POLICY & PRACTICE

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HHS Issues Privacy Breach Rules

The federal government is requiring physicians and other entities covered under the Health Insurance Portability and Accountability Act to notify individuals when their protected health information has been breached. The interim final rule, issued in August, goes into effect this month. Under the rule, physicians have up to 60 calendar days from the detec-tion of unauthorized access of protected health information to notify the patient. If the breach involves more than 500 individuals, the Health and Human Services secretary and a major media outlet in their area must be notified. "This new federal law ensures that covered entities and business associates are accountable to [HHS] and to individuals for proper safeguarding of the private information entrusted to their care," said Robinsue Frohboese, acting director of the Office of Civil Rights at HHS. "These protections will be a cornerstone of maintaining consumer trust as we move forward with meaningful use of electronic health records and electronic exchange of health information." But there are exceptions to the breach rules: Notifications are not necessary if the information that was disclosed is unlikely to be retained. For example, if a nurse gives a patient the wrong discharge papers but quickly takes them back, it's reasonable to assume that the patient could not have retained that protected information, according to HHS. More information about the regulation is available at www.hhs.gov/ocr/privacy.

Osteoporosis Hospitalizations Rise

The hospitalization rate resulting from injuries associated with osteoporosis climbed by 55% between 1995 and 2006, according to data from the Agency for Healthcare Research and Quality. Hospitalizations from an osteoporosis injury climbed from 55 stays per 100,000 individuals in 1995 to 85 stays per 100,000 individuals in 2006. The increase brought the number of hospital stays up to 254,000 in 2006, resulting in $2.4 billion in hospital costs. Injuries from osteoporosis accounted for about a quarter of the total number of hospital stays associated with a diagnosis of osteoporosis in 2006. Some of the most common injuries reported included spontaneous and stress fractures, hip fractures, pelvic fractures, contusions, and leg and arm fractures. The AHRQ findings are based on a nationally representative sample of community hospitals around the country.

Bill Would Cap Monthly Drug Costs

Patients with rheumatoid diseases could benefit from new federal legislation introduced last month. The Affordable Access to Prescription Medications Act (S. 1630) would establish a national cap on the cost of prescription drugs. Drug costs would be capped at $200 per prescription and $500 per month for all prescriptions, if the bill is enacted. The caps would apply to all public and private insurance plans, including Medicare prescription drug plans, according to Sen. Jay Rockefeller (D-W.Va.), who introduced the bill. Enacting a national cap on drug expenditures could cut costs in half for some individuals, Sen. Rockefeller estimated. The bill would also expand the Medicare exceptions process to help more patients get access to specialty drugs at lower costs. The bill is supported by the Arthritis Foundation and the Lupus Foundation of America.

Lilly Payment Data Now Public

Eli Lilly & Co. has made good on its promise to publish how much it pays physicians and other health care professionals in consulting fees, honoraria, and the like. The drugmaker detailed the payments for the first quarter of 2009 at www.lillyfacultyregistry.com. The company said that it listed 3,400 people in the database. The average payment per service was $1,000, and each professional conducted an average of six activities, according to Lilly. The company's "faculty" members provide a wide variety of services, including patient and professional education and advising Lilly on clinical trials and how to communicate results. In September 2008, Lilly said it would voluntarily make physician payments public, but by February of this year, the company was required to do so as part of a Corporate Integrity Agreement with the federal government.

Information Tech Is Growing

The electronic exchange of health information among physicians, hospitals, health plans, and patients has increased substantially, the nonprofit group eHealth Initiative (eHI) found in its annual survey of 150 community-based "health information electronically" initiatives. Respondents reported a nearly 40% increase in the number of initiatives that were advanced enough to be exchanging information. According to eHI, these groups said that information technology is cutting redundant tests, avoiding some medication errors, and reducing staff time spent handling lab results and doing clerical tasks. The federal government is to spend at least $300 million on health information technology over the next 2 years as part of the economic stimulus of the American Recovery and Reinvestment Act of 2009. "We have a great opportunity to expand [health information technology] efforts with the new funding coming out in 2009 and 2010," said eHI chief operating officer Jennifer Covich in a statement.

—Mary Ellen Schneider

Medicare Physician Group Demo Achieved Modest Savings

BY SUSAN BIRK

CHICAGO — The Medicare Physician Group Practice Demonstration achieved modest cost savings and quality enhancements in the ongoing project's first 2 performance years, researchers reported at the annual research meeting of AcademyHealth. Data released in August reinforce that finding.

The project involves 10 large, geographically diverse physician group practices with a total of 5,000 physicians caring for 200,000 Medicare fee-for-service beneficiaries. The practices include multispecialty groups, integrated delivery systems, faculty groups, and a physician network.

During each year of the project, each group was retroactively assigned a population of Medicare beneficiaries, with an average of 20,000 patients per group (range, 10,000-37,000). Each group was held accountable for total Part A and Part B expenditures for these patients.

Patients had complete freedom of choice in providers and were not required to receive care through the participating group practice. However, only patients who received most of their outpatient evaluation and management for the year from the group practice were assigned to the group. Groups that kept increases in expenditures below 2 percentage points of their target growth rate shared up to 80% of the savings; Medicare retained 20%.

The group practices assumed all business risks associated with investments related to their participation in the demonstration, and there was no guarantee of savings. "Savings are a function of the ability of the group to control growth in Medicare spending as well as changes in [health] status of their assigned population over time relative to their local market," explained John Pilotte, a senior research analyst at the Centers for Medicare and Medicaid Services. The groups were free to make whatever investments and enhancements they felt were necessary to reach their quality and efficiency goals.

In the first year of the demonstration, two participating group practices earned a total performance payment of $7.3 million and two lost a total of $1.5 million, Gregory Pope of RTI International in Waltham, Mass., a nonprofit research and development firm working with the CMS, reported at the meeting. In the second year, four groups shared a total payment of $13.8 million and one lost $2 million. Savings to Medicare totaled $677,000 and $1.6 million for the first and second years, respectively.

Results for the third year were announced in August; five physician groups will receive performance payments totaling $25.3 million as part of their share of $32.3 million of savings generated for the Medicare Trust Funds in that year, the CMS announced.

Quality was assessed by the groups' adherence to 27 measures as indicated by Medicare claims and clinical records data. The measures, developed by the CMS in collaboration with the American Medical Association and the National Committee for Quality Assurance, covered heart failure, diabetes, coronary artery disease, hypertension, and preventive care.

Two practices complied with 10 of the quality markers in performance year 1, whereas five groups complied with all 27 quality markers in the second year, said Musetta Leung of RTI International.

In the second year, all group practices met all of their quality targets for heart failure and coronary artery disease. Achieving the diabetes-related quality measures remained a challenge. Still, second-year performance data indicated significant improvements, she said.

In the third year, all 10 groups achieved benchmark performance on at least 28 of the 32 measures reported, according to the CMS. Two groups—Geisinger Clinic in Danville, Pa., and Park Nicollet Health Services in St. Louis Park, Minn.—achieved benchmark performance on all 32 performance measures.

Over the first 3 years of the demonstration, the physician groups increased their quality scores an average of 10 percentage points on 10 diabetes measures, 11 points on 10 heart failure measures, 6 points on 7 coronary artery disease measures, 10 points on 2 cancer screening measures, and 1 percentage point on 3 hypertension measures.

"Leadership and champions within the organization are really important," said Mr. Pilotte of CMS. ■

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