Medicare Rule Focuses on Outpatient Imaging, Quality

BY ALICIA AULT
Associate Editor, Practice Trends

Medicare is making good on a promise to reduce what it sees as runaway costs for certain imaging services in its final rule on hospital outpatient payments for 2009.

The Centers for Medicare and Medicaid Services (CMS) also said that it will continue to hold outpatient departments accountable for quality of care by reducing payment when there has been a failure to meet reporting requirements.

The rule also covers ambulatory surgery centers (ASCs), and contains a separate set of requirements for those facilities.

In July, the CMS had proposed to increase outpatient pay by 3% in 2009; that has been increased to 3.6% in the final rule. Hospitals (and other entities that receive payments under the outpatient system) that do not report on the 11 quality measures required for 2009 will see their payments reduced by 2% in 2010, for an update of 1.6%.

Quality is a big centerpiece of the new rule. The CMS put hospital outpatient departments on notice that, in the near future, it expects to propose the withholding of payment for care related to illnesses or injuries acquired during the outpatient encounter. Hospitals are already being held accountable for acquired conditions on the inpatient side.

The final rule, published in the Nov. 18 Federal Register, applies to 4,000 outpatient departments, according to the CMS. The agency expects to pay $30 billion in 2009 for outpatient services, up from an estimated $28 billion this year.

As proposed earlier in the year, the CMS said that it will now make only a single payment for multiple images made in a single outpatient session.

The agency created five imaging-payment groups: ultrasound; computed tomography and computed tomographic angiography without contrast; CT and CTA with contrast; magnetic resonance imaging and magnetic resonance angiography without contrast; and MRI and MRA with contrast.

Most device-related procedures in cardiology, neurology, and gynecology will receive minimal increases in payment.

The agency also followed through on its proposal to institute four new payment groups for visits to "Type B" emergency departments (defined as those that are not open around the clock). Type B reimbursement will be lower than reimbursement for full-service emergency departments. ■

MedPAC Mulls Bundling for Hospital-SNF Readmissions

BY ALICIA AULT
Associate Editor, Practice Trends

WASHINGTON — The Medicare Payment Advisory Commission recently debated whether to recommend that payments for the hospital and postacute care be bundled together.

The issue arose out of concerns about frequent rehospitalizations and readmissions to skilled nursing facilities (SNF).

Analysis of data from 2004 to 2006 showed that 63% of skilled nursing facility residents were admitted to a hospital then discharged back to an SNF; 31% had two or more SNF-hospital-SNF cycles, MedPAC staff member Carol Carter said at a recent meeting of the commission.

A previous report by the Health and Human Services Department's Office of Inspector General found that patients who had three or more such cycles had a lower quality of care, said Ms. Carter.

The MedPAC analysis also found that patients who had repeat hospitalizations and readmissions to SNFs were more likely to be dual-eligible for Medicare and Medicaid and to be sicker than other patients. Of the readmissions, 51% were dual-eligible, compared with 33% of those who did not have repeat visits. Patients who had four or more hospital-SNF stay cycles during the 2-year period were also more likely to be classified as clinically complex than were nonrepeat patients, said Ms. Carter.

Some 74% of repeat patients were hospitalized for what were classified as "potentially avoidable" conditions, such as heart failure, respiratory infections, and urinary tract infections, she said.

Repeat hospital-SNF visits were much higher for patients in freestanding SNFs and in for-profit SNFs, Ms. Carter said.

She added it was probably not possible to eliminate all hospital readmissions. But she suggested aligning payment incentives between SNFs and hospitals, saying each entity could, under the current system, be rewarded for admissions to their facilities. She said SNFs can often convert patients from lower-paying Medicaid to higher-paying Medicare after a long hospital stay.

Ms. Carter proposed the Centers for Medicare and Medicaid Services start publicly reporting rehospitalization and readmission rates and consider using potentially avoidable rehospitalizations as a pay-for-performance measure.

Finally, she recommended bundling payments for the hospital and SNF, following the same path MedPAC has suggested for hospitals to hold inpatient and outpatient providers accountable for readmissions.

MedPAC meets again this month and in December, in preparation for its March report to Congress. It did not say when it would again take up the issue of rehospitalized SNF patients. ■

POLICY & PRACTICE

Poor Marks for PQRI

Most physicians who participated in Medicare's 2007 Physician Quality Reporting Initiative found the program at least moderately difficult, according to a survey conducted by the American Medical Association. Only 22% of respondents to the online survey were able to successfully download their feedback report. Of those who downloaded the report, less than half found it helpful. In an open-ended question about their experience with the program, nearly all the responses were negatives, according to the AMA. The results are based on responses from 408 physicians. The AMA plans to work with Congress and the administration to alter the program to provide physicians with interim feedback reports and an appeals process. A recent survey from the Medical Group Management Association reported similar problems in accessing feedback reports.

Many Have Drug 'Gap' Coverage

A total of 13% of Medicare beneficiaries enrolled in Part D prescription drug plans and 63% of those in Medicare Advantage plans with prescription benefits had some form of coverage in the "doughnut hole," or coverage gap, according to a Centers for Medicare and Medicaid Services study on Part D drug claims. The study, which included data on Medicare drug claims for the 25 million Part D beneficiaries, also indicated that the vast majority of enrollees used the drug benefit: In the program's first year, 90% of enrollees filled at least one prescription. In addition, the use of generic drugs has been high in Part D, rising from 60% in 2006 to nearly 68% in the first quarter of this year.

Resuscitation Practices Ineffective

An overwhelming majority of emergency physicians believe that resuscitation practices in the United States are not very effective, according to a survey released by the American College of Emergency Physicians. In addition, more than half of emergency physicians surveyed believe that poor survival rates from sudden cardiac arrest are related to the aging population, while one-quarter of respondents said that obesity has contributed most to poor survival rates. Increased bystander CPR, faster patient-to-doctor time, improved data collection and sharing, and greater use of technology all are critical to improving resuscitation, the survey concluded. "It is necessary for communities to encourage more CPR trainings, offer more access to a broader range of critical life-saving technologies, and report sudden cardiac arrest cases more consistently," said ACEP President Nick Jouriles.

HIPAA Enforcement 'Limited'

The Centers for Medicare and Medicaid Services has not provided effective oversight and has taken only "limited actions" to ensure that covered entities adequately implement patient privacy regulations contained in the Health Insurance Portability and Accountability Act of 1996, according to a report from the Health and Human Services Department's Office of Inspector General. The OIG found that the CMS had not conducted any compliance reviews of covered entities, and instead relied on complaints to target investigations. However, the CMS has received very few complaints about violations, the report said. "As a result, the CMS had no effective mechanism to ensure that covered entities were complying with the HIPAA security rule" or that electronic health information was being adequately protected, the report concluded. CMS has taken steps to begin conducting compliance reviews in an effort to identify security problems and vulnerabilities under HIPAA, the OIG said.

Mass. Blues Require e-Prescribing

Blue Cross Blue Shield of Massachusetts said it will require all physicians to prescribe electronically beginning in 2011 in order to qualify for any of the health plan's physician incentive programs. Currently, 99% of primary care physicians and 78% of specialists participate in the insurer's incentive programs, which reward physicians for meeting nationally recognized quality standards and patient safety goals. Currently, e-prescribing is an optional measure in the plan's incentive programs. The insurer said it realized that start-up costs involved with implementing an e-prescribing system continue to be a barrier to adoption for physicians, and said it would provide some financial assistance for doctors in 2009 to offset those start-up costs. A 2006 study by the plan showed that physicians who used an e-prescribing device were able to choose more cost-efficient drugs, and therefore saved 5% on their drug costs relative to physicians who did not use the technology.

Program Cuts Illicit Drug Use

A government-supported program used to screen patients seeking health care for signs of substance abuse can reduce illicit drug use among patients seeking medical care in a wide variety of health care settings, a study found. The Screening, Brief Intervention, and Referral to Treatment program uses a variety of techniques to screen patients for signs of substance abuse. If a patient screens positive, immediate steps are taken to help the patient effectively deal with the problem. The study, published in Drug and Alcohol Dependence, found that rates of illicit drug use dropped by nearly 68% 6 months after patients using illicit drugs had received help through the screening program. Illicit drug users receiving brief treatment or referral to specialty treatment also reported other quality of life improvements. The Substance Abuse and Mental Health Services Administration has been awarding grants to expand the screening program since 2003.

—Jane Anderson