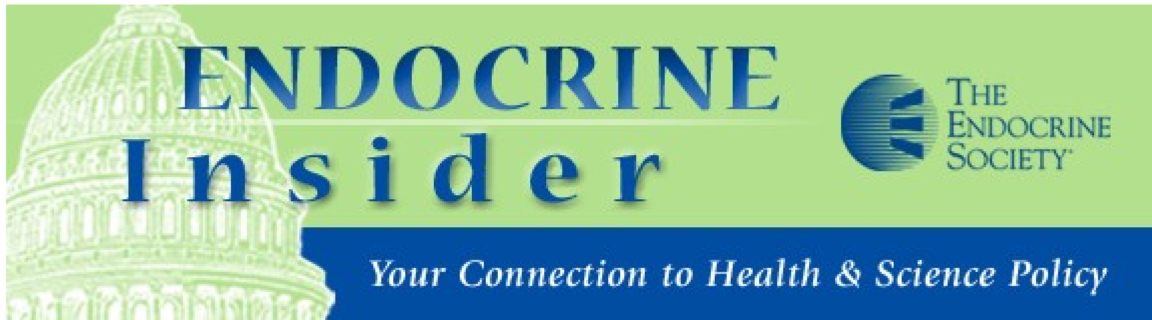

March 23, 2005

Society Grassroots at Work: Senate Votes to Increase NIH Funding in FY 2006 Budget Resolution

On March 16, 2005 the Senate voted 63 to 37 to accept an amendment proposed by Sen. Arlen Specter (R-Penn.) to the FY 2006 budget resolution that will allow for an additional $1.5 billion for the National Institutes of Health (NIH) in the appropriations process. The amendment increases the budget's function 550, all health programs funded in the budget, by $1.5 billion for NIH.

The increase would be offset by a reduction in function 920, an administrative account. With the amendment, the Senate budget resolution will allow $29.9 billion for NIH in FY 2006. The House resolution, approved by the Budget Committee March 10, matches the President's request, allowing NIH a $28.4 billion for FY 2006. While the budget resolution does not provide actual money, it does give the appropriation's committee—the committee that actually provides funding to NIH—a spending blueprint from which to make decisions on funding levels.

In advance of the resolution the Society sent a member alert urging Society members to contact their Senators urging support of the Specter amendment. In response to this alert more than 600 Society members contacted their representatives in the Senate to help push for the ultimate passage of the amendment.

Congress May be Sold on Pay-for-Performance

The Endocrine Society recently learned that the system Medicare uses to pay physicians may be converted to a pay-for-performance (P4P) system in which doctors are compensated, much like a bonus, for providing more efficient, high-quality care. While not conveying a sense of fait accompli, this was the message delivered by House Ways & Means Committee staff members at a meeting of specialty societies earlier this month. One staffer also noted that any hope of fixing the Sustainable Growth Rate (SGR), the flawed Medicare payment formula, is "inexorably linked" to changing the Medicare physician payment system to a pay-for-performance system.

Put another way, any effort to alleviate future payment cuts must be tied with some type of pay-for-performance (P4P) system. If the SGR has a chance of being removed or fixed in some way, physicians must consider a change in the way Medicare pays them.

Specifically mentioned by the committee was a P4P program, which is administered by the National Committee on Quality Assurance (NCQA), known as Bridges to Excellence.

The Endocrine Society, along with other specialties, met last week with a representative of the NCQA to learn more about the program. The committee asked for feedback from specialty societies on this or another model program to determine its feasibility for application to Medicare.

Rep. Nancy Johnson (R-CT), chair of the House Ways and Means Committee's Subcommittee on Health, said March 15 that she will consider ways to integrate quality incentives into any potential new Medicare physician payment structure. Speaking at a subcommittee hearing on pay-for-performance for physicians, Rep. Johnson also expressed concern about attempting this integration in advance of adequate universal technology to collect clinical data on which to base the quality standards.

During a Capitol Hill briefing last Friday, representatives from the American College of Physicians asserted that Medicare's physician reimbursement system should be converted to a P4P system only after a large, voluntary demonstration project proves the efficacy of tying physician reimbursements to performance measures. (CQ HealthBeat, 3/18)

2006 Physician Pay Cuts Not Final

According to the Health and Human Services Office of the Budget, physician payment rates will be cut by approximately 4.3% beginning in 2006 and continue until 2011. By that time, the cuts will have accumulated to a total drop of almost 23% in reimbursement rates. The AMA estimates that by 2013, Medicare payment rates will be less than half what they were in 1991, after adjusting for practice cost inflation.

On the bright side, the March 2005 MedPAC report to Congress states that an increase in [physician] payments in 2006 would increase Medicare spending and beneficiary liability, but would maintain access to physician care and physician willingness to serve Medicare beneficiaries.

Payment experts also are predicting that Congress will pass another one-year, 1.5% update for 2006 (Medicare physicians received 1.5% payment increases for the past two years). While there are obvious benefits to this, it may be another band-aid fix to a long-term problem that is the Sustainable Growth Rate (SGR)—the flawed Medicare payment formula—and the seven-year cuts mandated by the Medicare Modernization Act of 2003 (MMA).

The Endocrine Society continues to work with the AMA and other specialty societies to correct the SGR flaw in addition to exploring other avenues for fixing Medicare's faulty payment system.

NIDDK Welcomes Five New Members to Advisory Council, Including Endocrine Society Member

Secretary of Health and Human Services Michael O. Leavitt has appointed five new members to the Advisory Council of the National Institute of Diabetes and Digestive and

Kidney Diseases (NIDDK), the Institute announced today. In addition to Society member Jeffrey Scott Flier, M.D., NIDDK Director, Allen M. Spiegel, M.D., welcomed the following members at NIDDK's February meeting: Janice Lee Arnold, M.D.; Janet O. Brown-Friday, R.N., M.S.N., M.P.H., the Clinical Manager of the Diabetes Clinical Trials Unit at the Albert Einstein College of Medicine in the Bronx, New York; and William L. Henrich, M.D..

Dr. Flier is the George C. Reisman Professor of Medicine at Harvard Medical School in Boston, Massachusetts. He is also the Chief Academic Officer and Harvard Faculty Dean for Academic Programs at Beth Israel Deaconess Medical Center in Boston. Dr. Flier's research interests include the study of molecular biology of insulin action in health and disease, the pathophysiology of obesity and weight regulation, the physiology of leptin, and transgenic models of diabetes and obesity. From 1974 to 1978, Dr. Flier served as a Clinical Associate in the Diabetes Branch of the National Institute of Arthritis, Metabolism, and Digestive Diseases, the predecessor of the current NIDDK, in Bethesda, Maryland. He joins the Diabetes, Endocrinology, and Metabolic Diseases (DEM) Subcommittee.

Established by law and charter, the NIDDK Advisory Council meets three times annually to advise the NIDDK about its research portfolio. The Council typically undertakes broad issues of science policy. Members of the Advisory Council are drawn from the scientific and lay communities, are appointed for 4-year terms, and represent all areas within the Institute's research mission. An important role of the Council is to provide second-level peer review of grant applications that have been scored by scientific review groups. The Council members are an important liaison between the research communities they represent and the NIDDK, which supports each community's research efforts.

Clinical Trials Registry Gains Finance Chairman's Support

A Senate bill that would establish a database of the results of all publicly and privately funded clinical trials is being reintroduced with the support of Finance Committee Chairman Charles Grassley (R-Iowa).

The "Fair Access to Clinical Trials Act" was introduced by Sens. Grassley and Chris Dodd (D-Conn.) Feb. 28. It is similar to the FACT Act introduced by Dodd in October.

One change to the bill is a provision requiring FDA to "make internal drug approval and safety reviews publicly available," Grassley said in a statement on the Senate floor.

The bill would maintain the National Library of Medicine's ClinicalTrials.gov website as a registry of ongoing trials for serious or life-threatening diseases, but would also establish a database of all clinical trials for drugs, biologics and medical devices.

Trials would have to be registered in the database to obtain approval from a U.S. institutional review board. Foreign trials submitted to FDA or used in advertising would also have to be registered in the database.

The bill also follows standards and recommendations made by outside organizations.

The bill mandates that the results of trials be made publicly available, which "satisfies the recommendation of the American Medical Association," Grassley said.

Civil monetary penalties for trial sponsors that fail to comply are retained in the new version of the bill.

Grassley said he intends to introduce legislation establishing an independent office of drug safety within FDA in March.

Senate Leader Willing to Deal on Malpractice Reform

Senate Majority Leader Bill Frist (R-TN) has reached out to Senate Democrats in order to find a compromise on medical malpractice reform. Frist announced that he is willing to consider changes that go beyond just caps on malpractice awards. Senate Democrats have resisted malpractice reform legislation that included caps on awards. The Senate Republican has stated that he is open to other changes, including modifying "joint and several liability" in lawsuits, placing "reasonable limits" on attorneys' fees, and overhauling insurance laws. The House has repeatedly passed medical malpractice legislation, but it has failed on numerous occasions in the Senate.

AHRQ Finds Preventing Diabetes Complications Could Save $2.5 Billion Yearly

A recently released report from the Agency for Healthcare Research and Quality (AHRQ) estimates that the nation could save nearly $2.5 billion a year by preventing hospitalizations due to severe diabetes complications. The report estimates that reducing hospital admissions for diabetes complications could save the Medicare program $1.3 billion annually and Medicaid $386 million a year. Nearly one-third of patients with diabetes were hospitalized two or more times in 2001 for diabetes or related conditions, and their costs averaged three times higher than those for patients with single hospital stays—$23,100 versus $8,500. Furthermore, the risk of hospitalization for cardiovascular disease was two to four times higher in women with diabetes than in those who did not have diabetes. African-American, other minority, and poor patients regardless of race or ethnicity were more likely to be hospitalized multiple times for diabetes complications than non-Hispanic white and higher income patients.

The report suggests that hospitalizations for diabetes complications are generally considered preventable with high-quality health care and patient adherence to treatment. Clinical studies suggest that prevention activities, quality outpatient care, and greater patient self-management of diabetes may prevent or reduce the prevalence of cardiovascular disease, lower extremity amputations, and multiple hospitalizations associated with diabetes. In addition, the report highlights that patient self-management—taking medications appropriately, controlling blood sugar levels, and managing diet with regular exercise—is an important component of diabetes care.

The Agency also offers pulic policy recommendations that focus to minimize diabetes complications, recurrent hospitalizations, and their costs. The recommendations include offering interventions for cardiovascular disease to patients with diabetes; carefully monitoring people with diabetes who have a prior admission for diabetes to prevent repeat hospitalizations; consider enhancing interventions for more vulnerable populations with

diabetes, particularly racial/ethnic minorities, patients with public insurance coverage, and patients living in low-income areas. To access a copy of the complete report online, go to www.ahrq.gov/data/hcup/highlight1/high1.htm

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