Appropriations

Late in the day on July 18, the Senate Appropriations Subcommittee on Labor/HHS passed its spending bill by voice vote. The measure totals $606 billion, which is $5 billion more than the figure requested by the President. In a win for family medicine, Section 747 received a 22.4 percent increase, which would boost spending from the FY 2006 level of $41 million to $50 million. The President had requested zero dollars. Family medicine is noted in the report as receiving $31 million of the $50 million figure.

Only one other program, the Public Health, Preventive and Dental cluster, received additional dollars, which amounted to a 1 percent increase from current levels. All other programs were either zeroed out or received level funding. While the increase for Section 747 is on top of a substantial cut in funding last year (54 percent), the fact that we received an increase at all is a testament to the numerous calls made by our Key Contacts to their Senators. Nevertheless, we will continue to seek opportunities to increase the funding level as the process continues.

On July 20, the full committee considered the bill and made virtually no changes. Following are highlights from the measure of interest to family medicine.

- Overall, the Title VII and VIII Health Professions programs received $304 million, an increase from the FY 2006 level of $295 million. Title VIII nursing education programs received $149.7 million, which is the same amount they received in FY 2006, the amount requested by the President and the figure in the House bill.

- The Agency for Healthcare Research and Quality AHRQ received $318.7 million under the bill, the amount provided by the House and the level requested by the President. This figure includes $84 million for "determining ways to reduce medical errors" (including $50 million for HIT) and $15 million for comparative effectiveness research. The agency also is instructed to continue its work on medication errors.

- Community Health Centers received $1.9 billion, which is an increase from the FY 2006 level of $1.7 billion. The President also had requested $1.9 billion.

- The National Health Service Corps received $125.5 million, the same amount provided in FY 2006 and the figure requested by the President. The House had allocated $131.5 million.

- All rural health programs received $170 million, an increase from the FY 2006 level of $160 million and a significant increase from the House funding level of $99 million.

- The NIH received $28.5 billion, which is $220 million more than the amount for FY 2006 and an increase of $200 million from the President’s request.
• Section 317, which provides vaccines to all Medicaid-eligible children, received $479.3 million, down from $504 million in FY 2006. The President had asked for $492 million. In the report, the committee expresses concern that 317 immunizations grants are not covering newly-recommended vaccines and asks for a report from CDC by March, 2007 on how much funding would be necessary to cover the cost of new vaccines, as well as other information.

• Pandemic Flu Preparedness funding within the Centers for Disease Control received $119 million.

No further formal action on the Labor/HHS spending bill is expected in the Senate until after the November elections. However, behind the scenes, Appropriations Committee members may try to determine how to boost the allocation for Labor/HHS by $2 billion, which could allow additional funding for health programs, including Section 747.

On the House side, it is not clear whether the Labor/HHS spending bill will go to the floor for a vote. The bill has been mired in politics since the Appropriation Committee approved an amendment for an increase in the minimum wage.

Translational Research at NIH
At the request of the AAFP and the Academic Family Medicine Advocacy Alliance, the Senate Appropriations Committee added a provision to its report on the spending bill that encourages NIH to engage in more translational research. Following is language in the section on the National Institutes of Health:

*The Committee is very supportive of translational research and strongly encourages the NIH to integrate such research as a permanent component of the research portfolio of each institute and center. The committee urges NIH to begin discussions to determine how best to facilitate progress in translating existing research findings and to disseminate and integrate these findings at the practice level. Translational research should also include the discovery and application of knowledge within the practice setting using such laboratories as practice-based research networks. This research spans biological systems, patients, and communities, and arises from questions of importance to patients and their physicians, particularly those practicing primary care.*

While this is a provision in the committee report and does not have the force of law, it is a strong indicator of the funding committee’s preferences.

Rural Training of Family Physicians
At the request of AAFP and AFMAA, the Senate Appropriations Committee also inserted the following language on rural training tracks:

*The committee is concerned that the agency has not yet issued regulations to implement the Integrated Rural Training Track program as authorized in section 407(c)(1)(iv) of the Balanced Budget Refinement Act of 1999, Public Law 106-113, for graduate physician training in rural areas. Without implementation of the IRTT, programs to train family physicians to practice in rural and frontier communities will continue to be unable to meet the requirements for GME.*
programs developed for urban and suburban areas. The Committee urges the agency to develop such regulations and directs the agency to report back to the Committee on Appropriations on its progress by April 1, 2007.

The report language will be followed by a letter from the Congressional Rural Caucus to CMS providing them with the definition of rural training developed by AAFP and AFMAA. This definition would allow programs with 3 months rural training (in certain states with low population densities) to remove the cap on residency slots. While the National Rural Health Association had recommended four months of training, the Graham Center and AFMAA provided peer reviewed data showing that in order to capture sufficient family medicine programs, three months of rural training was the appropriate amount.

Medicare Payment for Imaging Services
Members of the health subcommittee of the House Energy and Commerce Committee on July 18 criticized congressionally mandated cuts in Medicare payment for imaging services as having a potentially damaging effect on the health of beneficiaries. The reductions, passed as an attempt to stop rapidly increasing Medicare spending on computed axial tomography (CAT) and other such procedures could actually end up increasing spending, according to some subcommittee members.

Early detection of a disease costs less than treating the disease in advanced stages, Rep. Lois Capps (D-CA) said. The cuts were made with a "sledgehammer" and could affect access to care, Rep. Capps said. Rep. Sue Myrick (R-NC), a breast cancer survivor, told the subcommittee that ultrasound saved her life.

Scheduled to go into effect in January 2007, the spending provisions were part of Medicare/Medicaid spending reductions in the Deficit Reduction Act (DRA), signed into law in February. The cuts included a cap on the technical (not the professional) component of reimbursement for physician office and diagnostic imaging centers. With the exception of mammography, Medicare may reimburse no more than the rate paid for these services under the hospital outpatient prospective payment system (OPPS).

In addition, the DRA said that, beginning with the 2007 fee schedule, CMS would pay the technical component of an imaging service at 50 percent if a previous procedure on the patient during the same session was on a contiguous body part.

Subcommittee members expressed the belief that these changes would require beneficiaries to go to hospitals for imaging procedures, where the prospect of inconvenient locations, longer waits, and higher copayments would discourage them from seeking the tests.

Subcommittee Chairman Nathan Deal (R-GA) reminded the lawmakers that the provisions helped pay for the delay in the implementation of a highly controversial 4.4 percent reduction in overall physician Medicare reimbursement and allowed payments to remain flat at 2005 levels through 2006. However, Rep. Frank Pallone, Jr. (D-NJ) told the hearing that the imaging sections were placed in the DRA without hearings,
studies, or other input on the impact they could have on beneficiaries’ access to imaging services.

Some of the problems being discussed at the hearing "are yet another example of what goes wrong when legislation is cobbled together and passed in haste," Rep. John Dingell (D-MI), the Senior Democratic member on the full committee, said.

The leading witness, Herb Kuhn, director of the Center for Medicare Management at the Centers for Medicare & Medicaid Services, said that interested parties will have a chance to offer input in the next three to four weeks after his agency proposes regulations to implement the DRA imaging provisions. Final rules will be published in the fall. "We are still working on the proposed rules for 2007 for both OPPS and the physician fee schedule," he said. "The fee schedule [proposal] will contain the specific impacts of the DRA imaging provision."

As an example of the concept behind the DRA changes, Kuhn said that the 2006 physician fee schedule pays $903 for the technical component of magnetic resonance imaging scan of the brain or abdomen, while under the hospital OPPS, the payment is $506. The differences vary by procedure, he said, but "Medicare is often paying significantly larger amounts under the physician fee schedule than the OPPS."

CMS staff realizes "that significant technological advances in imaging capabilities have made a difference in clinical practice and in the lives of patients," Kuhn said. "However, we want to ensure that our payment systems reflect clinically appropriate care and do not provide inappropriate incentives for growth in volume and intensity of services with limited clinical benefit."

Spending on imaging under the physician fee schedule rose from $6.6 billion to $13.7 billion between 2000 and 2005, Kuhn said. Imaging spending grew at an annual average rate of 15.7 percent, compared to 9.6 percent for all fee schedule services, he stated.

Another witness, Glenn M. Hackbarth, chairman of the Medicare Payment Advisory Commission, said commissioners are concerned that not all the factors behind the growth in imaging may be appropriate. These include physicians’ interest in supplementing their professional fees with revenues from ancillary services and the use of imaging for "defensive medicine," as protection for malpractice suits. Further, he cited a study from Dartmouth Medical School that found that regions providing more imaging services do not have higher survival rates for beneficiaries. However, he said that MedPAC (which advises Congress on Medicare issues) has not studied the potential effects of the DRA and the concept of limiting payments to the rate in OPPS did not originate with MedPAC.

Two medical professionals on the subcommittee – Reps. Charles Norwood (R-GA), a dentist, and Michael C. Burgess (R-TX), an obstetrician – were among the most vocal in attacking the provisions. Rep. Norwood asked for proof that the growth in imaging is not a positive trend. Rep. Burgess discussed the importance of the use of CAT scans in appropriately diagnosing different types of stroke.
Medicare Health Savings Accounts
The Centers for Medicare & Medicaid Services (CMS) announced on Thursday, July 20 new steps to provide beneficiaries with access to coverage through consumer-directed health plans in the Medicare Advantage programs in 2007. In addition to new Medical Savings Account (MSA) coverage, beneficiaries will have access to coverage with additional features similar to health savings accounts (HSAs) through a demonstration program that permits Medicare Advantage organizations to offer more flexible accounts. Until now, the HSA-type plans have not been available to people with Medicare.

In Congress Next Week
MEDICARE PHYSICIAN PAYMENT
On Tuesday, July 25, and Thursday, July 27, the House Energy and Commerce Subcommittee on Health will hold hearings titled “Medicare Physician Payment: How to Build a Payment System that Provides Quality, Efficient Care for Medicare Beneficiaries.”

EMERGENCY HEALTH CARE
On Thursday, July 27, the Health Subcommittee of the House Ways and Means Committee will hold a hearing on the status of emergency health care and the administration of health care services. Witnesses include officials from the Institute of Medicine and the hospital industry.

State Government Relations
Three states (Massachusetts, New Jersey and North Carolina) and the District of Columbia were in session this week. North Carolina’s regular session will adjourn next Wednesday, July 26th.

Insurance Coverage
Maryland - Maryland’s groundbreaking “Wal-Mart” law was struck down this week in US District Court, on the grounds that it violates ERISA. The law—which passed the legislature overwhelmingly despite a veto by Governor Bob Ehrlich (R)—requires large employers in the state to spend a certain percentage on health care coverage for their employers. Also known as “Fair Share” legislation, the goal was to force large, low-wage employers to provide coverage to more employees; this followed several reports of large numbers of Wal-Mart employees enrolling in Medicaid. Several other state legislatures addressed similar bills in the recently-concluded sessions, but none other than the Old Line State passed a Fair Share/Wal-Mart bill. Maryland’s Attorney General plans to appeal the court’s decision.

State Finance
An accounting rule promulgated by the Government Accounting Standards Board (GASB) goes into effect later this year. While the GASB generally issues rules that are little noticed, this regulation could have a significant impact on state budgets. The new rule requires states to drop their current “pay-as-you-go” budgeting for health care benefits for retired public employees and begin prospective budgeting for future retiree costs. Any state not accounting for this unfunded liability will see its credit rating diminish on Wall Street. The few states to aggressively pursue this change are finding
their unfunded liability dramatically larger than anticipated. Maryland, for example, estimated originally $3-$6 billion liability, but following a second estimate the state found itself facing a $20 billion cost. In the next year, this new rule will put an additional health cost burden on already stretched state budgets.

**Medicaid**

**Colorado** – The last private Medicaid HMO will discontinue the Colorado Medicaid program in August leaving its 65,000 patients – mostly the aged and disabled – without health care. Don Hall, CEO of Colorado Access, said that a pending 15 percent cut in what the state reimburses for care, on top of years of losing money providing Medicaid coverage, forced the company to end its contract with the state. Colorado Access lost $7.4 million on Medicaid in 2004. State statutes dictate a formula based on past expenditures for calculating Medicaid reimbursements.

Colorado began offering HMOs to Medicaid participants in 1995 to control costs. The state's Medicaid budget more than tripled from 1990 to 2004. Four Medicaid HMOs sued in 2004 citing underpayment by the state. The state settled and the HMOs left the Medicaid program. Most of the 446,000 citizens on Medicaid participate in a fee-for-service program. As providers declined to accept Medicaid patients, the most sick opted for Colorado Access.

Under Colorado's Medicaid laws, managed-care insurers get paid 95 percent of the rate doctors, clinics and direct-care providers receive for taking care of Medicaid patients. Colorado Access will continue covering elderly clients enrolled in Medicare, the Child Health Plan Plus and the behavioral health portion of Medicaid - three areas that have subsidized Colorado Access's Medicaid segment.

**Medical Liability**

**Missouri** - Gov. Matt Blunt (R) has signed a bill requiring insurance companies to base their medical malpractice rates only on their loss-experience in Missouri, not in other states. In addition, the Missouri Insurance Department will have the ability to reject malpractice rates that are considered excessive or discriminatory. Insurers also will be required to provide a 180-day notice if they plan to discontinue offering medical malpractice policies in the state.