High-Volume Hospitals Yield Better Survival

Medicare data show link in patients with myocardial infarction, heart failure, pneumonia.

BY DENISE NAPOLI

Hospitals with high volumes of patients who have myocardial infarction, heart failure, and pneumonia have lower 30-day mortality rates for each of those conditions, compared with hospitals that treat fewer such patients.

The relationship between hospital volume and mortality diminished among high-volume hospitals, and was no longer significant once the number of patients exceeded a threshold for each condition, according to a cross-sectional analysis of Medicare claims from more than 4,000 hospitals.

The study is the first to examine the relationship between hospital volume and death from heart failure.

It is one of the few studies that examines the link between volume and mortality in myocardial infarction and pneumonia, wrote Dr. Joseph S. Ross of the Mount Sinai School of Medicine, New York, and his associates (N. Engl. J. Med. 2010;362:1110-8).

The researchers analyzed data on fee-for-service Medicare patients aged 65 or older who were hospitalized between Jan. 1, 2004, and Dec. 31, 2006, with myocardial infarction, heart failure, or pneumonia. The mean age for all patients was 80 years. To avoid survival bias, for each patient who had multiple admissions for one of the three conditions in a given year, one admission per year was selected at random for inclusion in the analysis. Transfers between facilities were tallied with the index hospital.

The findings could pave the way for policy makers to 'attempt to increase volume at only the smallest-volume hospitals, perhaps by ensuring that small hospitals are not located in proximity to one another.'

To categorize hospital volume as low, medium, or high, the investigators stratified into quartiles the mean annual number of patients hospitalized for each condition during the 3-year study period.

Hospitals in the first and second quartiles were categorized as low volume, those in the third quartile as medium, and those in the fourth quartile as high.

"A substantial proportion of hospitals in the first quartile of volume were subsequently excluded for having 10 or fewer cases with each condition," the authors wrote.

For MI, 734,972 patients were included in the analysis. About 10% of hospitals were classified as low volume for MI (17 mean annual patients), 22% as medium volume (70 patients), and 68% as high volume (236 patients). For the 1,324,287 heart failure patients, 13% of hospitals were classified as low volume (42 mean annual patients), 24% as medium volume (157 patients), and 62% as high volume (422 patients). And for the 1,418,252 pneumonia patients, 18% of hospitals were classified as low volume (59 mean annual patients), 26% as medium volume (179 patients), and 56% as high volume (405 patients).

When mortality was compared for low-, medium-, and high-volume hospitals, a jump from a lower category to the next-higher category carried a risk-adjusted odds ratio for 30-day mortality of 0.89 for MI, 0.91 for heart failure, and 0.95 for pneumonia. All three odds ratios were statistically significant.

For each condition, there was a volume threshold above which an increase of 100 patients in the annual volume was not significantly associated with lower 30-day mortality. The threshold was 610 patients for MI, 500 patients for heart failure, and 210 patients for pneumonia, Dr. Ross and his associates reported.

The findings could pave the way for policy makers to "attempt to increase volume at only the smallest-volume hospitals, perhaps by ensuring that small hospitals are not located in proximity to one another" through the use of certificate-of-need regulations or critical-access hospital programs, the authors said.

The study was partly supported by the Centers for Medicare and Medicaid Services and the National Institute on Aging. Several investigators reported financial or other relationships with pharmaceutical firms and insurance companies. ■

Medicaid Expansion Underway, Mandates Start in 2014

BY MARY ELLEN SCHNEIDER

One of the cornerstones of the health care reform law is a massive expansion of the Medicaid program.

Starting in 2014, all states will be required to expand eligibility of their Medicaid programs to all adults at or below 133% of poverty, regardless of whether they have children or are disabled. And states can now choose to open up programs to these new enrollees early.

This is the first time in the history of the Medicaid program that states can receive federal funds for providing coverage for adults based solely on income levels.

In April, officials at the Centers for Medicare and Medicaid Services released the first details on how the new eligibility requirements will work.

States that choose to begin enrolling these newly eligible adults before 2014 will receive federal matching payments at the regular Federal Medical Assistance Percentage (FMAP) rate.

In 2014, states will be required to expand eligibility of their Medicaid programs to all adults at or below 133% of poverty, regardless of whether they have children or are disabled.

Starting in 2014, they will receive an increased matching rate for certain people in the new eligibility group, according to the CMS. The agency plans to issue separate guidance on this issue later.

The immediate impact on states will probably vary based on whether they are already covering some of the newly eligible adults with their own funds. In those states, the new federal money will mean an immediate savings.

States that do not already offer expanded coverage will be spending new money to pick up their share of covering new beneficiaries.

Another question is how the expansion of the Medicaid program will impact access to care.

In many states, Medicaid pays physicians at rates well below Medicare levels, and some estimates suggest that, around the country, only about half of primary care physicians even accept new Medicaid patients.

Under the Health Care and Education Reconciliation Act passed as part of health reform, Congress raised Medicaid payments up to Medicare levels for primary care providers starting in 2013 and 2014.

A survey of 944 primary care physicians conducted by United Health Group found that 67% think that new Medicaid patients will struggle to find a suitable primary care physician if the Medicaid expansion is not accompanied by other reforms, such as payment increases. If payment is increased to at least Medicare levels, about half of physicians (49%) said they would be willing to take on new Medicaid patients.

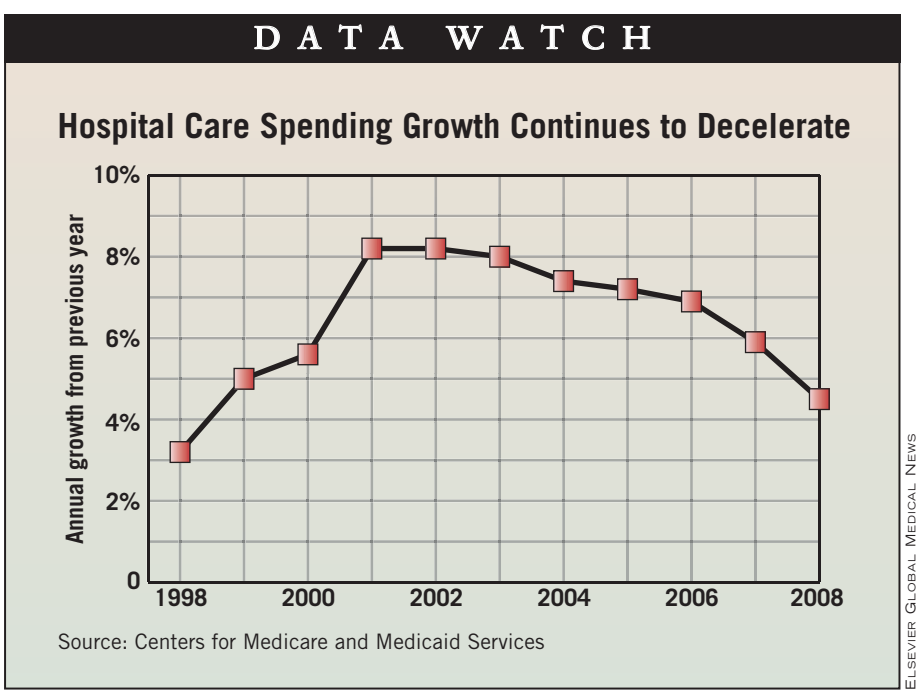
"Having a Medicaid insurance card is not the same as having a primary care doctor that will treat you," Simon Stevens, executive vice president of UnitedHealth Group and chairman of the UnitedHealth Center for Health Reform and Modernization, said during a news conference to discuss Medicaid expansion.

"Unfortunately, that disconnect between Medicaid benefits and health care access has in some places been growing in recent years," he added.

UnitedHealth Group estimates that the cost to permanently boost Medicaid payments to physicians would be about $63 billion from 2013 to 2019, with about $50 billion of that cost currently not funded by the health care reform law.

What needs to be avoided, Mr. Stevens said, is a new Medicaid "doc fix problem" in which the federal government or the states temporarily make adjustments to Medicaid physician payments after 2014 in the same way they have been heading off payment cuts in Medicare in recent years. ■

DATA WATCH



Source: Centers for Medicare and Medicaid Services

Elsevier Global Medical News