POLICY & PRACTICE

Ex-FDA Chief Fined

Former Food and Drug Administration Commissioner Lester Crawford, D.V.M., Ph.D., has been sentenced to 3 years of supervised probation and fines of slightly less than $90,000 for charges stemming from his ownership of stock in companies regulated by the FDA. The penalty exceeded a $50,000 fine in a plea agreement Dr. Crawford and federal prosecutors struck last year but still spared the former FDA chief jail time. U.S. Magistrate Judge Deborah Robinson of the District Court for the District of Columbia also ordered Dr. Crawford to perform 50 hours of community service. Dr. Crawford resigned his FDA administrator post in September 2005 after just 2 months and did not give a reason for his resignation. In October 2006, he pleaded guilty to charges of having a conflict of interest and false reporting of information about stocks that he and his wife owned. Prosecutors said that Dr. Crawford filed seven incorrect financial reports with a government ethics office and Congress beginning in 2002.

Insurance Cost Sharing

Fewer than 24% of private sector employees covered by employer-sponsored health insurance do not pay a portion of their own premium, down from 35% in 1998, according to a report from the Agency for Healthcare Research and Quality. In both years, employers were more likely to offer no-contribution single coverage than no-contribution family coverage. In 1998, 18% of employees eligible for health insurance from their employer worked in a firm that offered at least one family coverage plan that required no employee contribution; by 2004, that rate had fallen to 13%, the report said.

Majority Want Access Guarantee

Nearly two-thirds of Americans believe that the federal government should guarantee access to health care, and 60% are willing to pay more in taxes for that guarantee, according to a poll released last month by the New York Times and CBS News. Half of those polled said they would be willing to pay as much as $500 a year in additional taxes, while nearly 8 in 10 said they thought it was more important to provide universal access to health insurance than to extend the Bush administration's tax cuts. In addition, a quarter of those with insurance said that they or someone in their household had gone without a medical test or treatment because insurance would not cover it; 60% of those without insurance reported the same situation. The nationwide telephone poll of 1,281 adults was conducted in late February 2007.

Hospital Demonstration Extended

The Centers for Medicare and Medicaid Services has approved a 3-year extension of the Premier Hospital Quality Incentive Demonstration, a value-based purchasing project involving more than 260 hospitals across the country. Recently released second-year results of the demonstration show "substantial improvement" in quality of care across five clinical focus areas, including acute myocardial infarction, heart failure, coronary artery bypass graft, pneumonia, and hip and knee replacement, with total gains in quality over the first 2 years of 11.8 percentage points, according to a CMS statement. The hospitals involved have received incentive payments for providing high-quality care. During the first 3 years of the project, only top-performing hospitals have been eligible for incentive payments, but the 3-year extension will test the effectiveness of offering incentive payments to hospitals achieving a defined level of quality (or quality threshold) or achieving the greatest improvement in quality and a quality threshold.

Medicaid Growth Sustainable

Expected growth in government revenues is likely to be large enough to sustain Medicaid spending increases over the next 40 years while still allowing substantial real growth in spending for other public services, according to a study published in the journal Health Affairs. The analysis by the Kaiser Family Foundation's Commission on Medicaid and the Uninsured looked at both potential long-term Medicaid spending and the availability of government revenues to support it. "While a substantial component of state government spending, Medicaid is not likely to be the financial burden squeezing out other public priorities that some policy makers fear," said study coauthor Richard Kronick of the University of California, San Diego, in a statement. After accounting for demographic and health coverage trends such as an aging population and declines in employer-sponsored insurance, the study found that Medicaid's share (17% in 2005) of national health expenditures is expected to remain about the same until 2025 and then rise slowly to 19% by 2045. "Efforts to reduce the growth in Medicaid by shifting costs or threatening coverage will ultimately require better controlling the rate of growth of health spending overall," Diane Rowland, executive director of KFF's commission, said in a statement.

Hospitals Embrace IT

Nearly half of all community hospitals reported moderate or high use of health information technology (IT) in 2006, compared with 37% in 2005, according to recent survey results from the American Hospital Association. Hospitals also reported dramatic increases in the use of computerized alerts to prevent negative drug interactions; in 2006, 51% of hospitals were using real-time drug interaction alerts, up from 23% in 2005. Larger hospitals were more likely than smaller hospitals to have heavy use of health IT, AHA said.

—Jane Anderson

Medicare Pay Fix Won't Be Cheap or Easy to Achieve

BY JOEL B. FINKELSTEIN
Contributing Writer

WASHINGTON — It won't be cheap to fix Medicare's problematic physician pay formula, but lawmakers aren't saving any money by waiting to replace it either, experts testified at a hearing of the Senate Finance Committee.

"We have been kicking this can down the road for the past 5 years. This committee, and certainly Congress, understands it's not going to get any easier," said Dr. Cecil Wilson, board of trustees chairman for the American Medical Association.

Peter Orszag, Ph.D., director of the Congressional Budget Office, testified that "in health care, we get what we provide incentives for. We currently provide lots of incentives for advanced technologies and high-end treatment, and we get a lot of that. We provide very little incentive for preventive medicine and get very little of that."

Early in 2006, lawmakers asked the Medicare Physician Advisory Commission (MedPAC) to examine ways to shift those incentives. Their findings were presented to the committee a few days before MedPAC members presented the commission's annual report to Congress.

Commissioners were unable to forge a consensus on what should be done to replace the sustainable growth rate (SGR) system, MedPAC Chairman Glenn Hackbarth testified. Instead, the commission offered lawmakers two alternative approaches—one that doesn't include an SGR-like spending target and one that does. (See box.)

Eliminating spending targets would require Congress to create a whole new system with incentives to physicians to provide high-quality, low-cost care, Mr. Hackbarth said. Keeping targets would simplify payment reform but still would require changes to make the system more equitable.

About spending targets, Dr. Wilson said, "No amount of tinkering can fix what is broken beyond repair." Doctors account for a small portion of increasing premiums, but they are the only group that has spending targets imposed on them, he added.

"The AMA asks that Congress ensure that physicians are treated like hospitals and other providers by repealing the SGR and enacting a payment system that provides updates that keep pace with increases in medical practice costs. We, in turn, are committed to helping assure appropriate use of services," he said.

No matter whose plan is embraced, fixing the SGR system is unlikely to come cheap. The Congressional Budget Office has estimated that current proposals will cost anywhere between $22 billion and $330 billion over 10 years.

"There are lots of steps, including [health information technology] and comparative effectiveness, that offer at least the potential to bend that curve over the long term, but the cost savings may not show up in the next 10 years," Dr. Orszag testified. "Given the scale of the problems that we face, we need to be trying lots of different things and recalibrating all the time," he said.

There are good ideas out there, Mr. Hackbarth testified, but the Centers for Medicare and Medicaid Services is the bottleneck. "We've got some very promising demonstrations under way, but it takes us forever to get them developed, in place, gather results, and translate them into policy," he testified. The agency doesn't have the staff or information systems to move forward expeditiously.

"We're trying to run [Medicare] on the cheap. That won't work if we are trying to innovate at the same time," Mr. Hackbarth said. ■

Which Path Leads To Better Care?

In testimony to the health subcommittee of the House Ways and Means Committee, Mr. Hackbarth said that the MedPAC commissioners struggled with their task of choosing an alternative to the current sustainable growth rate (SGR) system.

The commissioners couldn't agree on just one solution, he said, so they offered two proposals, deemed "Path 1" and "Path 2."

Path 1 calls for repealing SGR and eliminating the system of expenditures targets. The MedPAC report suggests that Congress should implement new ways to improve incentives for physicians and other providers to offer quality care to their patients at lower costs. This could be done in the following ways:

- ► Giving the Centers for Medicaid and Medicare Services the authority to pay providers differently based on performance measures
- ► Ensuring accurate prices by identifying and correcting mispriced services
- ► Encouraging coordination of care and use of care management, especially for patients with chronic conditions

Path 1 also calls for collecting information on physicians' practice styles and sharing the results with other physicians across the country.

The commission proposes that Medicare use the results to adjust payments to physicians and base rewards on both quality and efficiency.

Path 2 calls for pursuing the approaches in Path 1 but also includes a new system of expenditure targets. The MedPAC report states that expenditure targets are necessary because they put "financial pressure on providers to change."

Path 2 proposes that expenditure targets be applied to all providers in an effort to encourage different providers to work together at keeping costs as low as possible.

—Glenda Fauntleroy