FY2014 President's Budget
Released April 10, 2013

The following ACP staff analysis outlines those provisions in the President's FY2014 budget that are of significance to the College and its priorities.

Provision in FY2014 President's Budget	ACP Policy
Sequestration: The President calls for the cancellation of sequestration and has proposed several revenue raisers, making it a revenue neutral proposal.	In the 2013 State of the Nation's Health Care address, ACP "urges Congress and the administration to reach agreement on a plan to replace across-the-board sequestration cuts and prevent potential future disruptions in funding for critical health care and instead enact fiscally- and socially-responsible alternatives to reduce unnecessary health care spending. A fiscally and socially-responsible alternative should build on the progress being made in reducing healthcare cost increases and focus on the real cost-drivers behind unnecessary spending."
Primary Care Training and Enhancement Program: Section 747. The FY 2014 Budget Request is $50,962,000 to fund activities that will improve the quality of primary care providers, increase the capacity of physician assistant (PA) education programs, promote inter-professional practice, enhance medical education through curriculum innovation and improve the distribution and diversity of the healthcare workforce. The increase in dollars is earmarked for 28 new physician assistant programs.	Mainly consistent with ACP policy, which supports increasing funding for health professions and nursing education through Title VII. Disappointing the increase is only going towards physician assistant programs and not to physician programs.
National Health Service Corps. In FY 2014 there is no discretionary funding request. The Affordable Care Act has appropriated $305,000,000 for the NHSC in FY 2014. This appropriation will fund 195 new scholarships, 16 scholarship continuations, 2,373 new loan repayment awards, 2,140 loan repayment continuations, 100 new Students to Service loan repayment awards, and 285 new State loan repayment awards.	Consistent with ACP policy. ACP supports increasing funding for the National Health Service Corps.
Centers for Medicare & Medicaid Services, Discretionary program management: The Budget supports the operation of the Health Insurance Marketplaces, also known as Exchanges, scheduled to begin enrollment in October of 2013. CMS will operate some or all Marketplace functions in over 30 states in 2014. The Budget requests $803.5 million for CMS activities to support Marketplace operations in FY 2014.	Consistent with ACP policy, which calls for the funding for planning and establishment grants to help states create and implement their individual state exchanges.
Adjustment to the Medicare Baseline. Prevent Reduction in Medicare Physician Payments. The Administration supports a period of payment stability lasting several years to allow time for the continued development of scalable accountable payment models. Such models would encourage care coordination, reward practitioners who provide high-quality efficient care, and hold practitioners accountable, through the application of financial risk, for consistently providing	Since exact specifics are unknown in the President's budget regarding reforms to Medicare's Sustainable Growth Rate (SGR) formula, it is difficult to comment except to say the proposed framework is largely consistent with ACP policy. Generally, ACP policy calls for repeal of the SGR, elimination of the SGR accumulated debt, and implementation of a system that provides stable, positive and predictable annual updates. Specifically: Congress should enact legislation that would permanently replace the current flawed Medicare SGR

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low-quality care at excessive costs. Following the period of stability, practitioners will be encouraged to partner with Medicare by participating in an accountable payment model, and over time, the payment update for physician's services would be linked to such participation. Cost: $15.399 billion for one year; $249 billion for ten years.	payment system with one that includes different payment models that meet criteria for value to patients. The legislation should provide stable payments for all physician specialties for at least five years while providing higher updates for undervalued evaluation and management services, require that different payment models (including Patient-Centered Medical Homes) be pilot-tested on a voluntary basis during the five year period of stable payments, and designate a specific transition period for broad adoption of the new models that have been shown to be the most effective based on the pilots. ACP has endorsed H.R. 574, the *Medicare Physician Payment Innovation Act of 2013*, as introduced by Reps. Schwartz (D-PA) and Heck (R-NV) on Feb. 14, 2013, which is consistent with ACP's specific policy as noted above.
Better Align Graduate Medical Education Payments with Patient Care Costs: The Medicare Payment Advisory Commission (MedPAC) has found that existing Medicare add on payments to teaching hospitals for the indirect costs of medical education significantly exceed the actual added patient care costs these hospitals incur. This proposal would partially correct this imbalance by reducing these payments by ten percent, beginning in 2014. In addition, the Secretary would have the authority to set standards for teaching hospitals receiving Graduate Medical Education payments to encourage training of primary care residents and emphasize skills that promote high-quality and high value health care delivery. Savings of $780 million over one year; $11 billion over 10 years.	This proposal is consistent with the December 2012 deficit reduction negotiations, but not consistent with ACP policy. ACP believes funding to primary care training programs should be increased and they should receive enough in order to have the most robust programs, therefore, we would oppose any cuts - whether IME or DGME. ACP policy states: "There should be a substantially greater differential in the weighted formula for determining direct GME payments for residents in primary care fields, including internal medicine. Training programs should receive enough funding to develop the most robust training programs and meet the requirements stipulated by their Residency Review Committees (RRCs).
Medicaid: As a central component of the nation's medical safety net, Medicaid is the primary source of medical assistance for millions of low-income and disabled Americans, providing health coverage to many of those who would otherwise be unable to obtain health insurance.	The Medicaid program should serve as the coverage foundation for low-income children, adults, and families regardless of categorical eligibility. Medicaid minimum eligibility standards should be uniform on a national basis and federally mandated Medicaid coverage expansions should be fully subsidized by the federal government. Further, policymakers should refrain from enacting policy changes that would result in vulnerable persons being dropped from Medicaid coverage.
National Health Care Workforce Commission (the Commission) was established in the Affordable Care Act to serve as a national resource on health care workforce policy for the Congress, the President, states and localities; communicate and coordinate with federal departments; develop and commission evaluations of education and training activities; identify barriers to improve coordination at the federal, state, and local levels and recommend ways to address them; and to encourage innovations that address population needs, changing technology, and other environmental factors affecting the health care workforce. The budget request includes $3 million.	Consistent with ACP policy. ACP supports funding of the Commission, which has appointed members but no funds to meet and do work.