Bush Proposes 2009 Cuts to Medicare, Medicaid

The budget proposal calls for freezing payments to inpatient, long-term care, and outpatient hospitals.

BY MARY ELLEN SCHNEIDER
New York Bureau

In the final budget proposal of his presidency, President Bush is proposing substantial cuts to hospitals, skilled nursing facilities, and graduate medical education.

Leaders in the Democrat-controlled Congress instantly declared the proposal dead on arrival.

Under the plan, the Bush administration has put forth 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, largely from hospital and other provider payments.

The idea is to slow down the growth rate of the program from 7.2% to 5% over 5 years. But critics say the cuts would harm hospitals that care for low-income patients and train physicians.

The FY 2009 budget proposal calls for freezing payments to inpatient hospitals, long-term care hospitals, skilled nursing facilities, hospices, outpatient hospitals, and ambulance services from 2009 through 2011. Payments would then drop 0.65% annually under the proposal.

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, including $450 million in outreach grants to states and other organizations to help enroll uninsured children in the program.

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

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 funding 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.

For example, the National Institute of Diabetes and Digestive and Kidney Diseases would receive an increase under the administration's proposal, but the $2.6 million bump amounts to a 0.15% increase over FY 2008. The American Diabetes Association is urging Congress to disregard the president's proposal and provide $112.5 million in additional funding, a 6.6% increase.

"We cannot afford not to invest in diabetes research, treatment, and prevention—the consequences for our health care system and our society will be too severe," Dr. John B. Buse, president of medicine and science for the American Diabetes Association, said in a statement. "The American Diabetes Association calls on Congress to align their priorities and provide funds to remedy this growing health crisis."

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 2009 budget 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.

Under the administration's budget request, the medical devices program at FDA would receive $291 million, an increase of $7 million. ■

Overcoming Resistance to Electronic Medical Records

BY GREG MUIRHEAD
Contributing Writer

MAUI, HAWAII — Physicians are needlessly resisting the inevitability of electronic medical records, according to Dr. Martin J. Bergman.

As of 2005, about 23% of office-based physicians used electronic medical records (EMRs), said Dr. Bergman, citing statistics from the Centers for Disease Control and Prevention's National Center for Health Statistics that were reported in 2006. In contrast, almost 80% of office-based physicians used billing software, he added.

Reasons for resistance include complaints that EMRs are difficult to complete, interrupt the office flow, and take too much time to administer and review, said Dr. Bergman of Taylor Hospital, Ridley Park, Pa.

"The first obstacle is cost," he noted. The cost of getting EMR software can range from $5,000 to more than $30,000, although the better software doesn't necessarily cost more.

EMR software can range from $5000 to more than $30,000. Once EMRs are established in the practice, physicians can expect significant savings.

Once EMRs are established in the practice, physicians can expect significant savings associated with their use. The practice will save on transcription fees, and dictation will no longer be needed.

"My example is 12 years ago, when I went into electronic records, I was paying just under $20,000 a year for transcriptions," he recalled. "I no longer use a transcriptionist. Over 12 years, I've saved close to $250,000 on transcription fees alone."

As for time difficulties, there is a "steep learning curve" in getting used to using EMRs; it takes about 3 months to become familiar enough with the software that it no longer slows down the physician's practice.

"Those first 3 months are ugly," he said. "After that, your productivity doubles."

Dr. Bergman pointed out that EMRs can be used to track metrics—measures of patients' progress—which is difficult to do with paper files.

Metrics can quickly help gauge the success of the practice, and the news is not always good. "Until you start doing metrics, you think you are doing better than you are," he said. "The majority of us are not using any form of metric."

Other benefits of EMRs include:

► **An increase in productivity.** Dr. Bergman observed that, now, paper records slow him down. EMRs give him instant access to entire histories, including lab tests and drugs used.

► **Easy creation of referral letters.** Print them by pressing a couple of buttons, and upon leaving the computer, he said, "I'm done when I'm done."

► **A tool for research.** Patient data can be graphed to show results of treatment over time, which provides a good source of private practice research.

► **Access to databases.** Data extracted from the EMR database can readily be shared with existing databases.

Patient data typically collected in an EMR include demographic information, active and comorbid diagnoses, currently and formerly used medications, and lab reports, he said during his presentation at a symposium sponsored by Excellence in Rheumatology Education.

EMR software offers two basic options: template software and database software. The choice might depend on whether the purchaser is in a solo practice or a group practice.

The solo practice will be better served by database software, which is flexible and can be altered on the fly to fit special information-gathering needs. But a group practice or hospital will more likely want template software, which is more rigid, and requires all users to fill in the same kinds of information in the same format.

Solo practitioners, Dr. Berman said, will probably not like working with rigid template software; they should look at flexible database software instead.

There are free, month-long demos of software available that allow determination of which one is appropriate for the practice.

Although patients can enter data directly into their EMRs at an office computer kiosk, some patients might find doing so difficult.

A personal digital assistant (PDA), which is often used by physicians to enter patient data in hospitals, also presents problems for some patients. A laptop is another option; however, because it may need to be replaced every few years, it may be a costly one.

Dr. Bergman gives his patients paper questionnaires; the answers are entered into the EMRs. His questionnaire comprises mostly check-off questions, which are easy for patients to fill it out quickly and for office staff to enter electronically.

After the patient's questionnaire information has been entered into an EMR at the office, Dr. Bergman can quickly open the patient's record, see the new information, and easily review information from the previous visit.

Dr. Bergman said that although he has been using EMR software from Stat Systems for 12 years, he is neither a spokesman for nor an owner of the company. ■