Policy & Practice

Trading Choice for Savings

More patients are willing to limit their choice of physicians and hospitals to save on out-of-pocket medical costs, the Center for Studying Health System Change (HSC) reported.

Between 2001 and 2003, the proportion of working-age Americans with employer health coverage willing to make this trade-off increased from 55% to 59%—after the rate had been stable since 1997, the study found. Low-income consumers were the most willing to give up provider choice in return for lower cost.

In addition, the proportion of chronically ill working-age adults with employer coverage who are willing to trade choice for lower costs rose from 51% in 2001 to 56% in 2003.

The study's findings were based on HSC's Community Tracking Household Survey. In 2003, the survey included 20,500 adults aged 18-64 with employer-sponsored health coverage; in 2001 it included 28,000 working-age adults with employer coverage.

Physicians Prefer Paper

When it comes to recording patient health information, most doctors and hospitals still prefer paper to the computer, the Centers for Disease Control and Prevention reported.

Ambulatory medical care surveys conducted from 2001 to 2003 revealed that only 17% of physicians' offices had electronic medical records to support patient care. Less than a third of hospital facilities (31% of hospital emergency departments and 29% of outpatient departments) had electronic records.

Physicians under age 50 years were twice as likely as those over that age to use computerized physician order entry systems, the CDC reported.

Part B Costs Expected to Rise

Payments for Medicare Part B services—coverage for physician visits and outpatient services—are expected to grow at an annual average rate of about 6.9% over the next 10 years, the program's trustees announced in their annual report.

More use of services such as office visits and lab and diagnostic tests account for the accelerated growth in Part B costs—and needs further detailed examination, said Mark McClellan, M.D., administrator of the Center for Medicare and Medicaid Services.

Medicare's hospital fund in the meantime isn't expected to dry out until 2020, 1 year later than estimated in last year's report. "However, if you look at historical projections, President Bush has presided over an unprecedented drop in solvency," countered Rep. Pete Stark (D-Calif.), ranking Democrat on the House Ways and Means health subcommittee, in a statement.

Smoking Cessation Counseling

It's official: Medicare is adding coverage for smoking and tobacco cessation counseling for certain beneficiaries who want to kick the habit. The coverage decision applies to Medicare patients whose illness is caused or complicated by smoking, such as heart disease, cerebrovascular disease, lung disease, or osteoporosis—diseases that account for the bulk of Medicare spending.

It also applies to beneficiaries whose medications are compromised by tobacco use. "It is our hope that Medicare's decision to pay for smoking cessation counseling will encourage and help seniors quit smoking once and for all," Ronald Davis, M.D., trustee with the American Medical Association, said in a statement.

Of the 440,000 Americans who die annually from smoking-related disease, 300,000 are aged 65 and older, according to the Centers for Disease Control and Prevention. The CDC in 2002 estimated that 57% of smokers aged 65 and older reported a desire to quit smoking.

Risk Minimization Guidances

The Food and Drug administration has released three guidance documents to help industry improve its methods of assessing and monitoring the risks associated with drugs and biologic products in clinical development and general use. One document addresses risk minimization action plans (RiskMAPs) that industry could use to address specific risk-related goals and objectives. How the new guidance protocols would specifically address a drug with red safety flags such as Vioxx (rofecoxib) "is hard to speculate," Paul J. Seligman, M.D., director of the Office of Pharmacoepidemiology and Statistical Science with the FDA's Center for Drug Evaluation and Research, said at a press conference. "It would be difficult for us to come up with a drug that would allow us to walk through the guidances," as all drugs need to be evaluated on a case-by-case basis, Dr. Seligman said.

Report on Health Care Disparities

Disparities related to race, ethnicity, and socioeconomic status continue to plague the health care system, according to the 2004 National Healthcare Disparities Report from the Agency for Healthcare Research and Quality.

Using comparable data from 2000 and 2001, researchers analyzed 38 measures of effectiveness for health care and 31 measures of access to care. Of the measures tracked for these two consecutive years, AHRQ found that blacks received poorer quality of care than whites for about two-thirds of the quality measures and had worse access to care than whites for about 40% of access measures.

Hispanics, Asians, American Indians, and Alaska natives also scored lower than whites on quality measures and access to care. Poor people received lower quality of care for about 60% of quality measures and had worse access to care for about 80% of access measures, than those with high incomes.

—Jennifer Silverman

Hospital Midwives Seek the Right to Certify False Labor

BY JENNIFER SILVERMAN
Associate Editor, Practice Trends

WASHINGTON — Federal regulations should recognize the expertise of nurse-midwives in certifying false-labor cases in the hospital, Deanne Williams, a certified nurse-midwife, testified at a meeting of the Department of Health and Human Services technical advisory group on the Emergency Medical Treatment and Labor Act.

Under EMTALA, "only a physician is recognized to certify that a woman who presents to a hospital for evaluation is actually experiencing false labor," said Ms. Williams, executive director of the American College of Nurse-Midwives (ACNM). In the college's view, the regulation fails to acknowledge the scope of practice under which certified nurse-midwives and certified midwives are authorized to treat patients, she said.

"Midwives have a very long history of working collaboratively with physicians to provide women's health care, with a particular focus on care during the maternity cycle," Ms. Williams said, adding that midwives attend more than 10% of the vaginal births in the United States, and 98% of the births attended by midwives occur in hospitals.

EMTALA's requirement for physician certification "places unnecessary costs on the hospital, which is required to take physicians away from other matters to certify that the woman is in false labor, when a certified nurse-midwife or certified midwife is also licensed to make that decision," Ms. Williams testified.

While EMTALA regulations require a signed certification that a woman is experiencing false labor and may be discharged, "there is no requirement in the regulations that a physician must personally examine the patient," noted one advisory group member, Charlotte Yeh, M.D., an emergency physician and the CMS regional administrator for Region I in Boston.

The law's interpretive guidelines explain further that a physician must be contacted by the qualified medical professional—i.e., nurse-midwife—to ensure that the woman with contractions has false labor. The guidelines leave it up to the individual hospitals to determine whether physicians should personally examine the patient, she said.

The issue before the technical advisory group is whether the latitude provided by EMTALA's interpretive guidelines is sufficient to protect patients, yet recognizes the value that nurse-midwives bring to labor and delivery, Dr. Yeh told this newspaper. "Or, the [technical advisory group] could say that the regulations are too prescriptive, and that certification should be removed altogether, letting individual hospitals decide who's qualified to determine emergency medical conditions" in patients.

It's clear that ACNM's request "would necessitate a change," David Siegel, M.D., an emergency and internal medicine physician in Tampa, Fla., and the panel's chairman, indicated. Dr. Siegel asked that the panel seek formal input from the American College of Obstetricians and Gynecologists and other appropriate medical specialty organizations on their policies regarding this issue.

Warren Jones, M.D., Medicaid director for the state of Mississippi and a past president of the American Academy of Family Physicians, emphasized that the panel should seek input from the AAFP on this issue. "There needs to be a recognition that ob.gyns. are not the only physicians who deliver babies and provide maternity care. Family physicians do a lot of that. Many of them work with nurse-midwives, and many of them provide it in rural areas where it's really needed," he told this newspaper.

The advisory committee also will need to consider that in some states, nurse-midwives are already recognized as qualified to determine false labor, Dr. Yeh said. What the nurse-midwives want is for those qualifications to be recognized by CMS, she said.

Robert Bitterman, M.D., a representative of the American College of Emergency Physicians, and a participant at the meeting, noted that the regulations might not have to be changed at all.

"If you hearken back to the actual statute, the word 'labor' does not appear anywhere in the definition of an emergency medical physician in EMTALA. Therefore, whether someone is in actual labor or in false labor is entirely irrelevant," he stated.

EMTALA is meant to be a limited law, Dr. Bitterman continued. "It asks: Is this pregnant woman having contractions, and if so, is it safe to go home, and if doing so would pose a hardship to the baby or the mother." Therefore, it's perfectly appropriate under EMTALA for nurses, physicians, family physicians, or pathologists to perform the screening exam if they're the ones designated by the hospital to make those types of decisions, he said.

"It's a myth to think that physicians and hospitals don't send home patients if they have active labor. We do it every day because it's an early active labor, and because it's safe to do so—and it meets the elements of the statute," Dr. Bitterman said.

Dr. Yeh clarified that the word "labor" did in fact appear in the EMTALA statute under the definition of a transfer, and that a false-labor discharge qualified as a transfer.

EMTALA was enacted in 1986 to ensure public access to emergency services regardless of ability to pay. The Medicare Modernization Act of 2003 required that the department of Health and Human Services establish a technical advisory group to review EMTALA regulations. It is required by law to meet at least twice a year.

The group will advise HHS and the administrator of the Centers for Medicare and Medicaid Services on issues related to EMTALA. It is composed of representatives of hospital, physician, and patient groups, plus CMS staff and state government officials. ■

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