers may apply for awards of up to \$500,000 a year for up to 3 years. Funds must be spent to cover the costs of establishing or expanding a primary care residency program (including expenses related to curriculum development, recruitment, training, and retention of residents and faculty, accreditation, and faculty salaries during the development phase) and cover technical assistance provided by entities including area health education centers (AHECs). HHS is instructed to give preference to applicants that have an existing affiliation agreement with an AHEC.

The Health Resources and Services Administration (HRSA) is in the midst of gathering information, comments and suggestions to assist in implementing the Teaching Health Center program. SGIM would like to weigh in with views on how this program could work to expand the GIM workforce. Of particular

interest are model curricula that illustrate how an internal medicine resident could pursue ambulatory training in a community health center, while also meeting requirements for training in inpatient settings. Examples of where such a program is already in place would also be useful, including any vignettes SGIM members may have about previous or existing partnerships and their successes or challenges.

***If you have an interest in health professions education and training issues, please contact Dr. Angela Jackson, whose contact information is at the end of this report.***

## **Research Subcommittee Issues**

The Research Subcommittee continues to work hard on funding and the advancement of research issues at the National Institutes of Health (NIH), the Department of Veterans Affairs (DVA), and the Agency for Healthcare Research and Quality (AHRQ), and among others. A quick review of the status of programs within the subcommittee's jurisdiction is in order.

Starting with the National Institutes of Health, both the House and Senate are recommending \$32.3 billion for FY11, the same level as recommended by the President in his budget submission to Congress. This 3.2 percent increase will cover the rate of biomedical inflation, but allow for no growth in NIH.

Within the NIH budget, the Senate included a \$50 million line item for the Cures Acceleration Network (CAN), which was authorized in the Affordable Care Act. The summary of the House bill says that it is making available "up to \$50 million" but they have yet to release the precise language of their bill, continuing to make it difficult to ascertain if the provisions are identical.

Both the House bill (which has passed) and the Senate bill (which is out of committee) recommends \$590 million for VA medical research, a \$10 million increase over the current year and equal to the President's recommended level of funding. The Research Subcommittee is working to identify the specific amount of this money that is going to health services research.

Both the House and Senate subcommittees took significant cuts in the President's recommended levels for AHRQ. You may recall from earlier updates that the President recommended bringing AHRQ's funding level from \$397 million in the current year to \$611 million, with a significant increase for CER. Based on the subsequent passage of the Affordable Care Act and the creation of PCORI, the House cut \$200 million from the recommended level and the Senate cut \$214 million.

As you can see, there is no shortage of issues before the subcommittee and there is a constant need for additional assistance.

***If you have an interest in research issues, please contact Dr. Ira Wilson, whose contact information is at the end of this report.***

### **Clinical Practice Subcommittee Issues**

SGIM submitted comments to the CY 2011 Physician Fee Schedule proposed rule. The proposed rule outlined Medicare payment to physicians in CY 2011, but also began implementing sections of the Patient Protection and Affordable Care Act (ACA). In our comments, we addressed the implementation of the primary care bonus payment, how CMS will address misvalued services and the new Medicare annual wellness visit.

We remain concerned that the limitations on the primary care bonus payment, specifically the requirement that 60 percent of a primary care physician's billings be the listed evaluation and management codes. Physicians who provide continuity of care by seeing patients in the hospital and the office or who have labs in their offices may be disqualified. In our comments, we stressed the importance of ensuring that the primary care physicians who are supposed to benefit from the bonus do so.

One of SGIM's longstanding priorities is addressing the disparity in RVUs between cognitive and procedural services. ACA directed the Secretary of the Department of Health and Human Services to review misvalued codes. However, we expressed our concern about whether the RUC as currently structured could complete this task and stressed the importance of utilizing health services research to develop appropriate work values.

While SGIM supports the annual wellness visit as outlined in the ACA, we implored CMS to ensure that physicians are able to bill for all the work done in the office visit since it is unlikely that patients will make two trips to the office, once for the wellness visit and another for the standard office visit.

When the final physician fee schedule rule is released at the end of October, we will know if CMS modified any of its proposals based on the comments of SGIM and other interested groups.

***If you have an interest in clinical practice issues, please contact Dr. Scott Joy, whose contact information is at the end of this report.***

### **Health Policy Executive Committee Contact Information**

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