POLICY & PRACTICE

WANT MORE HEALTH REFORM NEWS? SUBSCRIBE TO OUR PODCAST – SEARCH 'POLICY & PRACTICE' IN THE ITUNES STORE

Ob.Gyns. Begin to E-Prescribe

About a third of ob.gyns. are actively e-prescribing in their practices, according to a new report by the Surescripts e-prescribing network. That puts ob.gyns. in the middle of the electronic pack. Cardiologists are the top e-prescribers, with 49% of using the technology regularly. Close behind are family physicians (47%), internists (45%), gastroenterologists (38%), and pediatricians (36%). About 36% of all office-based physicians were e-prescribing in 2010, and 1 in 10 prescriptions was delivered electronically, up from 1 in 18 in 2008. E-prescribing is being driven primarily by federal legislation, including health care reform, according to Surescripts. Some 326 million prescriptions were routed electronically in 2010, compared with 190 million in 2009, a 72% increase.

Episiotomies Down, C-Sections Up

The use of episiotomies fell 60% between 1997 and 2008, but cesarean sections rose 72%, according to data released by the Agency for Healthcare Research and Quality. The percentage of births by cesarean section rose from 21% in 1997 to 33% a decade later. At the same time, the rate of repeat cesareans nearly doubled, from 8% to 14%. The AHRQ report, which is based on data on inpatient hospital stays in the United States, also found that cesarean sections were more common in privately insured patients than in those without insurance. The report also noted decreases in the use of episiotomies and forceps. The use of forceps in vaginal births dropped by a third, from 14% in 1997 to 10% in 2008. About 29% of vaginal births involved episiotomies in 1997, compared with 12% in 2008, a drop of about 60% in a decade.

State Defunds Planned Parenthood

Indiana Gov. Mitch Daniels (R) has signed legislation withholding state funds from any health care entity other than hospitals or ambulatory surgery centers that provides abortions or operates with an abortion provider. The new law effectively strips state funding from Planned Parenthood clinics in Indiana. The law also bars health plans from providing coverage for abortions except in cases of rape, incest, or the risk of substantial injury to the woman. Any woman seeking an abortion would have to view fetal ultrasound imaging unless she provides a written refusal. Planned Parenthood of Indiana is challenging the law in court.

Report Finds Reform Pro-Women

The growing number of women who lack adequate health care will be aided by provisions in the Affordable Care Act, according to a report from the Commonwealth Fund. After a random national survey of 1,362 men and 1,671 women aged 19-64 years, the group calculated that 27 million women were uninsured in 2010, 42 million women had trouble paying their medical bills during the past decade, and 45 million avoided getting health care because of the cost. One of the main reasons for access problems is that women in their reproductive years face insurance premiums that are 84% higher than those for men the same age, the report asserted. However, uninsured women will gain coverage through provisions of health reform, such as increased Medicaid eligibility, subsidized private insurance in state insurance exchanges, and a ban on insurance underwriting based on health or gender, according to the report.

Headaches Take a Toll

Headaches were the main cause of 3 million emergency department visits and 81,000 hospital stays in the United States, according to an analysis of 2008 data by the Agency for Healthcare Research and Quality. Those figures represented 2.4% of ED visits and 0.2% of hospitalizations, respectively. Migraines made up one-third of the headache emergencies and two-thirds of the hospital stays for headaches. The ED visits increased during the summer months, peaked in September, and were lowest during February and December. Three-fourths of the headache sufferers were women, who also were four times as likely to have migraines as men were.

CME-Funding Dilemma Persists

Although physicians and other medical professionals say they're concerned that commercial funding of continuing medical education might bias the information provided, most are not willing to pay more to offset or eliminate such funding, a study in the Archives of Internal Medicine showed. Researchers surveyed 770 physicians, nurses, nurse practitioners, and physician assistants at CME sessions and found that the vast majority – 88% – said that commercial support of CME introduces bias. However, only 15% would eliminate commercial support from CME activities and only 42% said they were willing to pay more in an effort to cut industry financial involvement. Most CME participants also significantly underestimated the amount of commercial funding for their courses, the authors wrote, adding that "the dilemma remains of how to provide quality CME either with alternate funding or at reduced cost."

–Mary Ellen Schneider

House Could Have SGR Fix(es) Ready by Summer

BY FRANCES CORREA

FROM A HEARING OF THE HOUSE ENERGY AND COMMERCE COMMITTEE'S SUBCOMMITTEE ON HEALTH

WASHINGTON – A plan to finally replace Medicare's much maligned Sustainable Growth Rate payment formula could be unveiled by this summer, federal lawmakers predicted at a committee hearing.

"Here's the bottom line: If we get to December and we're doing an extension, that's a failure on our part," Rep. Michael Burgess (R-Tex.) said at the hearing . "We need a permanent solution that's predictable, updatable, and reasonable for this year – and nothing else will do."

"Whatever virtues the SGR had when it was created 14 years ago, … it's clear that they have vanished," noted Rep. Henry A. Waxman (D-Calif.). He added that in the past 2 years, Congress has had to pass legislation six times, blocking fee cuts of up to 21% or more.

COURTESY AMERICAN MEDICAL ASSOCIATION

"What will work in one part of the country will not work in another," Dr. Cecil B. Wilson (center) asserted.

Approximately 30 medical associations responded to the House subcommittee's request for suggestions and proposals in developing a new system. Speaking Thursday with a five-person panel of experts from medical associations and health policy organizations, House subcommittee members considered alternatives to the current SGR formula, which some participants labeled as anything but sustainable.

While the details of the plans vary, they do show a consensus on several fronts: repealing the SGR, moving away from the traditional fee-for-services payment model, and providing a 4- to 5-year transition period in which providers can experiment with a variety of payment systems.

The expert panel also stressed the importance of avoiding a "one size fits all" solution.

"I think we should also have a realization that what will work in one part of the country will not work in another part of the country, and that's why we have continued to talk about a variety of options," said Dr. Cecil B. Wilson, president of the American Medical Association. "There is a temptation to feel like we ought to figure out one rule … that solves it all."

Dr. Wilson pointed to the provisions in the Affordable Care Act that allow for a variety of models of accountable care organizations, embodying the concept of options in the medical system. In that spirit, Dr. Wilson said that the AMA has formed a physician leadership group to evaluate the effectiveness of alternative payment methods.

"The evidence shows that to achieve the savings that Congress is looking for, and to improve the quality of health care delivered to millions of patients in the country, reform must include investment in primary care," Dr. Roland A. Goertz, president of the American Academy of Family Physicians, noted in written testimony to the committee.

To strengthen primary care's role in Medicare, the AAFP backs payment reforms that would boost primary care reimbursement and support the concept of the patient-centered medical home (PCMH). The AAFP's proposal would create a blended reimbursement system for primary care delivered within a PCMH: fee-for-service payments and pay for performance, plus care management fees for PCMH-related activities that don't involve direct patient care.

To prepare for that new payment system, the AAFP has proposed a 5-year transition period with mandated pay increases for primary care physicians, an increase in the Primary Care Incentive Care payment from 10% to 20%, and a rule that Medicaid payments to primary care physicians will always be at least equal to Medicare payments.

Dr. David Hoyt, executive director of the American College of Surgeons, said the college is analyzing the use of bundled payments for surgery.

Dr. M. Todd Williamson, of the Coalition of State Medical and National Specialty Societies, introduced the option of private contracting, in which patients would be free to apply their benefits to a doctor of their choice, who would be free to opt out on a per-patient basis.

The panelists also asserted their belief that whatever plan chosen should be physician led, with financial support of the government.

"It would be very helpful if physicians could get better financial support in their own payment system to enable them to lead all of those efforts," said Dr. Mark B. McClellan, director of the Engelberg Center for Health care Reform and former administrator of the Centers for Medicare and Medicaid Services. "Right now, with fee-for-service staying the way it is, they're staying behind." He added that physicians can be the best sources for innovative and cost-saving mechanisms. ■