Home Care Physicians Promise 5% in Savings

BY JOEL B. FINKELSTEIN
Contributing Writer

WASHINGTON — A group of roving physicians wants to offer Medicare a money-back guarantee the program can't refuse.

Members of the American Academy of Home Care Physicians, a 10-year-old specialty society with a little less than a thousand members, met recently to discuss legislation being considered by Congress that would pay them a negotiated fee to direct a team of nurses and other professionals to care for patients with multiple chronic conditions in their homes.

The catch: If the physicians don't save Medicare at least 5%, then they will have to pay the government back some or all of their fee to make up the difference.

"If you make a bad bet, you risk 5% of the dollar. If you're taking patients who cost $50,000 a year on average, you're risking about [$2,500] a year," said Dr. Kevin Jackson, a house-call physician in Phoenix, Ariz., and a member of AAHCP's board.

But taking that risk can also pay off. After Medicare gets its 5%, the physician gets to keep 80% of whatever money they save on these patients. There was ample evidence presented at the meeting to suggest that the savings are out there for physicians who effectively manage these patients, keeping them out of the hospital or nursing home where medical support becomes much more expensive.

Dr. Steven L. Philips, president and chief executive officer of Geriatric Care of Nevada in Reno, reported that physicians in that state have been experimenting with this model for the past 10 years, culminating in a project last year that yielded savings of nearly 13% or $1.4 million per 1,000 patients.

In Philadelphia, comprehensive management of medically complex, homebound patients enrolled in a house-call program lead to an average savings of $33,000 per Medicare patient, according to Dr. Bruce Kinosian, of the city's Hospital of the University of Pennsylvania. And in Ohio, a similar program, within a couple years of being launched now saves more than $600,000 annually because of shorter hospital stays and reductions in inappropriate and redundant services through better coordination of care, said Brent T. Feorene, president of House Call Solutions in Westlake, Ohio.

In addition, in the middle of the nation's capital, a team of physicians, nurses, social workers, and office staff have been providing home-based care to more than 600 patients with a budget of $1.6 million generated through a combination of fee-for-services charges, philanthropy, and operational support from the local hospital.

"We get no formal credit for downstream revenue, and we actually were able to measure it. It was about $10 million in net revenue to the hospital, which is probably a million in pure profit—that was 2006. But that doesn't go toward our budget," said Dr. Eric De Jonge, director of geriatrics at the Washington Hospital Center.

However, under the Independence at Home (IAH) model physicians would get credit and some of the cash from those savings.

"This payment system is going to happen. It may be IAH; it may not be exactly IAH, but it's going to happen. Because, as we have all heard, Medicare literally is going to go broke. So unless they change the payment system, they're not going to have the money to take care of people and that politically is not tenable," Dr. De Jonge said.

Supporters of the proposal hope to attach it to a bill that lawmakers will have to pass this year. Given that the doctors are promising to cost less than what Medicare is already paying for these patients, it seems like a good bet that it may make it into law.

"There is a huge amount of excess in Medicare, wasted, harmful care. [Those data are] driving what [the Congressional Budget Office] and Congress is doing right now [on Medicare reform]. And it's driving them right toward IAH," Dr. De Jonge said.

Under the current legislative language, an Independence at Home demonstration project would be restricted to a very specific patient population, those with two or more chronic conditions including heart failure, diabetes, COPD, ischemic heart disease, peripheral arterial disease, stroke, Alzheimer's disease and other dementias, pressure ulcers, and hypertension. They also need to have been in the hospital, emergency department, or other intensive facility within the past 12 months and need help to perform two or more daily activities.

"We wanted to make sure that we got the costliest, sickest patients we possibly could. Why? Because the higher-cost these patients are, the easier it is to show savings," James Pyles, Esq., a partner at Powers, Pyles, Sutter and Verville, a Washington-based law firm that specializes in the health care and educational industries, told the small gathering of physicians.

Most of the savings are expected to come from keeping these chronically ill patients out of the emergency room and the hospital. Better management of their multiple conditions means that they are less likely to become acutely ill or if they do, a home-care physician can often provide urgent care services in the home. Also, by having more medical support in the home, patients can often be released from the hospital a day or two earlier than they otherwise would be.

"We are taking a system that discriminates against the costliest patients, managed care doesn't want them, most physicians don't want them, nobody wants these people because they're train wrecks. We take those people and we make them the most desirable people in the system," said Mr. Pyles, who also serves on the AAHCP board of directors. ■

POLICY & PRACTICE

FDA Hiring Experts

The Food and Drug Administration has begun a multiyear hiring initiative and plans to fill more than 1,300 positions within the next several months—nearly triple the number hired from 2005 to 2007, the FDA said. The agency said it is hiring hundreds of individuals with science and medical backgrounds, including biologists, chemists, medical officers, mathematical statisticians, and investigators, in part to implement the FDA's Food Protection Plan and the Import Safety Action Plan. Because of the critical need for scientific personnel, the federal Office of Personnel Management has granted authority to the FDA to expedite hiring of qualified candidates by eliminating certain rating and ranking preferences, making it possible for qualified candidates to start work in as little as 3 weeks.

RUC Recommendations Submitted

The American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) has submitted recommendations on the new Medicare medical home demonstration project to the Centers for Medicare and Medicaid Services. The RUC recommendations are specific to the development of the reporting mechanism and underlying data that CMS will use to determine payments in the medical home demonstration project. These data include physician work relative value and practice expense input recommendations, such as electronic medical record costs and nurse care coordination. The 3-year medical home demonstration project, mandated by Congress in 2006, will begin on Jan. 1, 2009.

Report: Food Safety in Crisis

Approximately 76 million people in the United States—one in four—are sickened by foodborne illnesses each year, and of these, an estimated 325,000 are hospitalized and 5,000 die, according to a report from the advocacy group Trust for America's Health. Medical costs and lost productivity resulting from foodborne illnesses in the United States are estimated to cost $44 billion annually, according to the report. The report blamed obsolete laws, misallocation of resources, and inconsistencies among major food safety agencies for leaving Americans vulnerable to foodborne illnesses. "We will not be able to adequately protect people from contaminated foods if we continue to use 100-year-old practices," said Dr. Jeff Levi, executive director of the group. "We need to bring food safety into the 21st century. We have the technology. We are way past due for a smart and strategic upgrade." The report noted that inadequate resources are spent on fighting modern bacteria threats. It also said that federal food safety efforts are fragmented and that no single agency has the ultimate authority or responsibility for food safety.

GAO: Prioritize Infection Control

The federal government is not doing enough to prevent hospital-acquired infections, and the Department of Health and Human Services needs to identify priorities and establish greater consistency in reporting rates, the U.S. Government Accountability Office found in a report. The report, titled "Health-Care–Associated Infections in Hospitals," notes that the Centers for Disease Control and Prevention has 13 guidelines for hospitals on infection control and prevention, but HHS has not prioritized these practices. In addition, although the CDC's guidelines describe specific clinical practices recommended to reduce infections, the infection control standards that the CMS and the accrediting organizations require of hospitals describe the fundamental components of a hospital's infection control program. The GAO concluded that the lack of department-level prioritization of CDC's large number of recommended practices has hindered efforts to promote their implementation.

Insurance Costs Rise Fast

Americans who get health insurance for their families through their jobs have seen their premiums increase 10 times faster than their incomes in recent years, according to an analysis of government data. The study, which was supported by the Robert Wood Johnson Foundation and conducted by researchers at the University of Minnesota, showed that the proportion of insurance premiums that workers pay for family coverage has remained constant over the years, but the dollar amount that workers contribute has increased substantially. The amount that workers pay for family coverage nationwide increased by 30% (from $8,281 in 2001 to $10,728 in 2005), whereas employee income rose by only 3% during the same time period. Meanwhile, the average cost employers pay for their share of family coverage increased by 28% (from $6,360 to $8,143) during the same time period.

Part D Helps Adherence

The Medicare Part D drug benefit has made it less likely that elderly beneficiaries will forego basic needs such as food or housing in order to pay for medications, a study published in JAMA found. In addition, the study found a small but significant decrease in cost-related medication nonadherence (that is, beneficiaries who fail to adhere to their medication regimens because of cost) among patients with good to excellent health. However, there was no net decrease in cost-related medication nonadherence among the sickest beneficiaries, the study found. Overall, 14% of beneficiaries reported skipping medication doses in 2005, but that figure dropped to less than 12% in 2006 after Part D was introduced.

—Jane Anderson