Fees for Cognitive Services a Snag

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Kolba, who is in private practice in Santa Maria, Calif.

How will a system of global fees for outpatient services fairly compensate for cognitive services? she asked. Rheumatology, endocrinology, and infectious diseases are all highly cognitive medical subspecialties facing this problem.

Speaking before the Health Subcommittee of the House Ways and Means Committee, Medicare Payment Advisory Commission (MedPAC) Chairman Glenn Hackbarth testified, "For a long time, I've been able to sit before this subcommittee and say that SGR is a problem, but we don't see an imminent threat to access. But we think we're getting closer to that tipping point" when that is no longer the case.

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In 2009, fee-for-service Medicare spent about $64 billion on physician and other health professional services, accounting for 13% of total Medicare spending, according to the 2011 MedPAC report, which noted that "among the 1 million clinicians in Medicare's registry, about half are physicians who actively bill Medicare."

In addressing the SGR, the report notes that "a main flaw of the SGR is its blunt approach.

"In setting across-the-board updates to Medicare's physician fee schedule, the system neither rewards individual providers who restrain unnecessary volume growth nor penalizes those who contribute most to volume increases. Also, the SGR does little to counter the volume incentives that are inherent in [fee-for-service] payments. In fact, volume growth is one of the major factors that has caused cumulative spending to exceed the SGR's cumulative target," according to the report.

This is encouraging news for rheumatologists, according to Dr. Kolba. "Rheumatologists have been taught to think. Our interventions prevent suffering in patients with rheumatic disease and save money because we do things right the first time. The other savings to society may be delayed by decades, but they are savings nonetheless."

The question remains how will any fee system compensate physicians fairly for cognitive services?

DR. KOLBA

In the absence of congressional action, the SGR requires physician payments to be cut by approximately 30% in 2012, according to MedPAC calculations.

Every year since 2002, Medicare spending has exceeded SGR targets, causing physician pay, by law, to be reduced. However, pretty much every year, and more recently, two or three times a year, Congress has stepped in to legislate a way to avoid those cuts. Cumulatively, the avoided cuts are becoming an ever-growing debt being carried on the federal ledger.

The White House, in its fiscal 2012 budget proposal, is proposing to reduce that debt over the next 10 years, at a cost of $370 billion. But the administration has figured out only how to pay for that fix for the first 2 years.

Mr. Hackbarth told the subcommittee that MedPAC will look into options for a new payment system but added that any new payment system will have a budget score attached to it. The question for Congress is "whether we're going to spend more by making last-minute adjustments piling more money into the existing payment system, or whether we're going to spend more strategically to achieve important goals for the Medicare program. We think the latter course is the wiser course," he said.

He added that the commission's goal is to develop a package with a budget cost, which will also achieve certain goals for Medicare reform; such a plan could be ready later this year.

MedPAC is charged with advising Congress on setting payment rates for physicians, hospitals, and other health care providers. Its recommendations are included in twice-yearly reports issued in March and June. ■

IMPLEMENTING HEALTH REFORM

Community-Based Care Transitions Program

Reducing preventable hospital readmissions is one goal of last year's health reform effort. The Affordable Care Act tests ways to bring readmissions down, including a new Medicare pilot project called the Community-Based Care Transitions Program. The 5-year pilot, which began earlier this year, offers funding to hospitals and community-based organizations that partner to provide transition care services to Medicare patients who are at high risk for readmission. Medicare officials have said that they expect hospitals will work with their community partners to begin transition services within 24 hours prior to discharge, provide culturally and linguistically appropriate post-discharge education, provide medication review and management, and offer self-management support for patients. Congress has provided $500 million to fund the program over 5 years.

Dr. Janet M. Nagamine, a hospitalist in Santa Clara, Calif., and a patient safety expert, explained the challenges associated with reducing hospital readmissions.

Rheumatology News: What are the challenges in reducing hospital readmissions?

Dr. Nagamine: We have to keep in mind that the length of stay has decreased dramatically while the acuity has increased dramatically. We need to recognize and separate those readmissions that are preventable versus those that are not. If you look back over the last 30 years, our length of stay is less than half of what it used to be. That means that for patients older than 65 years, they used to be in the hospital an average of 12.6 days. Now they are in the hospital for about 5.5 days. The challenge is to figure out why some patients come back. I believe that there are some things we can't affect that much. For example, many elderly patients with end-stage chronic conditions are likely to be readmitted. But there is also evidence that only about half of the patients who leave the hospital have followed up with their primary care physician within 30 days of discharge. That speaks to an opportunity that we can address. Too often people get fixated on readmission numbers, but you've got to look at the context, make sure you're focusing on preventable readmissions, and apply specific targeted interventions.

Money can be saved by changing the hospital discharge process and reducing readmissions.

DR. NAGAMINE

We also need to look at reengineering the discharge process. Even though length of stay has been reduced, we haven't really changed the way that we discharge patients. We walk in and we write an order in the morning that says discharge home and then there's a flurry of activity. We're now starting to do things in a more stepwise fashion, planning for discharge from the day patients come in. Reengineering the discharge process will involve everyone in the hospital as well as across the continuum of care.

RN: Is there a danger in focusing on readmissions? What factors need to be considered to ensure that hospitals that treat the sickest patients aren't labeled as ineffective?

Dr. Nagamine: That's where risk adjustment is really important. You've got to compare apples to apples. Some tertiary care centers see a lot of complex, sick patients, a very different population from that seen at the typical community hospital.

RN: Congress has appropriated $500 million to fund this program over 5 years. Is that enough?

Dr. Nagamine: I am not a health economist, but I think of this program as providing seed money to get things rolling. I doubt it would be enough to accomplish everything, but it would be seed money to start moving in that direction.

RN: The Affordable Care Act also tests bundled payments and withholding payment to hospitals that fail to reduce readmissions. What do you see as the best way to change payment policy to encourage a reduction in readmissions?

Dr. Nagamine: Payers need to create an incentive for the right behaviors. For example, in the process of reducing readmissions, physicians spend a lot more of their time in care coordination and education. Those things aren't compensated, thus those things really aren't happening as well or as frequently they should be.

RN: Hospitals can't reduce readmissions on their own. What do you see as the ideal partnership between hospital-based physicians and community-based primary care physicians? How far away are we from that ideal collaboration?

Dr. Nagamine: I think we're a lot further away from that ideal than we'd like to be. We need to create better linkages. Depending on the work setting, there are many challenges and barriers to getting in touch with primary care physicians. In large metropolitan areas with many hospitals, simply finding and connecting with the right physician can be a real barrier. The second barrier is making the follow-up appointments. You want to make sure that your patient is seen in a timely fashion and that the primary care physician has the discharge summary with pertinent details of the hospital stay as well as specific follow-up that is needed. Believe it or not, those things, which in the age of cell phones and all this technology should be easy, aren't. There are folks looking into electronic transfer of information and that's helping. But right now, we have a hodgepodge of different systems in various hospitals and medical clinics. Until we can get consistent transfer of information, we won't be doing as well as we should. Sometimes the primary care physicians don't even know their patient was admitted to the hospital when they see them in their office for a post-hospital visit. That's unacceptable. ■