

## Understanding the Current Fiscal Environment and Its Impact on ACP's Funding Priorities

### 2014 Leadership Day on Capitol Hill

#### Background

#### Where Things Stand

In this election year, Congress continues to be deeply focused on the budget, spending, and the national deficit. ACP's policy priorities will need to be understood in the context of their impact on federal spending. Leadership Day attendees need to be keenly aware that fiscal constraints continue to dominate the landscape and will challenge ACP advocacy efforts. Congressional staff, particularly in Republican offices, will likely question ACP policy priorities that have a cost, regardless of the merit of those priorities. ACP members should continue to focus on advancing ACP's policy priorities based on their expertise as physicians/future physicians and how these issues impact their practices, patients, and local communities. While ACP acknowledges the current fiscal constraints in place, we will continue to work diligently for investments in primary care and other priority programs that we believe will not only improve health outcomes but also help save federal resources in the future.

The background information below provides updates on the current fiscal state of the federal government, including basics about the budget, the annual appropriations process and ACP funding priorities, updates on across-the-board spending cuts known as sequestration and the federal debt ceiling, and several introduced bills that are of importance to ACP. Leadership Day attendees should be familiar with these fiscal issues because they have a tendency to frame much of the debate in Congress, and could also be very relevant in your meetings with lawmakers.

#### Background

##### **Budget 101**

The federal government runs on a fiscal year, from October 1 to September 30. We are currently in fiscal year 2014 (FY2014). This is not to be confused with Medicare, which operates on a calendar year, from January 1 to December 31; for Medicare, we are currently in calendar year 2014 (CY2014).

By law, the President must submit a budget proposal to the legislative branch, no earlier than the first Monday in January, and no later than the first Monday in February, although these deadlines in practice are often missed. The budget proposal is a detailed blue-print for spending and contains specific proposed spending amounts for each federal department and agency and also usually contains legislative proposals on presidential priorities.

The House Budget Committee and the Senate Budget Committee each develop a budget resolution, which is introduced in their respective chamber and voted on by their respective members. The budget resolution lays out the framework for Congress and sets forth spending targets and broad legislative proposals. The budget resolution includes an overall top line discretionary number, meaning the total amount of discretionary spending (defined below) that can be allocated by the Appropriations Committees, but it does not tell the Appropriations Committees how much each department gets in funding. The budget resolution includes legislative text with broad revenue and spending numbers but it does not give explicit language to the authorizing committees how to reach those numbers. The budget resolution is a non-binding resolution, meaning it does not have the force of law and the President does not sign it. The statutory deadline for having a conference budget resolution, meaning both chambers of Congress have passed the same resolution, is April 15, but Congress routinely misses the deadline. For FY2014 and FY2015, the Bipartisan Budget Act (BBA), enacted in December 2013, permits the House and Senate to deem the budget passed by using the previously agreed to overall topline numbers.

The spending side of the federal budget has two main components: mandatory spending and discretionary spending. **Mandatory spending** is not subject to the annual appropriations process and congressional approval. It includes programs such as Medicare, Medicaid, and Social Security. **Discretionary spending** is subject to the annual appropriations process

and congressional approval each year. Discretionary spending can also be called appropriated spending because the money is given out each year through the annual appropriations process, which Congress must approve.

In March, the President released his FY2015 budget proposal, which contains many policies that are largely consistent with ACP policy, including support for federal agencies and health programs that support primary care. Most notable is key funding for Title VII Health Professions programs, the National Health Service Corps, Graduate Medical Education (GME) and public health programs. A detailed analysis of the President's budget can be found [here](#).

In April, the House majority released its FY2015 budget proposal which, for the most part, is not consistent with ACP policy. It seeks to repeal the newly created health exchanges and Medicaid expansion option, as authorized under the Affordable Care Act. It would also turn the Medicaid program into a "block grant," which could reduce the number of people eligible for the program and their benefits, contrary to ACP policy. While this budget did pass the House, it is not expected to be considered by the Senate, nor is there any indication that the Senate plans to craft its own budget.

For more in-depth information about the House Republican FY2015 Budget Resolution and the President's FY2015 Budget proposal, as they compare to ACP policy, please see [here](#).

## **Appropriations**

In order to fund the federal government, Congress must pass their annual appropriations bills by the beginning of the fiscal year, which is October 1. Funding for the various federal agencies and their programs falls under one of 12 appropriations bills. So many of ACP's funding priorities fall under discretionary programs, which means that Congress must agree to fund them every year. If the October 1 deadline is not reached, Congress must pass a continuing resolution—a CR—which funds the government for a set amount of time, routinely at levels equal to the past fiscal year. If an appropriations bill is not passed, then the federal government, departments and agencies do not have any funds and will shut down.

FY2014 Appropriations - Completed: The Consolidated Appropriations Act of 2014 (CAA) (H.R. 3547), also known as an omnibus, became law in January 2014 and included all 12 of the annual appropriations—or spending—bills for FY2014. It funds the entire federal government through September 30, 2014, which means that we do not have to endure the threat of a possible government shutdown over appropriations through September. It includes a topline spending amount of \$1.012 trillion in discretionary spending (spending that results from appropriations bills), \$520 billion for defense discretionary and \$492 billion for non-defense discretionary spending.

FY2015 Appropriations - Underway: The annual appropriations process for FY2015 is currently underway, which means Congress is now considering how to fund federal government programs starting on October 1. Both the House and Senate Appropriations Committees intend to consider the 12 appropriations bills, preferably each separately, through their respective committees sometime in the spring. For FY2015, there will be a \$2 billion increase in the overall topline discretionary amount, to \$1.014 trillion.

With the FY2014 appropriations process complete, ACP is now advocating for funding for key federal health programs, most of which fall under "discretionary" spending, which must be approved by Congress. For Leadership Day this year, we want to see that the following discretionary programs are sufficiently funded come October 1.

- Title VII Health Professions: The health professions' education programs, authorized under Title VII of the Public Health Service Act and administered through the Health Resources and Services Administration (HRSA), support the training and education of health care providers to enhance the supply, diversity, and distribution of the health care workforce, filling the gaps in the supply of health professionals not met by traditional market forces, and are critical in helping institutions and programs respond to the current and emerging challenges of ensuring that all Americans have access to appropriate and timely health services.

Within the Title VII program, ACP urges funding for the Section 747, Primary Care Training and Enhancement program at \$71 million in FY2015, in order to maintain and expand the pipeline for individuals training in primary care. The Section 747 program is the only source of federal training dollars available for general internal medicine, general pediatrics, and family medicine. For example, general internists, who have long been at the frontline of patient care, have benefited from Title VII training models emphasizing interdisciplinary training that have helped prepare them to work with other health professionals, such as physician assistants, patient educators, and psychologists. Without a substantial increase in funding, for the fourth year in a row, HRSA will not be able to carry out a competitive grant cycle for physician training; the nation needs new initiatives supporting expanded training in multi-professional care, the patient-centered medical home, and other new competencies required in our developing health system.

- National Health Service Corps (NHSC): This federal program is vital in that it addresses the supply of primary care physicians for adults, which is dwindling while the demand for primary care is expected to grow at a rapid rate. The NHSC provides scholarships and loan forgiveness to enable primary care physicians to be trained to serve underserved communities. The program receives dedicated mandated funding from the Affordable Care Act (ACA) as well as discretionary dollars subject to the annual appropriations process.

ACP urges \$810 million in funding for the NHSC in FY2015, as requested in the President's FY2015 budget; this amount includes the \$310 million in already authorized mandatory funding. Since the enactment of the ACA, the NHSC has awarded over \$1 billion in scholarships and loan repayments to health care professionals to help expand the country's primary care workforce and to meet the health care needs of underserved communities across the country. With field strength of nearly 9,000 clinicians, NHSC members are providing culturally competent care to more than 10.4 million people at nearly 14,000 NHSC-approved health care sites in urban, rural, and frontier areas. The increase in funds would expand NHSC field strength to 15,000 and would serve the needs of more than 16 million patients, helping to address the health professionals' workforce shortage and growing mal-distribution. The programs under NHSC have proven to make an impact in meeting the health care needs of the underserved, and with increased appropriations, they can do more.

- National Health Care Workforce Commission: ACP urges full funding for the National Health Care Workforce Commission, as authorized by the ACA, at \$3 million in FY2015. The Commission is authorized to review current and projected health care workforce supply and demand and make recommendations to Congress and the Administration regarding national health care workforce priorities, goals, and policies. Members of the Commission have been appointed, but have yet to begin work due to a lack of funding from Congress. Most Republican members of Congress have been unwilling to support funding for the Commission because it was authorized by the ACA, which they oppose and have pledged to repeal. The College believes the nation needs a comprehensive workforce policy founded on sound research to determine the nation's current and future needs for physicians by specialty and geographic areas. The work of the Commission is imperative to ensure that federal dollars to support workforce programs and Graduate Medical Education are spent wisely and in the most effective way possible, based on an independent assessment of health care workforce needs. Funding for the Commission should be a priority for Congress, without regard to their views on the ACA.
- Agency for Healthcare Research and Quality (AHRQ): AHRQ is the leading public health service agency focused on health care quality. AHRQ's research provides the evidence-based information needed by consumers, clinicians, health plans, purchasers, and policymakers to make informed health care decisions. ACP is dedicated to ensuring AHRQ's vital role in improving the quality of our nation's health and recommends a funding level of \$375 million. This amount will allow AHRQ to help providers help patients by making evidence-informed decisions, fund research that serves as the evidence engine for much of the private sector's work to keep patients safe, make the healthcare market place more efficient by providing quality measures to health professionals, and ultimately, help transform health and health care.
- Insurance Marketplaces: ACP supports \$629 million in funding for the Centers for Medicare and Medicaid Services, Program Management for Marketplaces as requested in the President's FY2015 budget in order to carry

out its duties as necessary. Such funding would allow the federal government to continue to administer the insurance marketplaces as authorized by the ACA if a state has declined to establish an exchange that meets federal requirements. CMS now manages and operates some or all marketplace activities in over 30 states. Without adequate funding, it will be much more difficult for the federal government to operate and manage a federally-facilitated exchange in those states, raising questions about where and how their residents would obtain and maintain coverage. Inadequate funding would also make it more challenging for CMS to improve the next enrollment process for the marketplace plans created by the ACA, which will begin on November 15, 2014, and to exercise necessary oversight over the marketplace plans (such as oversight to ensure that the plans are meeting physician and hospital network adequacy standards). It is ACP's belief that all legal Americans – regardless of income level, health status, or geographic location – must have access to affordable health insurance, and although the ACA will fall short of covering all Americans, it will substantially reduce the number of uninsured legal residents. CMS need to be provided the funding needed to ensure that the ACA is implemented effectively.

### **Sequestration Update**

The Budget Control Act (BCA), enacted in 2011, put forth instructions that if Congress could not find a means to reduce the federal deficit by a specified amount over a certain time period then across-the-board cuts, known as “sequestration,” would be imposed. Sequestration was triggered in March 2013 and set into motion billions of dollars in automatic across-the-board reductions in virtually all federal agencies, which had devastating consequences for many federal health programs. In December 2013, the Bipartisan Budget Act (BBA), H.J. Res 59, was enacted and restored \$63 billion over two fiscal years in discretionary spending that would have been cut under sequestration, \$45 billion in FY 2014 and \$18 billion in FY 2015. The \$63 billion was divided evenly between defense and non-defense discretionary spending. The BBA also established the overall topline number discretionary spending level for FY2014 at \$1.012 trillion and for FY2015 at \$1.014 trillion.

ACP strongly urged Congress to replace the sequestration cuts to essential health programs in 2013 with a more responsible approach that takes into account the importance of each program and its effectiveness. ACP has provided Congress with recommendations for achieving hundreds of billions in healthcare savings in a more responsible way that targets the true cost-drivers in health care. Sequestration, by comparison, arbitrarily cuts highly effective and needed health care programs, such as NIH. Sequestration has also imposed a 2 percent payment cut on physicians, hospitals, and other Medicare providers, which will remain in effect until FY 2024 unless Congress replaces sequestration with a more responsible approach. ACP is pleased that the BBA partially restored sequestration cuts for discretionary spending in FY2014 and FY2015. However, it is important to note the BBA left in place sequestration for certain mandatory spending that was not exempt from sequestration including the sequestration cuts in Medicare payments to physicians and hospitals. Nonexempt mandatory sequestration is 7.2 percent for FY2014 and 7.3 percent for FY2015. Nonexempt Medicare spending is limited to a 2 percent sequester cut to providers by the BCA (the law exempts beneficiaries from the cuts).

### **Debt Ceiling Update**

The debt ceiling authorizes the U.S. Treasury Department to borrow funds up to a certain amount in order to meet the United States' current fiscal obligations, which includes spending authorized by Congress as well as interest on the debt; it is not authority to borrow money for new spending but rather to cover expenses already incurred by the federal government. In February, Congress passed and the President signed into law legislation that extends the debt ceiling borrowing authority until March 15, 2015.

### **Graduate Medical Education (GME)**

GME is a formal clinical training provided by approved residency and fellowship programs to physicians who have received an MD or a DO degree (or a foreign equivalent). It involves a period of training lasting at least three to seven years in which physicians are directly supervised in their learning as they progressively assume more responsibility for patient care.

GME Financing: The federal government recognizes the importance of supporting medical education and is the single largest contributor to GME. Funding is primarily provided through the Medicare program, which is an entitlement program where funding is mandatory. Medicare subsidizes education and training for over 90,000 residents in more than 1,100 hospitals. The number of federally funded GME positions was capped in 1997 and this limit has remained in place ever since, though there have been some exceptions that have allowed for some minor growth.

The costs of GME are recognized by Medicare under two mechanisms: (1) direct graduate medical education payments (DGME) to hospitals for residents' stipends, faculty salaries, administrative costs, and institutional overhead, and (2) indirect medical education (IME) adjustment developed to compensate teaching hospitals for the higher costs associated with teaching, the involvement of residents in patient care, and the severity of illness of patients who require the specialized services that are available in teaching hospitals. Because the results from IME payments are not as concrete as DGME payments, since the amount is tied to a hospital's Medicare inpatient volume and case mix along with their training program size (subject to their resident cap number), more scrutiny is being given to IME payments. Although the Medicare Payment Advisory Commission (MedPAC) has consistently found that the IME payments teaching hospitals receive are higher than the actual cost of treating Medicare patients, it has not recommended cuts in IME payments. Rather, it has recommended that IME payments be linked to performance measures that teaching hospitals would have to meet in order to receive their full IME adjustment. However some lawmakers have used MedPAC's findings to support cuts to IME as a cost saving measure rather than reallocating those funds.

With increased focus on the national deficit, entitlement programs, such as Medicare, face greater scrutiny. There has been an increased interest in transparency and accountability for the nearly \$10 billion that the federal government spends on GME annually. This means that funding for GME is at risk, as noted below, which is of concern to ACP:

- In his FY2015 budget request, President Obama also called for a \$14.6 billion reduction of IME payments. The proposal would reduce IME payments by 10 percent, beginning in 2015. In addition, the Health and Human Services 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. ACP is not supportive of the proposal, and believes that GME funding should be preserved so that training programs can develop the most robust programs and meet the requirements stipulated by their Residency Review Committees (RRCs). However, ACP acknowledges that there needs to be more transparency and accountability to ensure funds are appropriately designated toward activities related to the educational mission of teaching and training residents with the skills and experiences necessary to meet the nation's health care needs. ACP has not endorsed recommendations by MedPAC and others to create a performance-based GME payment system. The College acknowledges that such a system is an idea that is worth exploring but cautions that it should be thoughtfully developed and considered in a deliberate way to ensure that goals are achieved without destabilizing the system of physician training. More details on the College's policy on the issue can be found [here](#).
- Congress, in its effort to find obligatory offsets to pay for the cost of various pieces of legislation, has targeted GME funding in years past. This threat continues to exist today as Congress continues to search for ways to pay for its legislative initiatives.
- The federal government's vital investment in training physicians also is threatened by the automatic 2 percent across-the-board cut in Medicare program payments to physicians and hospitals, including Medicare GME payments, as a result of the "sequester" mandated by the BCA which has been extended to FY2024 by the one-year SGR patch bill, the *Protecting Access to Medicare Act of 2014* (H.R. 4302).

GME Reform: There have been calls for broad reform of the Graduate Medical Education (GME) system to achieve a greater alignment of financing with the public's health care workforce needs. The Institute of Medicine has formed a committee that will develop a report with recommendations for policies to improve graduate medical education (GME), with an emphasis on the training of physicians. Specific attention will be given to increasing the capacity of the nation's clinical workforce that can deliver efficient and high quality health care that will meet the needs of our diverse population.

To that aim, in developing its recommendations the committee will consider the current financing and governance structures of GME, the residency pipeline, the geographic distribution of generalist and specialist clinicians; types of training sites; relevant federal statutes and regulations; and the respective roles of safety net providers, community health/teaching health centers, and academic health centers.

In addition, the President has outlined in his FY2015 budget proposal targeted support for GME. The budget requests \$530 million in FY2015 for a new competitive grant program that will fund teaching hospitals, children's hospitals, and community-based consortia of teaching hospitals and/or other health care entities to expand residency training, with a focus on ambulatory and preventive care, in order to advance the Affordable Care Act's goals of higher value health care that reduces long-term costs. The new Targeted Support for Graduate Medical Education Program will incorporate two existing HRSA programs, the Children's Hospital Graduate Medical Education program and the Teaching Health Center Graduate Medical Education program. Current awardees in those programs will be eligible to compete for funding through the Targeted Support's competitive grant program, with a minimum of \$100 million set-aside specifically for children's hospitals in FY 2015. The Budget proposes to continue mandatory funding for the new Targeted Support for Graduate Medical Education program annually in FYs 2015-2024, for a total investment of \$5.2 billion.

The President's budget is meant to support 13,000 residents over 10 years, which is consistent with ACP policy of expanding GME slots although insufficient to reverse a growing shortage of primary care physicians for adults and other specialties (including many internal medicine subspecialties) also facing shortages. The existing caps on the number of Medicare-funded GME positions available makes it impossible to fund GME training positions in the numbers needed to slow or reverse growing shortages of physicians in primary care and other fields.

As outlined in ACP's policy paper entitled, [\*Aligning GME Policy with the Nation's Health Care Workforce Needs\*](#), ACP makes the following key recommendations to Congress.

- GME financing should be transparent, and all payers should be required to contribute to a financing pool to support residencies that meet policy goals so that the costs of GME financing are spread across the health care system.
- Payment of Medicare GME funds to hospitals and training programs should be tied to the nation's health care workforce needs and place a priority on primary care in order to create a well-functioning health care system.
- GME caps should be strategically lifted, as needed, to permit training of an adequate number of primary care physicians, including general internists, and other specialties facing shortages.

The existing GME caps need to be strategically adjusted to increase the number of funded positions in specialties that have been shown by independent studies to be facing the greatest shortages, including internal medicine and other primary care disciplines. However, Congress would have to agree to enact these increased funding levels and the caps for the specific specialties facing the greatest shortages; if these specialties receive increased funding, overall GME funding levels would have to increase to maintain current GME funding levels for all other specialties. The AAMC has recommended that all GME caps and funding for all specialties be increased, which would add hundreds of billions of dollars more to Medicare expenditures on GME. While ACP agrees with the AAMC on the need for adequate GME funding, we have recommended the more strategic approach described above of selectively increasing GME funding for programs to train physicians in the specialties facing the greatest shortages. ACP also supports the concept of all-payer financing of GME, which would require that all insurers contribute to a fund to finance GME as a public good. Spreading the base of funding to all payers would help ensure sufficient and stable funding for GME and relieve Medicare from bearing a disproportionate share of the funding.

ACP-Endorsed Legislation: Several bills have been introduced that address the need to increase funding for graduate medical education and to strategically lift the caps on GME residency positions, particularly for primary care specialties.

- *The Resident Physician Shortage Reduction Act (S. 577 and H.R. 1180)*, introduced in the Senate by Senators Bill Nelson (D-FL), Charles Schumer (D-NY), and Harry Reid (D-NV) and in the House by Representatives Joseph Crowley (D-NY) and Michael Grimm (R-NY), will increase the number of Medicare-supported training positions for medical residents who choose careers in primary care. Specifically, the bill will provide for approximately

15,000 additional GME positions for medical residents. It will require at least 50 percent of the new positions to be allocated to specialties such as primary care that are currently facing a shortage. The current Medicare GME funding limits on residency training positions are impeding the establishment of new residency programs and additional training positions in existing programs. Increasing the overall pool of physicians will not assure that adequate numbers enter and remain in practice in primary care (general internal medicine, family medicine, and pediatrics). Instead, a more targeted approach is needed by strategically increasing the number of Medicare-funded GME positions in adult primary care specialties, as this bill proposes to do.

- *Training Tomorrow's Doctors Today Act (H.R. 1201)*, introduced in the House by Representatives Allyson Schwartz (D-PA) and Aaron Schock (R-IL), authorizes the Secretary of Health and Human Services to increase the number of GME slots by 15,000 over the next five years, providing additional opportunities for residents who choose careers in primary care or general surgery as it mandates that any hospital that receives funding for additional residency positions shall ensure that not less than 50 percent of the new slots are used to train residents in primary care or other residents in specialties facing shortages.

H.R. 1201 would also establish and implement procedures under which payment for indirect medical education is adjusted based on the reporting of quality measures of patient care specified by the Secretary of Health and Human Services. ACP believes that the concept of a performance based GME payment system is worth exploring but cautions such a system must be thoughtfully developed and evaluated with input from a variety of stakeholders including physicians involved in primary care training.

- *The Primary Care Workforce Access and Improvement Act (H.R. 487)*, introduced in the House by Representative Cathy McMorris Rogers (R-WA), authorizes the Secretary of Health and Human Services to conduct a five-year Medicare pilot project that would direct a share of Graduate Medical Education funding to medical education entities to test different models of primary care training. This bill gives the HHS Secretary the authority to test new models of care that demonstrate the capability of improving the quality, quantity, and distribution of primary-care physicians. Improved models of ambulatory training and exposure to team-based approaches to patient care, such as the patient-centered medical home, are essential to making careers in general internal medicine and other primary care specialties more attractive and relevant.

For more information on ACP's positions on the federal budget and appropriations, please visit the Advocacy section of ACP Online, [http://www.acponline.org/advocacy/where\\_we\\_stand/federal\\_budget/](http://www.acponline.org/advocacy/where_we_stand/federal_budget/).