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Budget/NIH Update

David B. Moore
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Government Relations
June 19, 2013
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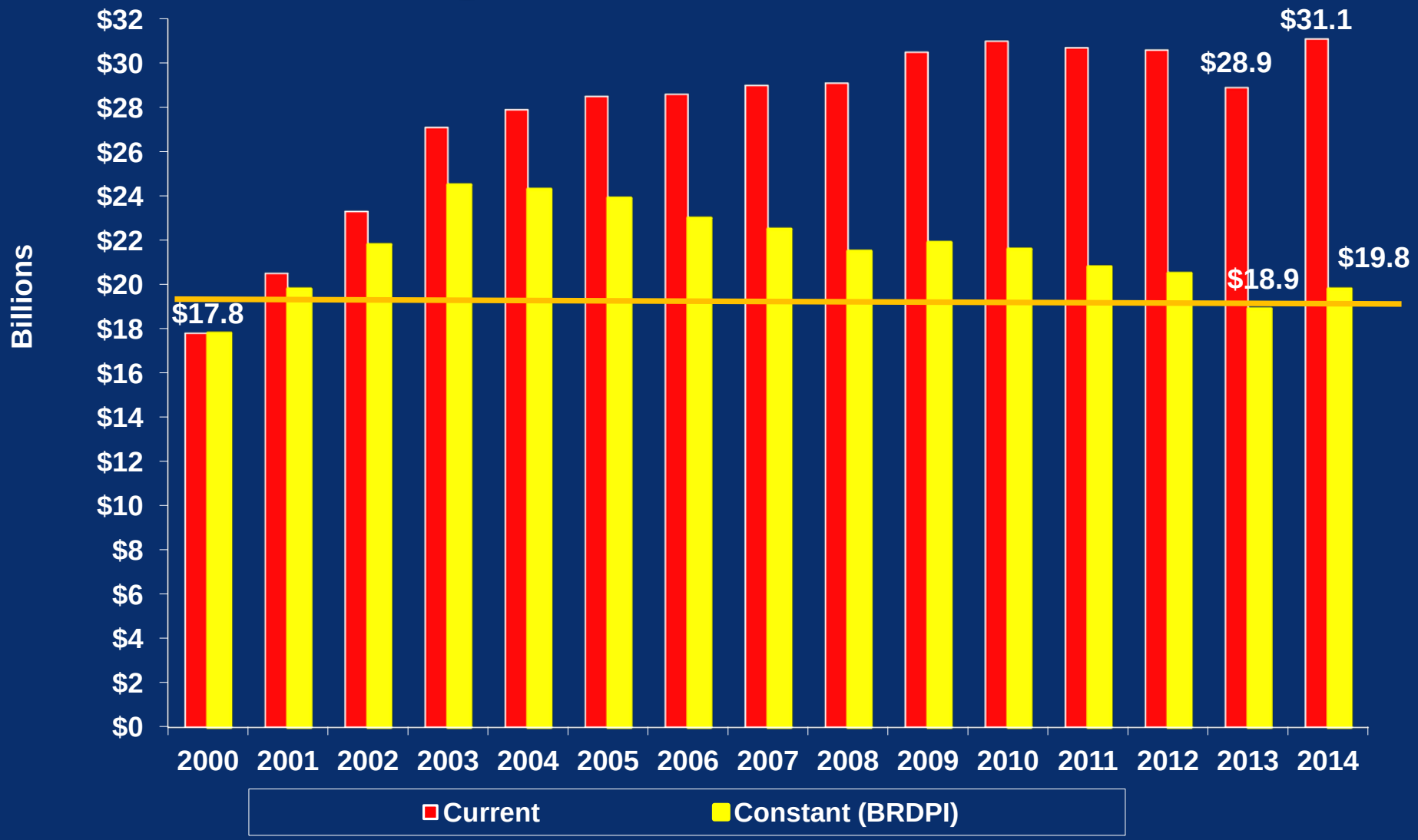
Association of
American Medical Colleges

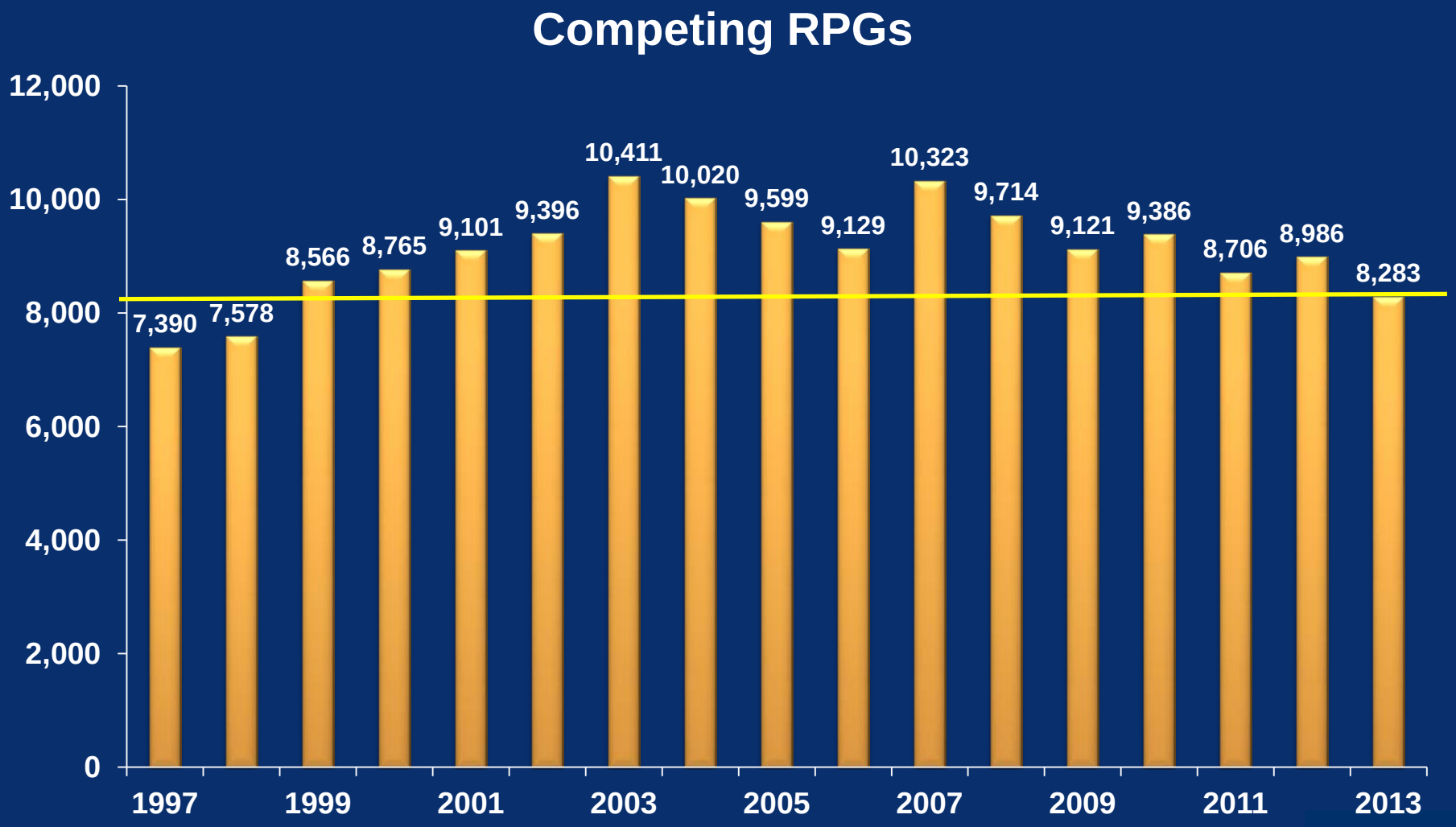
NIH Funding – FYs 2000-2014



Labor-HHS Budget Authority only

Sources: NIH Budget Office; House and Senate Appropriations Committees

NIH Competing RPGs Lowest Since 1998



Source: NIH Budget Office

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Discretionary Spending Caps – FY 2014 [in billions]

	FY 2013 Estimate (with sequester)	President's Budget (without sequester)	H. Con. Res. 25 (with sequester)	S. Con. Res. 8 (with sequester)
Defense		**$552**	**$552**	**$497**
Nondefense		**$506**	**$414**	**$469**
Labor-HHS	***$149.6***	***$165.8***	***$121.8***	***tbd***
Total	**$986**	**$1,058**	**$966**	**$966**

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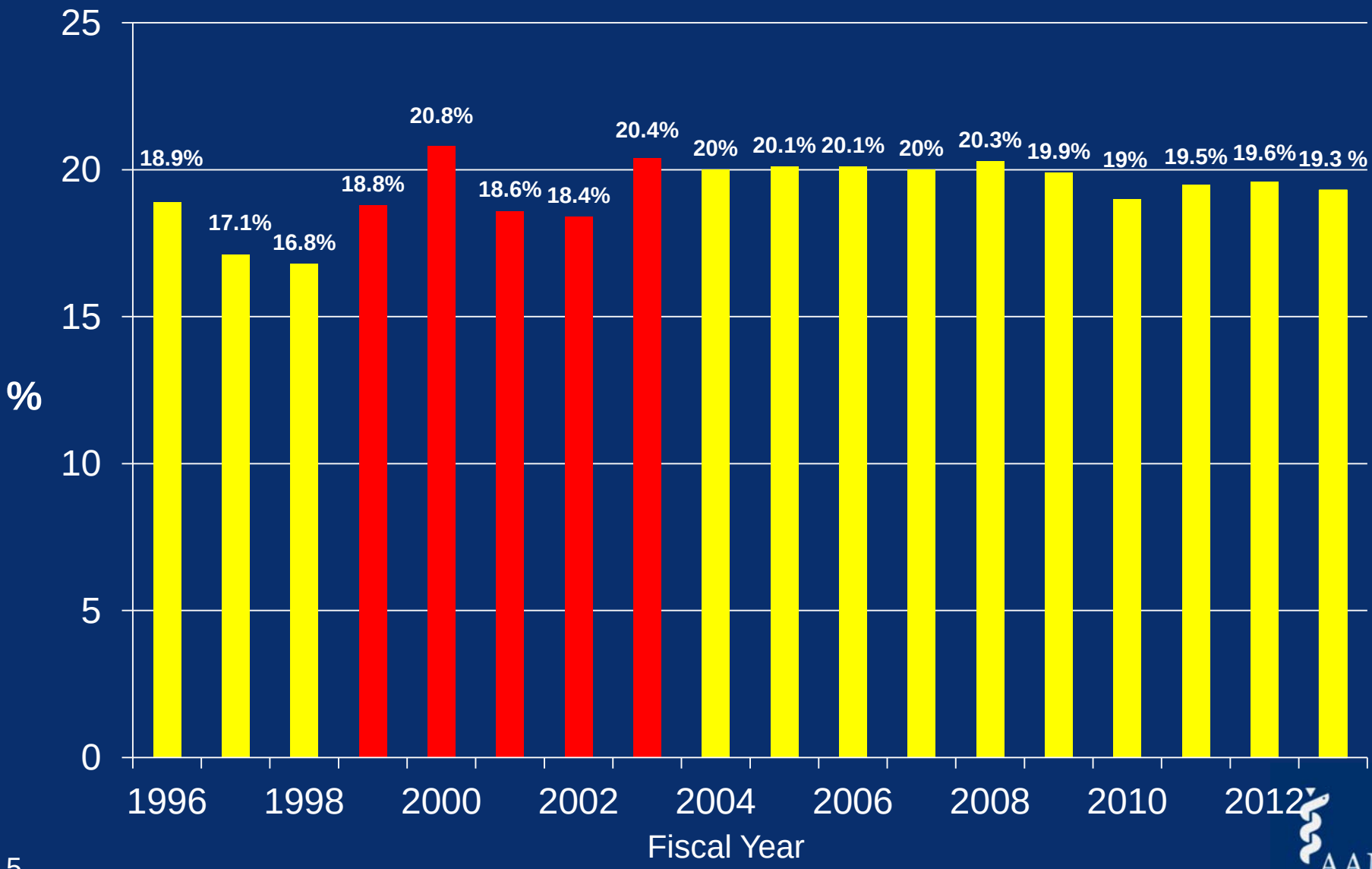
NIH As A Percent of Labor-HHS-Ed Discretionary Funding



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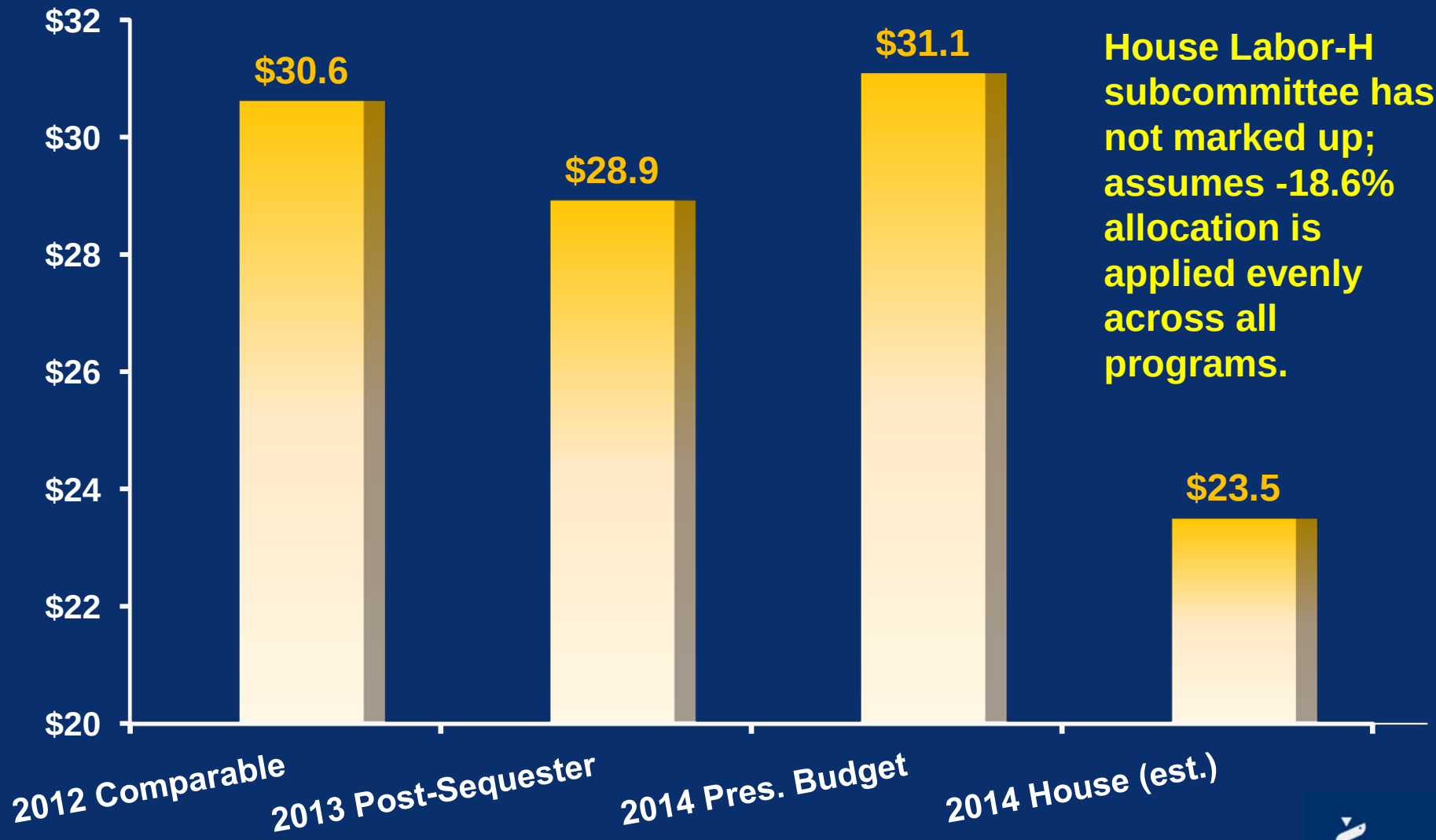
NIH Budget [in billions]



House Labor-H subcommittee has not marked up; assumes -18.6% allocation is applied evenly across all programs.

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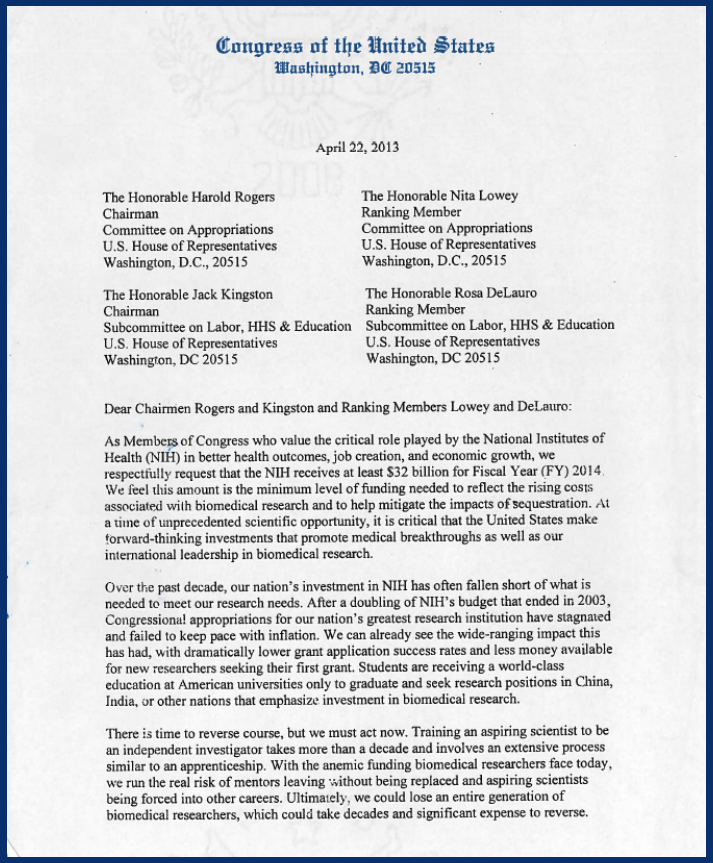
Congressional "Dear Colleague" NIH Sign-on Letters

Reps. Ed Markey (D-Mass.) and David McKinley (R-W.Va.) led letter with 168 Members of Congress, April 2013



Congress of the United States
Washington, DC 20515

April 22, 2013

The Honorable Harold Rogers
Chairman
Committee on Appropriations
U.S. House of Representatives
Washington, D.C., 20515

The Honorable Nita Lowey
Ranking Member
Committee on Appropriations
U.S. House of Representatives
Washington, D.C., 20515

The Honorable Jack Kingston
Chairman
Subcommittee on Labor, HHS & Education
U.S. House of Representatives
Washington, DC 20515

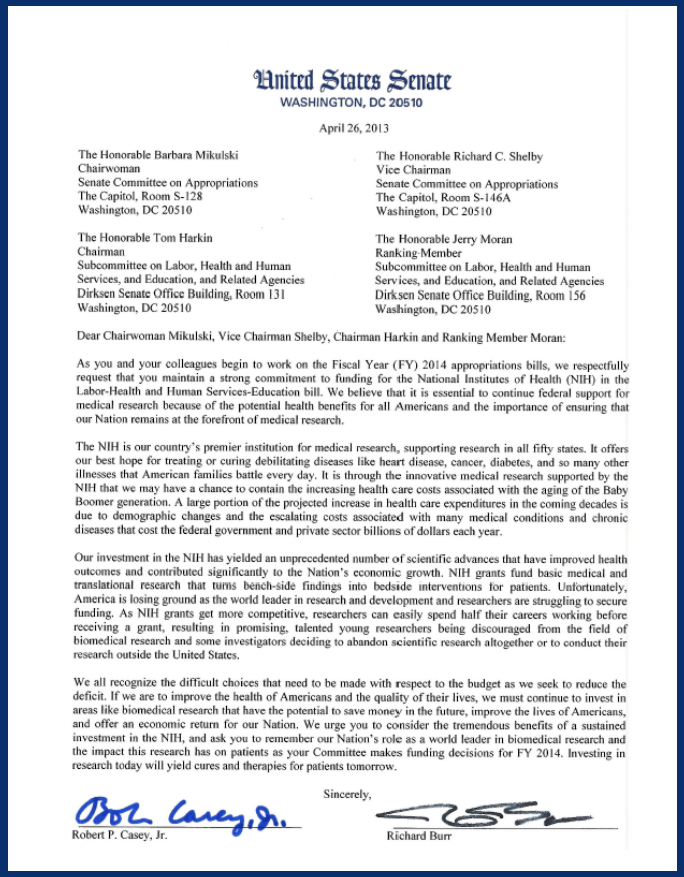
The Honorable Rosa DeLauro
Ranking Member
Subcommittee on Labor, HHS & Education
U.S. House of Representatives
Washington, DC 20515

Dear Chairmen Rogers and Kingston and Ranking Members Lowey and DeLauro:

As Members of Congress who value the critical role played by the National Institutes of Health (NIH) in better health outcomes, job creation, and economic growth, we respectfully request that the NIH receives at least $32 billion for Fiscal Year (FY) 2014. We feel this amount is the minimum level of funding needed to reflect the rising costs associated with biomedical research and to help mitigate the impacts of sequestration. At a time of unprecedented scientific opportunity, it is critical that the United States make forward-thinking investments that promote medical breakthroughs as well as our international leadership in biomedical research.

Over the past decade, our nation's investment in NIH has often fallen short of what is needed to meet our research needs. After a doubling of NIH's budget that ended in 2003, Congressional appropriations for our nation's greatest research institution have stagnated and failed to keep pace with inflation. We can already see the wide-ranging impact this has had, with dramatically lower grant application success rates and less money available for new researchers seeking their first grant. Students are receiving a world-class education at American universities only to graduate and seek research positions in China, India, or other nations that emphasize investment in biomedical research.

There is time to reverse course, but we must act now. Training an aspiring scientist to be an independent investigator takes more than a decade and involves an extensive process similar to an apprenticeship. With the anemic funding biomedical researchers face today, we run the real risk of mentors leaving without being replaced and aspiring scientists being forced into other careers. Ultimately, we could lose an entire generation of biomedical researchers, which could take decades and significant expense to reverse.



United States Senate
WASHINGTON, DC 20510

April 26, 2013

The Honorable Barbara Mikulski
Chairwoman
Senate Committee on Appropriations
The Capitol, Room S-128
Washington, DC 20510

The Honorable Richard C. Shelby
Vice Chairman
Senate Committee on Appropriations
The Capitol, Room S-146A
Washington, DC 20510

The Honorable Tom Harkin
Chairman
Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies
Dirksen Senate Office Building, Room 131
Washington, DC 20510

The Honorable Jerry Moran
Ranking Member
Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies
Dirksen Senate Office Building, Room 156
Washington, DC 20510

Dear Chairwoman Mikulski, Vice Chairman Shelby, Chairman Harkin and Ranking Member Moran:

As you and your colleagues begin to work on the Fiscal Year (FY) 2014 appropriations bills, we respectfully request that you maintain a strong commitment to funding for the National Institutes of Health (NIH) in the Labor-Health and Human Services-Education bill. We believe that it is essential to continue federal support for medical research because of the potential health benefits for all Americans and the importance of ensuring that our Nation remains at the forefront of medical research.

The NIH is our country's premier institution for medical research, supporting research in all fifty states. It offers our best hope for treating or curing debilitating diseases like heart disease, cancer, diabetes, and so many other illnesses that American families battle every day. It is through the innovative medical research supported by the NIH that we may have a chance to contain the increasing health care costs associated with the aging of the Baby Boomer generation. A large portion of the projected increase in health care expenditures in the coming decades is due to demographic changes and the escalating costs associated with many medical conditions and chronic diseases that cost the federal government and private sector billions of dollars each year.

Our investment in the NIH has yielded an unprecedented number of scientific advances that have improved health outcomes and contributed significantly to the Nation's economic growth. NIH grants fund basic medical and translational research that turns bench-side findings into bedside interventions for patients. Unfortunately, America is losing ground as the world leader in research and development and researchers are struggling to secure funding. As NIH grants get more competitive, researchers can easily spend half their careers working before receiving a grant, resulting in promising, talented young researchers being discouraged from the field of biomedical research and some investigators deciding to abandon scientific research altogether or to conduct their research outside the United States.

We all recognize the difficult choices that need to be made with respect to the budget as we seek to reduce the deficit. If we are to improve the health of Americans and the quality of their lives, we must continue to invest in areas like biomedical research that have the potential to save money in the future, improve the lives of Americans, and offer an economic return for our Nation. We urge you to consider the tremendous benefits of a sustained investment in the NIH, and ask you to remember our Nation's role as a world leader in biomedical research and the impact this research has on patients as your Committee makes funding decisions for FY 2014. Investing in research today will yield cures and therapies for patients tomorrow.

Sincerely,

Robert P. Casey, Jr.

Richard Burr

Senators Robert Casey (D-Pa.) and Richard Burr (R-N.C.) led letter with 50 Senators, April 2013

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The Ad Hoc Group for Medical Research
Luncheon Briefing

THE 10TH ANNIVERSARY OF THE HUMAN GENOME PROJECT:

A DECADE OF TRANSFORMATIVE RESEARCH

Thursday, June 20, 2013
12:00 p.m. to 1:30 p.m.
Rayburn House Office Building – Room B-339
(Box lunches will be available)

Featuring:

Francis S. Collins, MD, PhD
Director
National Institutes of Health

Eric D. Green, MD, PhD
Director
National Human Genome Research Institute
National Institutes of Health

This briefing is sponsored by Representative Louise Slaughter, Senator Tom Harkin, and the Ad Hoc Group for Medical Research.

Positive RSVP's only to Hayzell Gollopp at hgollopp@aamc.org.
This is a widely attended event.

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What You Can Do

- **Invite Members of Congress or staff to your campus to talk about contributions research makes to your community's health and economic vitality.**
- **Submit op-eds to local newspapers**
- **Run ads in local papers including the AAMC's logo, institution's logo, and other local groups**
- **Encourage faculty, students, and alumni to e-mail messages to the president and Congress on the consequences of sequestration (http://capwiz.com/aamc/home/)**

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Do no harm to research budgets

POSTED: February 22, 2013

Home > News > Opinion

Four FAU Deans: Cutting Health Institutes would be devastating

| THE LOOMING SEQUESTER

Sequestration threatens Medical College's research and education

By John R. Raymond Sr., Joseph E. Kerschner And Glenn Allen Bolton Jr. March 1, 2013

THE HUFFINGTON POST

In Defense of Research

Posted: 04/30/2013 12:54 pm

Home → Collections → Medical Research

Growth of bioscience research depends on continued funding

Orlando Sentinel

March 5, 2013 | By Bernie Machen | Guest columnist

Sequester cutbacks will harm health of Hershey Medical Center

By HAROLD L. PAZ
Updated: 03/16/2013 06:08:02 PM EDT

Medicines for the future: Lawmakers must not put at risk treatments for rare diseases

May 2, 2013 12:16 am

Guest commentary: Life-saving discoveries put on hold by research funding cuts

Pittsburgh Post-Gazette

ONE OF AMERICA'S GREAT NEWSPAPERS

Hurting the nation's health: Sequestration cuts in biomedical and behavioral research will rob Americans of economic gains and better lives

March 18, 2013 12:06 am

By Arthur S. Levine, M.D.

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Reps. Deutch and Frankel and FAU Researchers Discuss Sequestration's Impact on Funding for the National Institutes of Health, June 7, 2013

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A Conundrum

- House Appropriations Committee approved allocation for Labor-H subcommittee that is 18.6% below current level
- If applied evenly across all programs in subcommittee's jurisdiction, it would mean a $5.3 billion cut.
- Number of Capwiz responses (as of June 14)
  - 291 people sent 874 messages
  - Top states:
    1. Michigan – 112
    2. Georgia – 37
    3. Maryland – 19
    4. California - 14

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Potpourri:

Immigration
Veterans Affairs
Student Loans

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GME Immigration Policy

	J-1	H-1B
visa type	Exchange Visitor (**Training**)	Temporary **Work**
oversight	ECFMG Certification	State Licensure
testing	↳ USMLE Steps 1 and 2	↳ USMLE Steps 1, 2, and 3
visa caps	No numerical caps	Annual numerical and country caps (some exemptions)
duration	Valid for length of residency	Subject to durational limits (3 years, 6 with extension)
wage data	none	Requires prevailing wage data
fees	Less	More
brain drain	2-year home service (can be waived by U.S. public service)	“Shorter” pathway with greater flexibility (recruitment)
NEW?	academic medical center waiver slots	DOL posting, “equal or better” assurances, additional fees

VA Sole Source Contracting

Seeking Volunteers for Four Work Groups:

1) Contract Pricing and Documentation
2) Contract Performance and Quality Assurance, Credentialing, and Privileging
3) Contract Policy and Information Security
4) Training for Affiliates

www.va.gov/oaa/sole_source_teleconference.asp

Deadline: July 5

Meetings: July, August, September

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Student Loans: Medical Student Perspective

July 1 is not a deadline – $170,000 average already fixed at 6.8%

Market-based sustainability is critical – if not Congress cuts grad/prof to save undergrad

Proposals are comparable – all reduce grad interest rates, and close grad/undergrad gap

Partisan stalemate – more confusing than usual

This is a campaign issue? – probably won't sway my vote, and if it did, I probably won't know who to give the credit

What's Happening with GME?

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GRR Meeting Staff Update

- **GME Update**
- **Sustainable Growth Rate**

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June 19, 2013

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June 19, 2013

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Primary Care Update

Tannaz Rasouli
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June 19, 2013
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Association of
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HELP Subcommittee Hearings

30 Million New Patients and 11 Months to Go: Who Will Provide Their Primary Care?

January 29, 2013

AAMC Statement for the Record:
https://www.aamc.org/download/327162/data/aamcstatementforsenatehelpsubcommitteehearingonprimarycareshort.pdf

Successful Primary Care Programs: Creating the Workforce We Need

April 23, 2013

AAMC Statement for Record:
https://www.aamc.org/download/334538/data/aamcstatementforsenatehelpsubcommitteehearingonprimarycareworkf.pdf

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Building A Health Care Workforce for the Future Act (S. 1152)

Introduced June 12, 2013, by:

- Senator Jack Reed (D-R.I.)

  staff contact: Kate Mevis
  kate_mevis@reed.senate.gov

- Senator Roy Blunt (R-Mo.)

  staff contact: Kristina Weger
  kristina_weger@blunt.senate.gov

Summaries of the bill are available at the registration table. AAMC supports this bill.

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Building A Health Care Workforce for the Future Act (S. 1152)

Mentorship Program for Medical Students

- Developing Effective Primary Care Mentors
- Improving Mentorship Opportunities for Students

Grants for New Competencies

Study on E/M Documentation Requirements

State Scholarship Program

- Matching funds to states for scholarship programs
- At least 50% of funds for primary care scholarships

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July GME Summit

Christiane Mitchell
Director, Federal Affairs
June 19, 2013
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202-828-0526

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FY 2014 Inpatient PPS Proposed Rule Update

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FY 2014 Market Basket Update

- Market basket projected increase = 2.5 percent
  - Less 2 percent if hospital doesn't submit quality data
  - Less multi-factor productivity adjustment = 0.4 percent
  - Less an additional 0.3 percent (ACA)
  - Less 0.8 percent due to documentation and coding recoupment adjustment *(subject to comment)*
  - Less 0.2 percent offset for admission and medical review criteria *(subject to comment)*

FY 2014 Payment Update: 0.8%

However, other factors may affect your payments

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Additional Factors Affecting Aggregate Payments – FY 2014

Policy	Impact
DSH Payment Modification	-0.9%
Readmissions	-0.2%
Higher SCH rate update	+0.1%
Expiration of MDH Special Status	-0.1%
Frontier Wage Index Floor	+0.1%
MS-DRG reweighting/Wage Index Changes	+0.1%
Impact from Additional Factors	-0.9%

Payment impact analysis shows aggregate amounts decreasing 0.1%

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Documentation & Coding Proposal

- CMS proposes a -0.8 percent recoupment adjustment to begin to recover the $11 billion required by the ATRA.
  - ATRA requires the full adjustment ($11B) to be completed by FY 2017. CMS' proposal would begin phasing this in slowly.
  - CMS estimates the -0.8 percent for FY 2014 will recover almost $1B.

New DSH Payments Under ACA Sec. 3133

DSH payments will be split into 2 separate payments: "Empirically Justified" and the "Uncompensated Care Payment"

25% of DSH Payments ("Empirically Justified") will be paid the same way they have been paid.

75 % of DSH payments will be used toward the uncompensated care (UC) payment.

This 75% (UCC payment pool) will be reduced as the uninsured population decreases (11.2% reduction to the 75% pool in FY 2014)

UCC payments will be periodic interim payments instead of through the PRICER. This has implications for MA plans and Outliers.

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The New "Uncompensated Care Payment"

Factor 1	Factor 2	Factor 3
• 75% of what otherwise would have been paid as Medicare DSH Payments	• Reduces the 75% to reflect changes in the percentage of people under age 65 who are newly insured due to ACA Implementation.	• Represents a hospital's uncompensated care amount relative to the uncompensated care amount for all hospitals (expressed as a %)

Product of Factors 1 and 2 = Total UC Pool

UC Pool multiplied by Factor 3 = Your UC Payment

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How to Figure Out Your UC Payment

The UC Payment Pool = 75% x $12.338 = $9.2535 B

The Pool is Reduced by the Percentage Insured = $9.2535 x 88.8% = $8.217 B

UC Payment = $8.217 B x [(Your Hospital Medicaid Days + Medicare SSI Days) ÷ (Medicaid Days + Medicare SSI Days for All DSH Eligible Hospitals)] = YOUR UC PAYMENT

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PRICER Issue

- MA plans may end up underpaying hospitals if the DSH policy is implemented as proposed.
  - CMS PRICER will only report the immediate DSH payment and not the interim UC payment.
  - MA plans are often contracted to pay hospitals based on the amounts reported in the PRICER.
- AAMC will raise in comment letter.

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Looking ahead…

- CMS only plans to use the proxy for determining uncompensated care (Medicaid days + Medicare SSI days) temporarily.
- CMS is not proposing to use S-10 data in this proposed rule due to data deficiencies.
- CMS will likely propose to use S-10 data to determine uncompensated care costs in the future.
- Please get in touch if you have questions about S-10 reporting.

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GME – Labor & Delivery Days

- CMS proposes to include labor and delivery days as inpatient days in the Medicare utilization calculation.
  - L & D days would be considered inpatient days for purposes of determining Medicare share for DGME payments.
  - CMS estimates this change would decrease DGME payments by $15 M for FY 2014

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GME - FTE Residents at CAHs

- CMS clarifies that **a CAH is a provider**, and therefore, CMS proposes that **a hospital may not claim the time FTE residents are training at a CAH for IME and/or DGME purposes.**
  - Currently, teaching hospitals can count time that residents rotate to CAHs if the teaching hospital incurs the costs of stipends and benefits of the residents and the resident spends his/her time on patient care activities.
  - If CMS' proposal is finalized, teaching hospitals would no longer be able to count time residents spend training at CAHs.

GME – PRA Ceiling Freeze

- CMS provides notice that the "freeze" for per resident amounts (PRAs) that exceed the ceiling expires in FY 2014, as required by statute.

- This means that starting Oct. 1, 2013, the usual full CPI-U updates would apply to all PRAs for DGME payment purposes.

GME- Sec. 5506 Closure Notice

- Closure of **Peninsula Hospital Center** in Far Rockaway NY ("**Round 4**") of Section 5506.
  - Peninsula Hospital Center's IME cap is 28.32 and its DGME cap is 36.34.
  - Applications must be **received** by the **CMS Central Office** no later than **July 25, 2013**.
- CMS recently announced Round 5 of the Sec. 5506: Closure of Infirmary **West Hospital in Mobile, AL**, and **Montgomery Hospital of Morristown, PA**.
  - Infirmary West Hospital's IME cap is 31.74 and its DGME cap is 31.84. Montgomery Hospital's IME cap is 16.56 and its DGME cap is 15.33.
  - Applications for the slots must be received by 5 pm ET on **August 29, 2013**.

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Questions?

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Hospital Acquired Condition (HAC) Reduction Program

Mary Wheatley
Director, Physician Quality
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Association of
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Hospital Acquired Condition (HAC) Reduction Program

What is it?

- Penalty program for hospitals with worst performance on hospital-acquired conditions
  - Established by Section 3008 of the ACA
  - Automatic 1% reduction to 25% of all hospitals
  - Affects IME/DSH as well as Base DRG
  - This HAC program is in addition to the HAC Non-Payment Program

CMS Proposals

- What measures to use
- How to calculate the “worst quartile”

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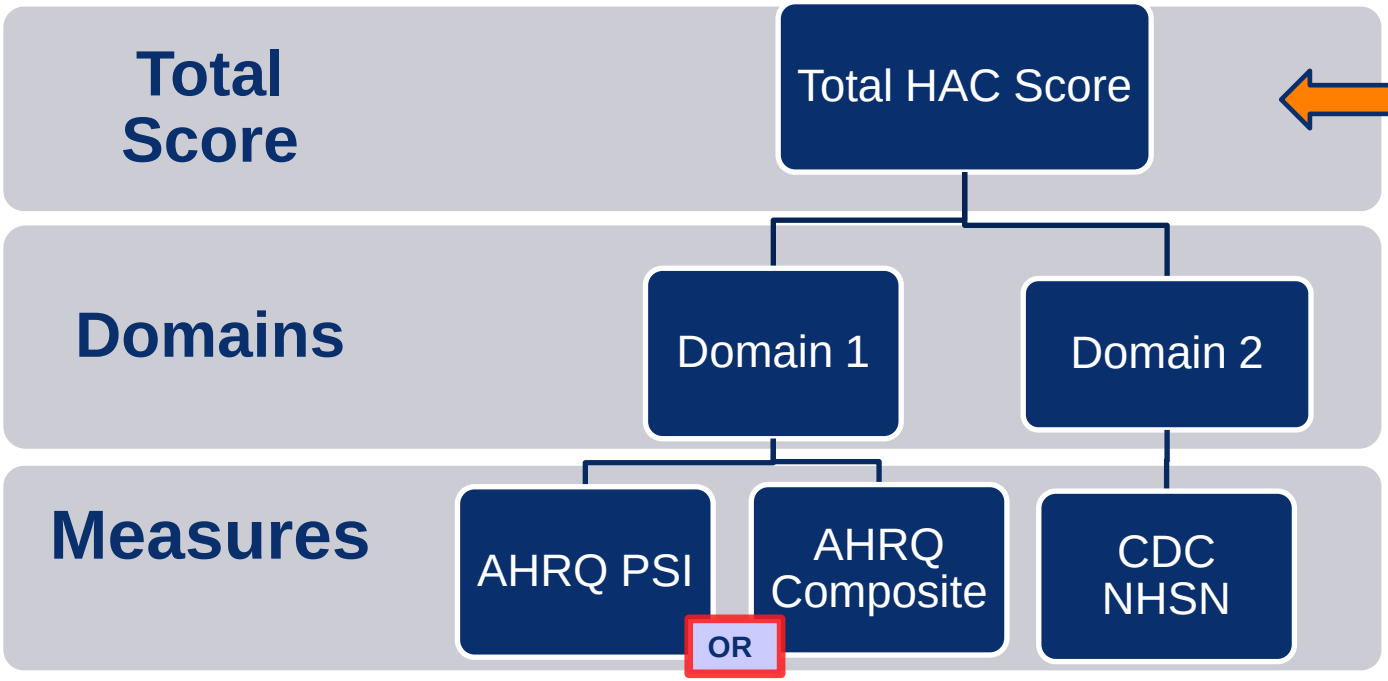
HAC Reduction Program Framework

Similar to VBP:



However:

- **Different methodology to assign points**
- **Worse performance = more points**
- **Most hospitals receive zero points for each measure**
- **No improvement points**
- **No incentive payments**

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CMS Estimates Teaching Hospitals will be Disproportionately Affected

CMS Analysis of Total HAC Scores under Proposed Rule, by type of hospital				
Hospital Type	Number of Hospitals In Analysis	Number of Hospitals in Worst Performing Quartile (Total = 858)	Percent of Hospital Type	Percent of Hospitals in Worst Performing Quartile
Urban	2461	731	29.7%	85.2%
Rural	964	127	13.2%	14.8%
Teaching	270	153	56.7%	17.8%
Nonteaching	3037	691	22.8%	80.5%

Calculation is based on CMS data, which has not been verified

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AAMC Concerns

- Disproportionate effect on teaching hospitals (and the impact on IME/DSH)
- Overlap of measures in HACs and VBP
- What is the best methodology –
  - Current measures have methodological issues
    - Clinically validated measures should have greater weight than claims-based measures
  - Impact of scoring adjustments
  - Lack of available data to study alternatives

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