Medicare Increases Stroke Benefit for Hospitals

The new DRG will increase reimbursement to hospitals for acute stroke care by about $6,000.

BY JOYCE FRIEDEN
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Medicare's decision to increase payment for stroke patients who receive tissue plasminogen activator likely will result in more stroke centers, but experts are divided over whether it will mean better care for patients.

"It's a great step forward," said William Barsan, M.D., professor and chair of emergency medicine at the University of Michigan, Ann Arbor. "This has been something in the works for a long time. We identified this as an issue that needed to be addressed soon after TPA was released."

Currently, the Centers for Medicare and Medicaid Services pays hospitals the same amount—about $5,700—under its diagnosis-related group (DRG) payment system for treating a stroke patient, regardless of whether TPA is used. But under a proposed regulation issued in August, CMS would develop a new DRG called "acute ischemic stroke with use of thrombolytic agents."

Although TPA costs about $2,000 per dose, the new DRG would pay hospitals about $6,000 more for these patients. That's because patients who receive TPA generally are sicker overall than other stroke patients, and often require more intensive treatment and longer hospital stays, according to a CMS spokeswoman.

That logic is further explained in the proposed regulation. The regulation's authors wrote that when they reviewed average charges for stroke patients, "we noted that the average standardized charges for all patients in DRG 14 ['Intracranial Hemorrhage or Cerebral Infarction'] were $18,997, but that the subset of 2,085 cases in which TPA was used had average standardized charges of $35,128." As a result, "we are changing the structure of stroke DRGs not to award higher payment for a specific drug, but to recognize the need for better overall care for this group of patients."

In addition to getting TPA to more patients, this change also will save CMS money if it goes through, said Joseph Broderick, M.D., professor and chair of neurology at the University of Cincinnati. "If you can keep patients out of rehabilitation and nursing homes because you improve things on the front end, you save Medicare and the health system money," Dr. Broderick said.

But Jerome Hoffman, M.D., professor of medicine and emergency medicine at the University of California, Los Angeles, is not so sure that giving more stroke patients TPA is a good idea. "There is not good evidence that TPA is beneficial in patients with stroke," he said. "It probably helps a few people and hurts a few people, and the balance is really unclear."

Aside from the issue of which patients should receive TPA, the increased payment will encourage hospitals to put more money into treating stroke patients, according to Dr. Broderick. "A lot of hospitals have not seen a reason why they should put more resources into [treating] strokes when, in essence, these kinds of patients are going to cost them money."

Now that they're being paid more for these patients, "more administrators will say, 'Why don't we have a stroke center? Why don't we have more patients who are treated with TPA?' " he said. "If they are going to get paid almost twice as much money, that's an incentive to see why the system is not working, why someone isn't taking the initiative."

But new financial incentives for hospitals may have little impact on what some experts say is fundamentally a clinical obstacle.

It's not that hospitals don't want to provide patients with proper care, said Dr. Barsan, but it takes a lot of effort to make TPA treatment work efficiently, especially because there is only a 3-hour window for administration once the stroke has occurred.

The 3-hour window is a big issue, Dr. Hoffman concurred. "Many people who are having a stroke wake up with symptoms, so it's hard to tell when they were last normal," he said. "So most people are outside the 3-hour window."

A survey Dr. Barsan and colleagues performed of more than 1,100 emergency physicians found that while 60% of respondents said they were "very likely" or "likely" to use TPA in an ideal setting with an appropriate patient and access to the proper equipment and personnel, another 24% of respondents said they would be unlikely to use the drug, and 16% said they were "uncertain" about the matter (Ann. Emerg. Med. 2005;46:56-60). Of this combined group, nearly two-thirds said they were concerned about a possible brain hemorrhage, another 23% listed lack of benefit from the drug, and 12% said they would not use it for both reasons.

Then there are the practical issues. "Ideally, you would have a 'door-to-needle' time of 60 minutes," Dr. Barsan said. This would require first rapidly identifying the patient when he or she arrives in the emergency department, then doing an exam and determining that the patient did have a stroke, and finally sending the patient for a CT scan to make sure it is not a hemorrhagic stroke, he said.

Even in the best of circumstances, all of this takes a while, Dr. Barsan said. That process can be made even longer if the required specialists are on call but not on site, because it can mean another 30-40 minutes to get them in, he added.

In the end, if the drug is used within strict guidelines, "I don't think it will matter all that much in terms of harm or benefit to patients," Dr. Hoffman added. "But when you put monetary or legal incentives on people to use it, and they use it a lot more because they think they're supposed to, it could be harmful."

Dr. Broderick noted that the proposed regulation was largely the result of the combined efforts of several medical organizations, including the American Academy of Neurology, the American Stroke Association, and the National Association of EMS Physicians. "This is a team effort of a lot of organizations who are very passionate about stroke care," he said. "To CMS's credit, they really listened well and made an informed and well-articulated decision." ■

Limits to Adolescents' Indoor Tanning Access Varies by State

BY MARY ELLEN SCHNEIDER
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If a 14-year-old girl walks into an indoor tanning facility in California, she would need parental consent to get a tan. But in Wisconsin, that same teen would be turned away at the door.

Twenty-one states and some counties restrict minors' access to indoor tanning facilities in some way, according to a recent analysis (Arch. Dermatol. 2005;141:524-5).

But restrictions vary widely, with some areas requiring written parental consent that can be signed outside of the presence of an operator, others requiring parental accompaniment, and still others prohibiting access for individuals under age 14 years.

Six states—Texas, Illinois, Wisconsin, California, North Carolina, and New Hampshire—have minimum age limits for indoor UV tanning. And over the past few years, there has been a growing interest in this area from state-level policy makers.

"The effectiveness of even the most stringent regulations is measurable only as far as enforcement is enacted on a local level," said Jessica Krant, M.D., of the dermatology department at the State University of New York Downstate Medical Center in Brooklyn, N.Y.

Where written parental consent is required, teens may forge their parent's signature, Dr. Krant said. And a new study shows that compliance with age limits and requirements for parental accompaniment vary. For example, in Wisconsin and Illinois, where restrictions have been in place for a number of years, compliance with age limits is about 89% and 74%, respectively. But in Texas, where age restrictions are newer, compliance is about 23% (Arch. Dermatol. 2005;141:959-62).

Uniform federal legislation could be helpful, said Jack Resneck Jr., M.D., president-elect of the California Society of Dermatology and Dermatologic Surgery. Without an overall federal policy, state dermatological societies have to fight this "one state house at a time," he said.

The American Medical Association recently approved a policy that calls for federal legislation to prohibit the use of indoor tanning equipment by individuals under age 18 years. The policy also supports the creation of a U.S. surgeon general's warning on all indoor tanning equipment about the correlation between UV radiation, the use of indoor tanning equipment, and the incidence of skin cancer.

"Children and teens are still growing and undergoing rapid development, so it's particularly critical that we take the necessary steps to help ensure their long-term health and well-being," AMA Trustee Ronald M. Davis, M.D., said in a statement.

Currently, there is no pending federal legislation or regulation that would prohibit access to tanning facilities by minors.

The growing public awareness and physician involvement in this area will eventually lead to proposed legislation at the federal level, Dr. Krant said, but it will be a tough political battle. Any effort would meet resistance from a strong corporate lobby of tanning bed makers and UV bulb producers, she said.

"Time will tell in terms of what we are able to accomplish on the national stage, but with so many national and world medical organizations behind our efforts, I am optimistic," said Dr. Krant.

But action is most likely to continue on the state level, unless members of Congress take an interest in this issue, said James Spencer, M.D., professor of clinical dermatology at the Mount Sinai School of Medicine, New York. "The momentum is there at the state level."

But John Overstreet, executive director of the Indoor Tanning Association, said the problem of teen tanning is overblown. Industry estimates are that less than 5% of indoor tanning customers are under age 18. And it's truly a nonissue for children under age 14, Mr. Overstreet said.

He predicted that the federal government would not act to further restrict the industry since the Food and Drug Administration already requires a warning statement on each device.

In addition to working with policy makers, doctors need to reach out to teens, Dr. Spencer said. The reality is that tanning is very popular among young people; they may know that it's not a good idea but they value looking good for the prom over the risk of skin cancer years down the road, he said.

"I think we have gotten the word out, but they just don't care," said Dr. Spencer, who is a former cochair of the National Council for Skin Cancer Prevention.

One way to make the message stronger is to limit the use of indoor tanning facilities by minors, Dr. Spencer said.

A mix of regulation and education is appropriate, said Daniel Krowchuk, M.D., professor of pediatrics and dermatology at Wake Forest University in Winston-Salem, N.C. Physicians have been trying to educate the public about sun exposure for many years and have been only modestly successful, he said. So Dr. Krowchuk thinks it makes sense to regulate an unhealthy behavior like tanning similar to the way many states have mandated the use of seatbelts. ■