POLICY & PRACTICE

Medicare Risk Reduction Demo

Officials at the Centers for Medicare and Medicaid Services are seeking proposals for a new demonstration project that will test the effectiveness of health promotion programs in the Medicare population. The Medicare Senior Risk Reduction Demonstration will target multiple risk factors for chronic diseases, including physical inactivity, obesity, smoking, depression, high blood pressure, high cholesterol, and high blood sugar. Officials will also look at underuse of Medicare preventive benefits. CMS officials plan to select up to five organizations to participate in a 3-year demonstration project; participants will be announced next spring. Officials plan to invite about 85,000 Medicare fee-for-service beneficiaries to take part. Beneficiaries will complete a risk assessment, receive information on their specific health risk factors, and receive referrals to community resources that can help them to make lifestyle changes. They will have the option of sharing the information with their physicians. "This demonstration can support doctors and other health professionals by providing support in their efforts to help seniors make important changes, such as starting an exercise program and using recommended preventive care," the agency said in a statement.

DEA Reverses Pain Rx Restrictions

A new proposal from the U.S. Drug Enforcement Administration would allow physicians to issue up to a 90-day supply of schedule II controlled substances in a single visit. The notice of proposed rule making, which was issued in September, is open for public comment until Nov. 6. If finalized, the proposal would reverse the agency's previous position that physicians must write new prescriptions each month. Instead, physicians would be able to issue three monthly prescriptions at once, specifying the fill date for each prescription. The agency also issued a statement aimed at answering physician questions about dispensing pain medications. "Today's policy statement reaffirms that DEA wants doctors to treat pain as is appropriate under accepted medical community standards," DEA Administrator Karen P. Tandy said in a statement. "Physicians acting in accordance with accepted medical practice should be confident that they will not be criminally charged for prescribing all appropriate pain medications." The American Academy of Pain Medicine (AAPM) praised the proposal, noting that it could help to eliminate the burden on cancer patients and others with chronic pain who have been forced to visit their physician every month for a new prescription, an AAPM statement said.

Fueling the Rise in Medicare Costs

The rapid growth in spending for Medicare beneficiaries is largely because of the increasing portion of those beneficiaries receiving treatment for five or more conditions in a year, according to a study published in an online edition of Health Affairs. Between 1987 and 2002, the number of beneficiaries who sought care for five or more conditions rose from about 9 million to 19.8 million. In 2002, beneficiaries with five or more conditions accounted for more than 75% of health spending, according to the study. And Medicare beneficiaries with three or more conditions accounted for 92.9% of health care spending in 2002. "One of the biggest challenges we face is that the Medicare system makes it very difficult for physicians to effectively treat people with multiple chronic illnesses," Kenneth E. Thorpe, the study's lead author and chair of the department of health policy management at Emory University, Atlanta, said in a statement. "Medicare's fee-for-service structure does not reimburse for services critical to medically managing chronic illness—preventative measures, monitoring medication intake and blood sugar." The researchers received support from the Pharmaceutical Research and Manufacturers of America.

Mammography Access 'Adequate'

The national capacity to provide mammography services is adequate, despite a 6% drop in the number of mammography facilities from 2001 to 2004, according to a recent report from the U.S. Government Accountability Office. In addition to the decrease in the number of facilities, the GAO reported a 4% drop in the number of machines, a 3% drop in the number of radiologic technologists, and a 5% drop in the number of physicians who interpret mammograms. Experts interviewed by the GAO said that the capacity nationwide is likely adequate to meet the current demand for screening and diagnostic mammograms but cautioned that there could be access problems in the future. The report was requested by Sen. Arlen Specter (R-Pa.) and Sen. Barbara Mikulski (D-Md.).

U.S. Cancer Deaths Decreasing

The rate of new cancers was stable from 1992 to 2003, but deaths from malignancies continued to decline, according to the "Annual Report to the Nation on the Status of Cancer" in the Oct. 15 issue of Cancer, published online in September. The cancer incidence for men was stable from 1995 to 2003, but the incidence for women increased from 1979 to 2003. Death rates decreased for 11 of the 15 most common cancers for men and for 10 of the 15 most common cancers for women. Incidence rates for breast cancer stabilized from 2001 to 2003, but it's not clear if that is a true trend, according to the report. Women saw a decrease in new cancers of the colon, uterus, ovaries, stomach, and cervix and an increase in non-Hodgkin's lymphoma, melanoma, leukemia, and lung, bladder, and kidney cancers. Men saw a decrease in colon, stomach, oral, and lung cancers but an increase in prostate, liver, kidney, and esophageal cancers, and in leukemia and myeloma.

—From staff reports

CMS Aims to Change Pay For Outpatient Procedures

BY ALICIA AULT
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In a sweeping, 1,000-page proposal, the Centers for Medicare and Medicaid Services is seeking to change how it pays for procedures performed in outpatient departments and at ambulatory surgery centers. Two goals are to rein in rising outpatient expenses and to level the payment differential between ASCs and outpatient departments.

In a statement, CMS Administrator Mark McClellan said that it was time to look more closely at outpatient payments: "Doing nothing is not sustainable from the standpoint of Medicare costs and beneficiary premiums, and we want public input on the best approaches to promoting high-quality, affordable care."

With 12% growth in 2006 and projected growth of 10% for 2007, outpatient costs are putting a squeeze on beneficiaries, who must make 25% copayments, Dr. McClellan said during a press briefing sponsored by the agency.

CMS is proposing that hospitals receive an average 3% increase in outpatient payments if they submit quality data on the inpatient side. Hospitals would be required to report on patient satisfaction to receive the full inpatient and outpatient update. They would also report risk-adjusted outcome measures, including 30-day mortality for acute myocardial infarction, heart failure, and pneumonia, and three measures from the Surgical Care Improvement Project. The agency said it anticipates asking for outpatient quality data as outpatient-specific measures are developed.

Hospitals that do not submit quality data will be penalized. Instead of the full outpatient rate, they'll receive the outpatient update minus 2%. Overall, outpatient spending—which covers general acute care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, long-term acute care hospitals, children's hospitals, and cancer hospitals—will hit $32.5 billion in 2007 under the proposed rule.

The agency is also proposing to increase from three to five the number of payment levels for visits to an outpatient clinic or emergency department. The maximum payment for clinic visits would be $133, up from $92, and emergency department visits would rise from $244 in 2006 to $345 in 2007. CMS also would create a new set of Healthcare Common Procedure Coding System (HCPCS) codes for visits to dedicated emergency departments (DEDs) subject to the Emergency Medical Treatment and Labor Act. The new codes would help CMS determine the relative cost of services provided at DEDs compared with emergent care furnished at a 24-hour-a-day, 7-day-a-week facility.

Most individual outpatient procedures will receive a small increase in reimbursement, but some are also slated for a reduction. Insertion, replacement, or repair of an implantable cardioverter defibrillator lead would be covered at $22,800 in 2007, up from $22,300 in 2006, and insertion or replacement of a pacemaker pulse generator would be paid at $16,400, up from $10,000, according to Washington Analysis, LLC, which follows Medicare developments for Wall Street.

Drug infusion devices would receive relatively large increases of 23%-56% but neurostimulator implantation would decrease from $11,600 in 2006 to $10,800, according to the report by Washington Analysis.

The rule would also change how hospitals are paid for drug infusions. Currently, hospitals are paid the same for each type of infusion, whether it takes an hour or several hours. Under the new rule, hospitals would be paid for the initial hour plus additional fees for more hours. They also would receive a larger payment for complex drug administration.

On the ASC side, the goal "is to help our beneficiaries get the outpatient care they need in the most appropriate setting, by eliminating payment differences that inappropriately favor one outpatient setting over another and that may add to Medicare costs," Dr. McClellan, who has since resigned his position, said.

In 2007, CMS is proposing to cap the amount paid to ASCs at no more than the reimbursement for outpatient departments, to produce at least $150 million in savings. The agency also proposed to add 14 more procedures to the list of what it will cover at ASCs in 2007—including wound repair, percutaneous vertebroplasty, repair of venous blockage, ligation of hemorrhoids, and percutaneous transcatheter stent placement—and another 763 procedures in 2008. Any procedure that is considered safe and does not require an overnight stay would be considered eligible for Medicare reimbursement in 2008.

ASCs said they had no objection to bringing payments in line with those received by outpatient departments. But the industry was upset over CMS's proposal for a 2-year phase-in of a new payment system, beginning in 2008. By 2009, ASCs would be reimbursed at 62% of the outpatient rate. The industry—which includes about 4,500 centers—had been hoping to receive 75% of the outpatient rate.

"The proposed payment rate will result in Medicare beneficiaries and the Medicare program paying more for outpatient surgery because patients' only choice for many surgical procedures will be the more costly hospital setting," said Kathy Bryant, president of the Federation of Ambulatory Surgery Centers, in a statement. The proposed rate will discourage many ASCs from offering certain procedures, said Ms. Bryant.

In a statement, the American Association of Ambulatory Surgery Centers called on members to submit comments to CMS objecting to the new proposal and to do the same with their congressional representatives.

CMS is receiving comments on the outpatient and ASC-payment proposal until Oct. 10. A final rule will be published later in the fall, the agency said. ■