



Bush’s FY 2009 budget freezes hospital Medicare payments

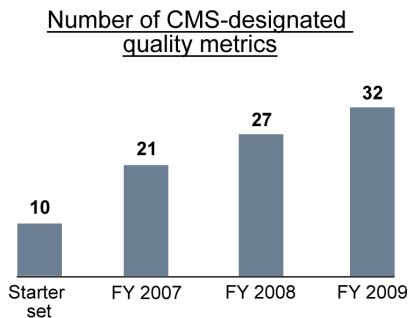
As part of a \$3.1 trillion budget proposal for fiscal year 2009 unveiled Monday, President Bush called for legislative changes that would reduce Medicare spending by roughly \$178 billion across the next five years, saying that the cuts are necessary to slow “unsustainable growth in entitlement spending” and ensure fiscal solvency, *CQ HealthBeat* reports.

See story #1

RESEARCH HIGHLIGHT

CMS systematically upping the ante

Since CMS kicked off its quality reporting effort a few years ago with a handful of metrics, the agency each year has expanded the requested metric set, and increased the amount of payment at risk for non-submitting hospitals. Notably, 14 of 27 metrics in FY 2008 are cardiac oriented—focused on heart attack and heart failure performance. To learn more about the quality arena and the future of cardiovascular services, please register for the Health Care Advisory Board’s 2007-2008 National Member Meetings.



Source: Advisory Board research, 2007

THIS DAY IN BRIEF

Blacks more likely to contract, die from severe sepsis, study says

Black patients contract severe sepsis—the 10th leading cause of death in the nation—at nearly twice the rate of whites and are far more likely to die from the bloodstream infection, according to a study in the Feb. 1 *American Journal of Respiratory and Critical Care Medicine*.

See story #2

Lifetime medical costs of healthy people higher than obese, smokers

A new Dutch study simulating the health care costs of the obese, smokers, and healthy individuals found that by living longer the healthy population incurred the greatest lifetime health care-related expenses.

See story #3

Hospitals promote specialist collaboration to streamline, improve care

In an effort to better integrate care and ease patient decision-making, some hospitals are implementing programs in which vascular surgeons and interventional radiologists partner to provide patients “one-stop shopping,” the *Chicago Tribune* reports.

See story #4

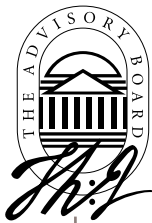
Oncology Roundtable announces Radiation & Imaging Update

The Oncology Roundtable is pleased to announce a new teleconference, “Radiation and Imaging Update 2008: Key Learning from ASTRO & RSNA,” scheduled to take place twice this winter.

See story #5

NAMES IN THE NEWS

Central DuPage Hospital (Ill.) (#4) ■ Columbus Regional Hospital (Ill.) (#7) ■ Fox Chase Cancer Center (Pa.) (#7)
Northwestern Memorial Hospital (Ill.) (#4) ■ Northwestern University Feinberg School of Medicine (Ill.) (#4)
University of Pittsburgh (Pa.) (#2) ■ Yale University (Conn.) (#7)



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Tuesday, February 05, 2008

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► Today's Headlines

1 Bush's FY 2009 budget freezes hospital Medicare payments

As part of a \$3.1 trillion budget proposal for fiscal year (FY) 2009 unveiled Monday, President Bush called for legislative changes that would reduce Medicare spending by roughly \$178 billion across the next five years, saying that the cuts are necessary to slow “unsustainable growth in entitlement spending” and ensure fiscal solvency, *CQ HealthBeat* reports. The largest Medicare reductions would come from “slowing the growth of hospital spending by freezing payment rate increases for three years”—changes that would cut \$4 billion from Medicare in FY 2009 and save \$64.2 billion across five years by lowering payment updates by 0.65 percentage points annually. Payment rates to rehabilitation facilities, skilled nursing facilities, long-term acute care hospitals, and hospital outpatient departments would also be frozen, while Medicare payments to hospitals serving a large number of low-income patients would drop by \$20.7 billion from 2009-2011. The budget outline also calls for slashing payments to hospitals and physicians by 0.4% each year in which general revenues fund at least 45% of Medicare outlays. Combined with administrative changes that would lower Medicare spending by an additional \$5 billion, the proposed program cuts would total \$183 billion and would reduce the yearly growth rate for Medicare spending from 7.2% to 5%, according to **HHS** estimates. Additionally, the budget would trim Medicaid spending by \$17.4 billion across five years through legislative action that would cut payments to states, and \$800 million through administrative changes—shaving a combined \$200.9 billion from federal spending on both programs across the next five years and reducing unfunded obligations by nearly one-third, according to the White House.

Despite all of the provider cuts, the budget proposal does not include plans to alter payments to private insurance companies for Medicare Advantage (MA) plans—estimated to cost roughly \$150 billion across the next decade. Saying that MA plans are “part of the future” and allow insurers to “offer beneficiaries greater choices and higher-quality health care,” HHS Secretary Mike Leavitt adds that cutting spending by roughly \$180 billion across five years will subsequently reduce payment to MA plans by approximately \$45 billion. *CQ HealthBeat* notes, however, that “the budget does not propose changing payment rate differentials between Medicare Advantage and traditional Medicare providers, which now tilt toward Medicare Advantage plans.”

Saying that the budget should be viewed as a “stark warning” for the Medicare program, Leavitt suggested that the Hospital Part A trust fund would be completely depleted in 11 years if Medicare’s current growth continues, adding that “putting off solving the problem is no longer acceptable.” The proposal is already facing harsh criticism from Democratic lawmakers and hospital groups, with Sen. Max Baucus (D-Mont.)—chairman of the Senate Finance Committee—saying “the administration ought to know that five years’ worth of Medicare and Medicaid cuts totaling \$200 billion are dead on arrival with me and with most of the Congress.” The president and CEO of the **American Hospital Association**, meanwhile, suggests that the proposed budget would have a “disastrous impact on the health care that millions of patients and families depend on” (Reichard, *CQ*, 2/4 [subscription required]; Armstrong, *CQ*, 2/4 [subscription required]; Fox, *Reuters*, 2/4; Godfrey, *Wall Street Journal*, 2/4 [subscription required]).

BUDGET PROPOSAL INCLUDES SCHIP EXPANSION

In a move that *CQ* notes might have caused Democrats to “warm to the president’s [FY] 2009 budget,” President Bush also called for a \$19.3 billion expansion of the State Children’s Health Insurance Program (SCHIP), including \$450 million in outreach grants to enroll eligible but currently unenrolled children. The budget would provide an additional \$4 billion each year across five years for

the program, nearly quadrupling the amount proposed in last year's budget, but still falling short of the Democrats' call for a \$50 billion SCHIP funding hike. The proposal also includes several policy provisions that were "deal breakers" for Democrats during SCHIP negotiations last year, including a cap on expanding the program to children in households earning above 250% of the federal poverty level; some states would be allowed to exceed this cap if certain conditions are met. According to acting CMS administrator Kerry Weems, the SCHIP proposal also includes a provision that would allow children in states that already exceed to 250% threshold to be "grandfathered [in] until they become ineligible" (Armstrong, [CQ](#), 2/4 [subscription required]; Reichard, [CQ](#), 2/4 [subscription required]).

2 Blacks more likely to contract, die from severe sepsis, study says

Black patients contract severe sepsis—the 10th leading cause of death in the nation—at nearly twice the rate of whites and are far more likely to die from the bloodstream infection, according to a study in the Feb. 1 *American Journal of Respiratory and Critical Care Medicine*. To shed light on racial differences in severe sepsis incidence and outcomes, researchers from the **University of Pittsburgh** conducted a population-based cohort study using 2000 U.S. census and hospital discharge data for about 71 million residents of Florida, Massachusetts, New Jersey, New York, Virginia, and Texas. After controlling for age and gender, the researchers found that blacks acquired the infection at a rate of 6.08 cases per 1,000 population, compared with an infection rate of 3.58 cases per 1,000 among whites and 4.06 per 1,000 for Hispanics. After adjusting for poverty and urban residence based on patients' ZIP code, Hispanics demonstrated the lowest rate of severe sepsis, while blacks still posted the highest rate. Black patients with sepsis, meanwhile, were also less likely than other patients with the infection to be treated in an ICU. The researchers also uncovered significant differences in the groups' ICU case-fatality rates; 32.0% of black patients treated in an ICU for sepsis ultimately died, compared with 29.3% and 30.4% of white and Hispanic patients, respectively.

In considering those racial differences, the researchers suggest that while the data "could signal biologic differences in susceptibility," part of the disparity in sepsis incidence could stem from "social determinants—things that are under the control of society." They point out, for instance, that black patients were more likely than white patients to receive care at hospitals that posted worse sepsis outcomes. Noting that their analysis did not account for a number of contributing factors—including differences in tobacco and pharmaceutical use and variations in health care access—the authors outline plans for a randomized, multicenter trial exploring sepsis and controlling for care access and quality. Meanwhile, they conclude that "focused interventions to improve processes and outcomes of care at the hospitals that treat a disproportionate number of black patients" could narrow the disparity in severe sepsis incidence and mortality (Barnato et al., *American Journal of Respiratory and Critical Care Medicine*, February 2008 [subscription required]; American Thoracic Society [release](#), 2/1; Steenhuisen, [Reuters](#), 2/1; Gevers, [MedPage Today](#), 2/1).

3 Lifetime medical costs of healthy people higher than obese, smokers

A new Dutch study simulating the health care costs of the obese, smokers, and healthy individuals found that by living longer the healthy population incurred the greatest lifetime health care-related expenses. For the study, published this week in the journal *Public Library of Science Medicine*, researchers from the Netherlands' National Institute for Public Health and the Environment created three hypothetical cohorts—obese, smokers, and healthy-living people with a BMI between 18.5 and 25—of men and women aged 20 years at baseline; the researchers simulated each population's probability of developing certain long-term diseases and used historical data to estimate

costs of treatment. The obese cohort recorded the highest annual health care costs until age 56, but the researchers found that “differences in life expectancy” played a key role in total lifetime health care spending; the average lifespan in the smokers and obese cohorts was 77 and 80 years, respectively, while the healthy-living group’s average lifespan was 84 years. As a result of being treated for chronic diseases later in life, the healthy-living cohort incurred the greatest lifetime health expenditures (\$417,000), followed by the obese (\$371,000) and the smokers (\$326,000). The study also found that lifetime costs for cancer—other than lung cancer, which is lower cost because of its quick progression and high mortality rate—and the costs associated with strokes were equal among all groups.

Noting that many public-health efforts focus on preventing obesity to cut health care spending, the authors conclude that obesity prevention can be a cost-effective approach to reduce morbidity and mortality but is “not a cure for increasing health expenditures.” In an accompanying perspective piece, a public-health professor at Oxford University notes that “this kind of simplification leaves out the numerous societal implications of obesity,” and he reiterates the importance of public-health efforts to prevent obesity (van Baal et al., *PLoS Medicine*, 2/4; McPherson, *PLoS Medicine* [editorial](#), 2/4; Cheng, [Associated Press](#), 2/5; [ScienceDaily](#), 2/4).

4 Hospitals promote specialist collaboration to streamline, improve care

In an effort to better integrate care and ease patient decision-making, some hospitals are implementing programs in which vascular surgeons and interventional radiologists partner to provide patients with “one-stop shopping,” the *Chicago Tribune* reports. Under the collaboration, specialists who have typically competed for patients work together to treat non-cardiac circulatory problems, such as lower-extremity peripheral arterial disease, carotid artery disease, and aortic aneurysms. Patients consult with both physicians within a few days—rather than waiting weeks for appointments—and then the specialists confer about each case and choose the best treatment option, sometimes performing the procedure together. According to a vascular surgeon at **Central DuPage Hospital** in Winfield, Ill., “patients get through the system much faster”; he adds that competition between specialists can distract from providing the highest quality patient care. In addition, such collaborative care means “patients get optimal treatment performed by the specialist who does it best,” according to the chief of vascular and interventional radiology at **Northwestern Memorial Hospital**, where vascular surgeons and interventional radiologists share patients under a collaborative agreement. A professor of surgery at **Northwestern University Feinberg School of Medicine** agrees, calling the collaborative approach “the future of vascular medicine” (Yablonsky Stat, [Tribune](#), 2/5 [registration required]).

► From the Advisory Board

5 Oncology Roundtable announces Radiation & Imaging Update teleconference

The Oncology Roundtable is please to announce a new teleconference, “Radiation and Imaging Update 2008: Key Learning from ASTRO & RSNA,” scheduled to take place twice this winter.

Growth prospects for radiation therapy and imaging markets appear bright, with promising clinical innovations and strong demand forecasted over the next decade. In hopes of keeping members up-to-date on the latest developments in the radiation therapy and imaging arena, this teleconference will highlight key findings from two of the most recent national society conferences—the **American**

Society of Therapeutic Radiology and Oncology (ASTRO) and the **Radiological Society of North America (RSNA)**. Specifically, this session will focus on the latest-and-greatest vendor offerings, as well as provide updates on key technologies such as IGRT, radiosurgery, proton beam therapy, and PET/CT.

The teleconferences are scheduled for Feb. 7 from 1 p.m. to 2 p.m. EST and March 4 from 1 p.m. to 2 p.m. EST.

For more information

Oncology Roundtable members may register for one of these teleconferences on the [Advisory.com website](#). For more information about the Oncology Roundtable, please contact Mollie Reed at reedm@advisory.com.

6 Infection control solutions: Elevating clinical quality

The Advisory Board's Quality Compass offers cohort members the ability to receive real-time intelligence regarding infections—by unit, physician, and condition—improve antibiotic regimens for patients with infections; and identify the root cause of infections to control outbreaks and reduce overall infection rates. Our unique vantage point in the health care industry allows the Advisory Board to combine innovative technologies with a world-renowned library of best practices that elevate organizational performance and patient care.

In addition, members are paired with an Advisory Board Dedicated Advisor, who is focused on each individual site to help maximize opportunity identification and realization and assist members in tracking their performance relative to benchmarks across key performance indicators. Other cohort services include teleconferences, case studies, and an annual summit meeting.

For more information

To learn more about Quality Compass or to speak to an Advisory Board representative about how Quality Compass can help your institution hit its infection control goals, please contact Chelsea Fleckenstine at 202-266-5710 or fleckenc@advisory.com.

► Regional Round-up

7 Around the nation: Bite-sized hospital and health industry news



- **Colorado:** The Blue Ribbon Commission for Health Care Reform—created by lawmakers in 2006 to find possible solutions to the state's health care crisis—last week presented five proposals to the Colorado General Assembly. According to the commission's report, the package of proposals would reduce the number of uninsured residents by an estimated 88%, extending coverage to roughly 694,500 additional state residents. In addition to promoting a system of shared responsibility, the comprehensive report—endorsed by 24 of the commission's 27 members—says the proposals are intended to be implemented in stages and reinforces the need for a range of interventions. The report recommends requiring all legal residents to have a minimum level of coverage—a goal that the state would achieve by expanding public programs, providing sliding scale subsidies, and requiring health plans to cover everyone (O'Hare, *Montrose Daily Press*, 2/3).

- **Connecticut:** In a study presented at the **Society for Maternal Fetal Medicine's** annual meetings in Dallas, researchers from **Yale University School of Medicine** say they have achieved a more than 60% reduction in adverse OB-GYN outcomes across the past two and a half years through the creation and implementation of new safety initiatives. Specifically, the team prioritized communications training, standardized interpretation of fetal monitoring, and created a new staff role—the patient safety nurse. In addition, the researchers sought to improve department staff members' perception of OB/GYN safety issues, ultimately increasing their awareness by 30% across the study period ([HealthDay](#), 2/3).
- **Florida:** Gov. Charlie Crist (R) last week unveiled a \$64 million proposal that would send health care workers to 14 counties with a high concentration of uninsured residents to identify those without coverage and help them receive medical attention or enroll in government health care programs. The three-year pilot project—part of Crist's budget proposal for the coming year—would also offer uninsured residents health screenings and then direct them to local health clinics in an effort to reduce the number of people visiting EDs for primary care services. According to the governor's office, the program could reduce the number of unnecessary hospital visits by 680,000 (Royse, [Miami Herald](#), 1/31).
- **Illinois:** The board of trustees at **Columbus Regional Hospital** has approved a \$108 million construction project that would add at least 60 private rooms, a new ED, and 225,000 square feet. The hospital will launch the project's first two phases—including the construction of a five-story pavilion—this year, and expects to complete the project in 2011 ([AP/Chicago Tribune](#), 2/3 [registration required]).
- **Pennsylvania:** **Fox Chase Cancer Center** will embark on an \$800 million expansion project under the terms of a deal between the hospital and Philadelphia council members that will allow the hospital to build on 19 acres in Burholme Park. As part of the agreement—which is still subject to committee approval—Fox Chase will contribute \$4 million to the city's capital program for projects throughout the community (Shields, [Philadelphia Inquirer](#), 2/1 [registration required]).

► Endnotes

8 Et cetera

Drug drop: California vending machines distribute medical marijuana

Patients approved for medical marijuana can “get their pot with a dose of convenience” by using one of several prescription vending machines that dispense the drug in at least three Los Angeles locations, the Associated Press reports. The large, black-armored machines require users to undergo fingerprint identification and swipe a prepaid, preregistered magnetic card before obtaining the “bright green envelope” containing marijuana in one-eighth or one-quarter ounce doses, capped at one ounce per person per week. While the machine's developer, Vincent Mehdizadeh, says the vending stations provide “convenient access, lower prices, safety, [and] anonymity,” agents from the Drug Enforcement Agency say “the invention may need unplugging.” The AP notes that the DEA and other federal agencies across the past two years have been shutting down medical marijuana dispensaries throughout California and charging their operators with felony distribution charges.

—Nguyen, [AP](#), 1/30