Research Also to Be Cut

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fully short of the needs of the nation's health, especially regarding older and poor Americans."

The proposal also outlines a payment freeze for inpatient rehabilitation facilities and ambulatory surgical centers in 2010 and 2011, followed by annual cuts. And home health agencies would also see a 0% update from 2009 through 2013 followed by annual payment cuts.

The proposal would reduce indirect medical education add-on payments from 5.5% to 2.2% over the next 3 years, and would eliminate the duplicate hospital indirect medical education payment for Medicare Advantage beneficiaries.

Hospitals would also face additional cuts under the plan. For example, the proposed budget would reduce hospital capital payments by 5% in 2009, and hospital disproportionate share payments would drop 30% over the next 2 years.

The FY 2009 budget plan also includes proposed legislative and administrative changes aimed at cutting nearly $18 billion from Medicaid over the next 5 years.

The administration's budget would reauthorize the State Children's Health Insurance Program (SCHIP) through 2013. The plan calls for a $19.7 billion increase to the program over 5 years.

One area that the administration's budget proposal does not address is the 10.6% physician pay cut scheduled to take place this July.

Dr. Flood, who also practices in Ohio, called this failure "irresponsible." "Many providers are telling me that they are very close to the edge of not being able to run businesses that are financially sound, and we all know what that means," he said.

In total, the administration is requesting $711.2 billion for the Centers for Medicare and Medicaid Services to cover mandatory and discretionary outlays for the Medicare, Medicaid, and SCHIP programs.

The request is a $32.7 billion increase over the FY 2008 funding level.

Federal research agencies are also facing cuts or freezes under the FY 2009 budget proposal.

The administration is proposing no increase for the National Institutes of Health, keeping the agency's budget at approximately $29.5 billion. Health advocates say the failure to expand NIH funding will hurt research efforts in several critical areas.

"While there is some financing available in the private sector, such as grants from the American College of Rheumatology's Research and Education Foundation, such sources can not possibly meet the needs of those seeking the answers to fundamental questions in rheumatology," said Dr. Flood.

"The ongoing failure of this administration to fund NIH research will continue to have negative repercussions for Americans who suffer from chronic disease today and for future generations."

The administration's budget proposal also calls for $8.8 billion in funding for the Centers for Disease Control and Prevention, a $412 million drop from FY 2008. The Agency for Healthcare Research and Quality would also face a cut under the proposal. The president is calling for $326 million in funding for the agency, a $9 million decrease from FY 2008.

The Food and Drug Administration would receive a $130 million increase over FY 2008, bringing the total funding to 2.4 billion in FY 2009. The FDA budget proposal includes increases in the human drugs and devices programs at FDA.

Under the plan, the human drugs program would receive $984 million in FY 2009, an increase of $68 million. The increase includes estimated user fees coming into the agency. The increases are slated to fund improvements in drug safety and regulation of biologic therapies. The budget includes a funding commitment of $389.5 million for drug safety, an increase of $36 million in FY 2008. In addition, the budget includes a proposal to grant the FDA new authority to approve follow-on biologic proteins through a new regulatory pathway. The administration also is seeking user fees to cover the costs of the new activity. ■

Denise Napoli, Assistant Editor, contributed to this story.

Proposal to Save Medicare Focuses on Quality, Efficiency

BY MARY ELLEN SCHNEIDER
New York Bureau

In response to a warning that the Medicare trust fund is in financial trouble, the Bush administration recently proposed legislation that would tie physician payments to quality, cap medical liability damages, and encourage nationwide adoption of electronic health records.

Health and Human Services Secretary Mike Leavitt submitted the proposed legislation to Congress last month, in response to the Medicare Trustees' warning for the second year in a row that general federal revenue would be needed to pay for more than 45% of program expenditures. Mr. Leavitt was required to submit the proposal under a cost-saving measure included in the Medicare Modernization Act of 2003.

"The Medicare program is on an unsustainable path, driven by two principal factors: projected growth in its per-capita costs, and increases in the beneficiary population as a result of population aging," Mr. Leavitt said in a letter to House Speaker Nancy Pelosi (D-Calif.). "Excess cost growth will not be brought under control until there is comprehensive reform changing Medicare's underlying structure."

Under the proposal, the HHS secretary would design and implement a system to tie a portion of the Medicare payment to providers to performance on quality and efficiency measures. Implementation would start in areas with well-accepted measures such as hospitals, physician offices, home health agencies, skilled nursing facilities, and renal dialysis facilities.

The legislation also would limit the length of time that individuals have to sue for medical malpractice, would cap noneconomic damages at $250,000 and punitive damages at $250,000 or twice the economic damages (whichever is greater), and would limit contingency fees paid to plaintiffs' attorneys. The HHS estimates that defensive medicine raises the cost of care in federal programs including Medicare, Medicaid, and Veterans Affairs, by about $28 billion a year.

Starting in 2009, the administration's proposal would also increase beneficiary premiums for Part D prescription drug coverage for single beneficiaries earning more than $82,000 a year and couples earning more than $164,000. The HHS estimates that the change would save more than $900 million in 2009 and nearly $3.2 billion over 5 years. The legislative proposal also requires the HHS secretary to develop a system to encourage the nationwide adoption and use of interoperable electronic health records and to make personal health records available to Medicare beneficiaries.

Mr. Leavitt urged Congress to adopt the proposed changes in conjunction with the administration's fiscal year 2009 budget proposal, which includes legislative and administrative proposals that would cut $12.8 billion from the Medicare program in fiscal year 2009 and about $183 billion over the next 5 years.

But the administration may encounter some trouble getting its proposals through Congress.

Sen. Edward Kennedy (D-Mass.), chair of the Senate Health, Education, Labor, and Pensions Committee, said the administration's proposed Medicare cuts were dead on arrival. "The administration has trumped up a phony crisis in Medicare to justify proposing deep cuts in quality health care for seniors while giving massive subsidies to HMOs and other insurance companies," he said in a statement. ■

Demo P4P Project Cuts Hospital Costs, Mortality Over 3 Years

BY ALICIA AULT
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Hospitals participating in a Medicare-sponsored, pay-for-performance demonstration project have sustained initial gains in quality improvement and seen a decline in mortality and costs for selected conditions over 3 years, according to data released by Premier Inc., a hospital performance improvement alliance.

The median hospital cost per patient dropped by $1,000, and the median mortality dropped by 2%. The project has 250 participating hospitals, and more than 1 million patient records were analyzed.

Premier, which manages the Centers for Medicare and Medicaid Services–funded Hospital Quality Incentive Demonstration project, estimated that if every hospital in the U.S. achieved the same benchmarks, there would be 70,000 fewer deaths each year and hospital costs would drop by $4.5 billion.

At a briefing, Mark Wynn, Ph.D., director of payment policy demonstrations at CMS, said the project is one of the agency's primary arguments in favor of value-based purchasing, a policy CMS regards as the most effective way to reward efficiency and value. "Relatively modest dollars can have huge impacts," he said.

Dr. Evan Benjamin, chief quality officer for Baystate Health System in Springfield, Mass., agreed. He was the lead author of a study looking at earlier data which found quality was higher among the 250 incentivized hospitals than it was in control hospitals that reported data publicly but were not given incentives (N. Engl. J. Med. 2007;356:486-96).

The demonstration project began in October 2003; data covered every quarter through June 2007.

Hospitals were given aggregate scores for each of five conditions—acute myocardial infarction, heart failure, coronary artery bypass graft, pneumonia, and hip and knee replacement—based on reporting for 27 process measures. Hospitals with fewer than eight cases per quarter were excluded, and all data were adjusted using the All Patient Refined–Diagnostic Related Groups (APR-DRG) methodology created by 3M Information Systems.

Overall, hospitals improved by an average 17% on a composite quality score used by the project.

There was a continuing downward trend in performance variation among the hospitals, with all moving toward the ideal, said Richard Norling, president and CEO of Premier Inc. Costs and mortality were lowest for the hospitals that were on target 100% of the time with 100% of patients, he said.

For instance, the mortality for coronary artery bypass graft patients was close to 6% at hospitals that met appropriate care benchmarks in only half the patients or fewer. Mortality was just under 2% for facilities that met those benchmarks in 75%-100% of the patients, Mr. Norling told reporters.

Attaining the goals of the demonstration project required cultural shifts and investments in information systems. Before the project, the Aurora Health Care system was reactive and was achieving only incremental quality improvement, said Dr. Nick Turkal, president and CEO of the Milwaukee-based nonprofit system. The system's 13 hospitals have 100,000 admissions annually. Data on meeting the pay-for-performance goals are given to employees every 60 days, and are updated regularly on the system's Web site for the public to see. Mortality and costs are down significantly, but "we're not done yet," he said. ■