SGIM
Society of General Internal Medicine
To Promote Improved Patient Care, Research, and Education in Primary Care and General Internal Medicine

THE CRD ASSOCIATES'

HEALTH POLICY REPORT

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The Headlines:

- **Is This Any Way to Run A Railroad…Or Fund the Government?**
- **Research funding Struggles in House Appropriations Bill**
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Is This Any Way to Run a Railroad… Or Fund the Government?

It is now the beginning of August. More than seven months of the calendar year are over. We are less than two months away from the start of the new federal fiscal year. This seems like a reasonable time to review where we are on the key research, training and practice funding issues that face the Congress and the Administration and that matter to SGIM members.

What happens in the next two months in Congress, and in the next four months, and probably in the next six months, is going to have a profound effect on funding, not only in FY13 but possibly for many years to come. First, this is where we are today.

The Senate Appropriations Committee has approved its FY13 appropriations bill to fund the Department of Health and Human Services, including the agencies that SGIM members relate to. The bill

includes a small increase for NIH; AHRQ, which has a complicated funding formula, decreases slightly from the current year; HRSA is slightly better funded than the current year and there are relatively few legislative riders included in the bill.

In the House, the comparable legislation has been approved by the Subcommittee but has not been considered by the full committee. And the numbers are not nearly as good. NIH, for example, is flat funded, which is effectively a decrease when biomedical research inflation is considered. AHRQ is actually eliminated – funded at zero. And, because the bill has not been to full committee, we cannot get a number yet for HRSA programs of interest, but overall the health professions section of the bill is cut.

With Congress in recess and scheduled to come back for only three weeks in September, the new fiscal year will start with all of these agencies funded by a Continuing Resolution (CR), probably at something close to current year levels, for six months. That is good news for AHRQ – since it will keep them in business – but a very bad way to run the government. By extending the CR until the end of March, Congress has kicked the proverbial can down the road on appropriations to the next Congress and the next President, who may or may not be the current President.

Getting appropriations out of the way for the time being does accomplish one thing: It clears the decks for Congress to address other major issues that are coming due again at the end of the year: the Bush-era tax cuts; the payroll tax holiday; the extension of unemployment benefits; the Sustainable Growth Rate (SGR) formula for physician reimbursement under Medicare; and, the biggest concern of all – sequestration.

The Budget Control Act of 2011 mandated that Congress reduce the deficit by designated amounts totaling $1.2 trillion dollars over ten years. Unless Congress eliminates $109 billion from the deficit in FY13, across the board cuts of approximately eight percent in all defense and non-defense discretionary spending will occur on January 2, 2013 – about four months

from now. The impact will be immediate and it will be drastic.

In testimony before the House Energy and Commerce Committee, for example, NIH Director Dr. Francis Collins estimated that 2,300 of the approximately 9,500 new grants for next year would be eliminated. He also indicated that not a single area of research or training would be spared the pain.

Three months after sequestration takes effect – if it does – the CR will expire and Congress will have to deal with FY13 funding again. And, of course, the FY14 budget and appropriations process will be ramping up at the same time.

All of this will make November, December, January, February, and March the quintessential "crunch time." SGIM's mission throughout this period will be to assure that Members of Congress and the Administration do not forget that behind all the budget numbers and the political machinations are patients with life-threatening diseases, senior researchers on the verge of breakthroughs, young researchers launching their careers, and thousands and thousands of jobs.

Research Funding Struggles in House Appropriations Bill

SGIM members who are involved in federally-funded research had to be shocked by the steps taken by the House Appropriation subcommittee that funds such agencies as the Agency for Healthcare Research and Quality (AHRQ), the National Institutes of Health (NIH) and others.

The numbers – and the legislative restrictions on research – were nothing short of remarkable.

NIH probably fared better than most agencies on the funding side. They received the same funding level as in the current year. However, there are a number of provisions included in the bill that should give health services researchers pause. For example, the bill sets the level of basic research funding at 55 percent of total NIH funding. This compares to the current level of approximately 52 percent. Clearly, things like training grants and translational research would pay a price if this were to become law.

Another provision of concern is language that prohibits NIH from spending any money on "patient-centered outcomes research." While the term is undefined, this appears to be targeted to suggest that NIH PCOR is duplicative of research conducted by the Patient-Centered Outcomes Research Institute (PCORI).

Finally, another provision in this section would reduce PI compensation from Executive Level II to Executive Level III, effectively attempting to reduce compensation by $20,000 per year for the second year in a row.

AHRQ, however, was the big loser in the bill. The subcommittee voted to eliminate the agency. Supplying no funding to AHRQ (if the provision survived to the final bill which is *very* unlikely) would require them to shut down upon enactment of FY13 funding. The irony of this measure is that it actually saves no money. AHRQ is largely funded by a tap on other HHS agencies, the largest being NIH. By zeroing out AHRQ, but not cutting the amount transferred from other offices, the net federal expenditure remains the same.

House funding for Training in Question

As noted earlier, the House appropriations subcommittee met July 18 to decide funding for health professions training. Although the detailed results of the meeting have not been released, all signs point to deep cuts in vital programs. We know, for example, that the panel has eliminated funding for the Area Health Education Centers, scholarships for the disadvantaged and the Health Careers Opportunity Program (HCOP). There is no indication as to what the subcommittee has recommended for the Primary Care and Enhancement program, but overall funding for health professions and nurse training programs has been cut by $100 million. As reported in the June update, the Senate committee voted a $10 million increase, $48.9 million in total, for the primary care training program.

CMS Releases CY 2013 Physician Fee Schedule Proposed Rule

Early in July the Centers for Medicare and Medicaid Services (CMS) released its annual proposal outlining provisions related to physician payment in 2013.

Payments for primary care physicians remains a major concern, and in response, CMS proposed to create a new post-discharge transitional care

management services codes, which would reimburse physicians for the services the non-face-to-face services they currently provide to ensure there are smooth transitions of care when a patient is discharged from a hospital, SNF or community mental health center.

CMS is proposing 1.28 work RVUs for this service and estimates that this would increase reimbursement for general internists by 5 percent.

CMS is also seeking comments on advanced primary care practices, which are practices implementing a medical home model. The agency is considering how this care model can be reimbursed within the current fee-for-service system.

Some of the issues this raised is how the agency would determine which practices would be considered advanced primary care practices and beneficiary attribution.

CMS Proposes Framework for the Value-Based Payment Modifier

The Affordable Care Act (ACA) mandated the creation of the value-based payment modifier (VBM) and that it apply beginning in 2015. With this 2013 proposed rule, CMS outlined how the VBM will apply to physicians.

Beginning in CY 2015, physician groups of 25 or more will be subject to the VBM; physicians will receive differential payments based upon the quality of care furnished to Medicare beneficiaries compared to the cost of care. To avoid all negative payment adjustments, physician groups can successfully participate in the Physician Quality Reporting System (PQRS). Those groups participating in the PQRS would only be subject to a negative adjustment if they opted for the quality tiering approach.

The potential negative adjustment will be set at -1.0 percent. However, the potential positive adjustment cannot be set at this time. The ACA dictates that the program be budget neutral, and the positive adjustment will depend on how many groups are penalized under the VBM.

This program will require groups to submit quality data, and CMS is attempting to harmonize the reporting with that of the PQRS. In CY 2017, the program will be expanded to apply to all physicians, making it necessary for all physicians to report in CY 2015.

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