Expanding TPA Benefit May Mean Better Care

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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 (CMS) 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."

CMS changed the stroke DRG to recognize the need for better overall care for these patients, not to award higher payment for a specific drug.

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.

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." ■

POLICY & PRACTICE

Census Bureau Statistics

The Census Bureau reports that 45.8 million Americans were without health insurance in 2004, up from 45 million in 2003. While the increase is statistically small, it means that "an additional 860,000 Americans live without the safety net of health insurance," J. Edward Hill, M.D., president of the American Medical Association, said in a statement. "As the decrease in employment-based health insurance continues, the AMA renews its call for health insurance solutions that put patients in the driver's seat, along with their physicians," Dr. Hill said. Some of these solutions may include refundable tax credits inversely related to income and individually selected and owned health insurance, he said. In other statistics, the number of people with health insurance increased by 2 million to 245.3 million between 2003 and 2004. Those covered by government health insurance rose from 76.8 million in 2003 to 79 million—driven by increases in the percentage and number of people covered by Medicaid.

Split on the Benefit

Patients' optimism of Medicare's new prescription drug benefit has improved over the last few months, although beneficiaries remain split on their support, an August poll conducted by the Kaiser Family Foundation indicated. About one in three seniors (32%) has a favorable impression of the benefit and an equal number (32%) have a negative one. This figure can be compared with April, when only one in five (21%) had a favorable impression of it. Comprehension of the benefit has improved: Overall, 37% of seniors now say they understand the new benefit "very" or "somewhat" well, up from 29% in April. Six in 10 seniors (60%) say they don't understand the benefit well or at all. Slightly more than one in five seniors (22%) say they plan to enroll in the benefit, up from 9% in April. The poll represented 1,205 adults aged 18 and older, including 300 respondents aged 65 years and older, interviewed by telephone by Princeton Survey Research Associates, on behalf of Kaiser.

Driven Into Debt

An estimated 77 million Americans aged 19 years and older—nearly two of five adults—have had difficulty paying medical bills, have accrued medical debt, or both, according to an analysis of the 2003 Commonwealth Fund Biennial Health Insurance Survey. Working-age adults incur significantly higher rates of medical bill and debt problems than adults aged 65 and older, with rates highest among the uninsured. "Even working-age adults who are continually insured have problems paying their medical bills and have medical debt," the analysis stated. Two-thirds of people with a medical bill or debt problem went without needed care because of cost—nearly three times the rate of those without these financial problems.

Walter Reed to Close

Walter Reed Army Medical Center in Washington, which has cared for hundreds of thousands of soldiers and dignitaries for the past 96 years, is slated to close as part of the base realignment and closure process. The medical center was tapped by the Department of Defense to be closed, and that recommendation was recently approved by members of the Defense Base Realignment and Closure Commission. The commission sent its final report to President Bush on Sept. 8. If the President agrees with the recommendations he will send the entire list to Congress for a vote. Congress must accept or reject the list in full, but they cannot amend it. If the closure is approved, most of the staff and services from the army hospital will be combined with services at the National Naval Medical Center in Bethesda, Md., and renamed the Walter Reed National Military Medical Center. Other services will be moved to a Fort Belvoir, Va. Closures and realignments must begin within 2 years of Congressional approval and must be completed within 6 years, according to the Base Realignment and Closure statute.

Obesity Rankings

It pays to live in the mountains and ski: Trust for America's Health reported that Mississippi has the "heaviest" obesity rate in the country, Colorado the least heavy. More than 25% of adults in 10 states are obese, including Mississippi, Alabama, West Virginia, Louisiana, Tennessee, Texas, Michigan, Kentucky, Indiana, and South Carolina. Rates have stayed the same in Oregon. A majority of governors have taken steps to initiate obesity reduction and control programs for state employees. However, most statewide initiatives aimed at the general public are limited to public information campaigns, said Trust for America's Health, a nonprofit organization that focuses on disease prevention.

Impact of Concierge Care

Due to their small numbers, it is unlikely that concierge care practices will contribute to widespread access problems for Medicare beneficiaries, the Government Accountability Office reported. In a recent survey, GAO identified 146 concierge physicians and analyzed responses from 112. According to the survey, most concierge practices are located on the East and West coasts, and nearly all respondents reported practicing primary care medicine. Annual patient membership fees ranged from $60 to $15,000 a year, with about half of respondents reporting fees of $1,500-$1,999.The Department of Health and Human Services has determined that concierge care arrangements are allowed as long as they do not violate any Medicare requirements. Some concierge physicians reported to GAO that they would like more HHS guidance.

—Jennifer Silverman