**Study**

**U-M Saves Big Money … And Not At A Cost To Quality Care**

>*CMS’s first P4P project dubbed a success.*

Better treatment needn’t necessarily come at a steeper price. This seems to be the hopeful find from a report by the University of Michigan’s Faculty Group Practice. The report, based on the facility’s participation in the Medicare Physician Group Practice Demonstration is Medicare’s first Pay for Performance Demonstration Project to work directly with physician groups.

**The short of it:** Older patients with heart disease and diabetes are getting better treatment than ever at the U-M Health System — even while U-M’s care for Medicare patients is costing less, the report shows. The data come from the second year of a national project undertaken by 10 large physician groups, including the U-M FGP, says a report published Aug. 15 on the Medical News Today Web site.

U-M claims that it was one of only 2 participating groups that achieved both of the project’s aims: namely, to provide the highest-quality care on all 27 of the project’s heart and diabetes measures, and to contain healthcare spending growth for all traditional Medicare patients, including those with costly chronic illnesses.

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**Insurance**

**AHIP On A Mission To Help Reform Healthcare Coverage**

> Organization embarks on campaign across America to hear the people’s opinions.

America’s Health Insurance Plans is on a trek across America looking for solutions to the challenges of affordable healthcare, and it wants to hear from the masses.

Detroit families and community leaders shared their healthcare stories and their priorities for healthcare reform at a roundtable on Aug. 13 with representatives from the health insurance industry.

Detroit is the second stop on a listening tour conducted by AHIP’s Campaign for an American Solution, said a release on AHIP’s Web site. The campaign hopes to build support for workable healthcare reforms based on principles such as coverage, affordability, quality, value, choice and portability, the release continued.

The campaign is seeking to engage with Americans from all walks of life and “seeking their input on our reform proposals and what the country can do to make coverage more affordable and more portable,” said Karen Ignagni, president and CEO of AHIP.

**AHIP Drafts Its Own Ideas Too**

AHIP’s board of directors drafted a range of policy proposals in recent years in an attempt to provide families with greater access to affordable healthcare coverage. These proposals would ensure all Americans have access to healthcare coverage and would repair the healthcare safety net by expanding Medicaid to cover every uninsured American living in poverty. In addition, they would make all children from low-income uninsured families eligible for the Children’s Health Insurance Program.

Additionally, the proposals seek to strengthen the employer-based healthcare coverage system for working families and guarantee access to healthcare coverage in the individual market.

The proposals seek to give working families a helping hand by providing tax credits on a sliding scale of up to 400 percent of the federal poverty line and give workers portability with a new tax-free portable health account that one can use to purchase any type of healthcare coverage. Individuals, employers, the federal government and state governments could all contribute to the account, AHIP said.

Lastly, the proposals seek to slow the growth rate of medical costs and improve the value consumers get for their healthcare dollars by rewarding quality, promoting wellness and prevention, and providing consumers with better access to information about what medical treatments are most effective.

The shocking reality is that currently, more than 1 million people in Michigan, or 10 percent of the state’s population, are uninsured, according to the Urban Institute and the Kaiser Commission on Medicaid and the Uninsured’s estimates, based on U.S. Census Bureau March 2006 and 2007 Current Population Survey data. The same report also estimates that nearly 47 million Americans do not have health insurance coverage.

**Opinion Piece**

**Kill 2 Birds With 1 Stone By Reducing Hospital Readmissions**

> Medicare could lower long-term care costs and avoid physician fee cuts.

High hospital readmission rates point to loopholes in the reimbursement mechanism — so say two authors in a Boston Globe opinion piece.

Reduction in hospital readmissions by Medicare beneficiaries could play a large role in reducing program spending — enough to avoid cutting physician fees, say Robert Pozen, a trustee of the Commonwealth Fund, and Cathy Schoen, senior vice president of the Fund. The cold hard facts: Medicare must reduce expenses by $20 billion annually over a decade beginning in 2010 to avoid reducing fees to physicians, the authors say, as quoted in a report published Aug. 14 on the kaisernetwork.org Web site.

“There is a straightforward way to pay for half of this fix,” and that’s through reducing hospital readmissions, Pozen and Schoen write. A Medicare Payment Advisory Commission study found that 75 percent of all 30-day hospital readmissions of Medicare patients in 2005 were...
Study, continued from cover

The U-M FGP, part of the U-M Medical School, includes all 1,500 U-M faculty physicians who care for patients at the three U-M hospitals and 40 U-M health centers. Many of the programs and innovations that U-M put in place for this project involved not only physicians but nurses, social workers, care managers and others who are involved in caring for Medicare patients at all U-M facilities, according to the report.

20,000 Medicare Participants, $460,000 In PQRI Earnings

The report collates data from approximately 20,000 Medicare participants who received nearly all their care at U-M during the year that began April 1, 2006. It excludes those who were enrolled in a Medicare Advantage plan offered by a private health plan and Medicare participants who received only limited care at U-M.

The demonstration project at U-M began by focusing on the quality of care of patients with diabetes, but in the second year it was expanded to include heart failure and coronary artery disease — both of which carry a high risk of emergency hospitalization and other care if not managed properly.

U-M is also participating in another Medicare performance incentive project, the Physician Quality Reporting Initiative (PQRI). In fact, U-M earned $460,000 for achieving high-quality care on 27 benchmarks through PQRI.

Why U-M’s newsworthy success? It’s due to the facility’s effort to redesign the way patients are cared for, to enhance coordination and efficiency and reduce the need for emergency care and repeat hospital stays, the report claims.

Some of the tactics that U-M has implemented to help improve care for Medicare patients include sub-acute care service, which brings U-M physicians and nurse practitioners specializing in geriatric care directly into certain nursing homes in certain areas of Michigan. U-M also put a strong focus on follow-up care in the home. U-M’s CHOICES (Creating Healthcare Options to Inpatient Care and Emergency Services) program provides a nurse practitioner and social worker who can travel to a patient’s home soon after he goes home from the hospital, to help with issues such as diabetes management.

Other measures implemented by U-M include Expanded Inpatient Geriatrics Consult Service and Emergency Medicine Consult/Referral Service.

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potentially preventable — or 13 percent of total admissions, Pozen and Schoen note. If these readmissions were eliminated, Medicare could save $12 billion annually, or more than half of its unfunded liability.

To achieve these savings, Congress should address three objectives, Pozen and Schoen say: decreasing complications during hospital stays, improving patient communication during the discharge process and tracking patients after discharge. But for these measures to work, “Medicare needs to create the right incentives,” because hospitals currently receive higher payments for patients being treated twice.

Possible solution: Congress should require readmission rates to be public, the authors write, and hospitals whose readmission rates are above the national average should receive lower reimbursements for a beneficiary’s second stay, while hospitals who have rates lower than the national average should receive higher reimbursements for a beneficiary’s first hospital stay.

“With the right incentives in place, Medicare should generate over $100 billion in savings over the next decade by bringing the high-cost areas down to the national average on 30-day rehospitalizations,” the authors conclude.
Incentives

E-Prescribing Continues To See Industry Praise, Despite Initial Cost

> Docs foresee a bonus, Medicare projects $156 million in savings over 5 years.

While CMS continues to gear up for its live conference on electronic prescribing, experts weigh in on the ups and downs of the program. The good news: There seems to be a lot more ups than downs.

**Biggest perk:** Electronic prescribing can make pharmacies’ lives easier by eliminating confusion about physician handwriting — and soon, it will also put more money in physician practices’ coffers.

Officials from the Centers for Medicare & Medicaid Services, the American Academy of Family Physicians and the Department and Health and Human Services offered a glimpse of where they see the e-prescription program going during a July 21 conference call.

**E-Prescribing Expensive, But Will Pay Off In Long Run**

An Institute of Medicine report revealed that more than 1.5 million Americans are injured annually by drug errors, and another study noted that pharmacists make more than 150 million phone calls per year to physicians to clarify what they wrote on prescriptions, HHS Secretary Mike Leavitt said during the call. “That’s a lot of people needlessly hurt and a lot of time spent trying to sort out bad handwriting.”

**What it means to physicians:** “Beginning in 2009 and over the following 4 years, doctors will be eligible for additional payments from Medicare when they prescribe electronically,” Leavitt said. “The first year they will get 2 percent extra, the next year 1 percent, and from 2011 and on, they will get a half a percent.”

By 2014, CMS will phase out the bonus payments, and physicians who aren’t e-prescribing will face penalties. “We expect that this will have a profound effect on the adoption and use of e-prescribing,” Leavitt said.

**The downside:** The cost of the e-prescribing system is approximately $3,000 per prescriber, said Kerry Weems, CMS’s acting administrator. Plus, practices will face recurring costs for the dedicated Internet line and maintenance that the systems require, which could cost physician practices between $80 and $400 a month, Weems said.

However, CMS suggests, spending that money will ultimately save money down the road. “We estimate that widespread adoption of the e-prescribing program could save Medicare as much as $156 million over a five-year period,” Weems said.

And don’t forget, the payment incentives will help practices fund the cost of the e-prescribing system, said James King, MD, AAFP’s president.

**Still Some Kinks To Iron Out**

Although experts praise the idea of e-prescribing, practices that have started e-prescribing have hit a few bumps in the road.

For example, King noted that he can’t currently e-prescribe all of his prescriptions because not all pharmacies have the ability to capture e-prescriptions. In addition, laws prevent him from e-prescribing narcotic medications.

**Another snag:** He is unable to e-prescribe across state lines, despite the fact that he practices in Tennessee, yet some of his patients live in Mississippi. On the upside, King expects that these issues will be worked out as e-prescribing grows in use.

**For more information:** To listen to a replay of the CMS call, dial 800-839-7073.

**Health**

**Working-Age Adults Show Chilling Increase In Major Chronic Illnesses**

> Cost of prescription drugs still a huge problem.

The number of working-age adults who have major chronic conditions drastically grew between 1997 and 2006 — and those without health coverage in this group experienced substantial depletion in access to healthcare, according to a new study by Kaiser Family Foundation researchers published July 22 on the Health Affairs Web site.

The number of working-age adults who reported having at least 1 of 7 major chronic conditions grew 25 percent since 1997, totaling 58 million by 2006. Apart from
the overall growth in the adult population, the increase over the period reflects rising rates of chronic disease prevalence among non-elderly adults, according to study authors Catherine Hoffman and Karyn Schwartz.

The research focused on non-elderly adults with chronic conditions, as their greater healthcare requirements make them particularly susceptible to changes in the economy and the healthcare system. Studies show that people with chronic conditions account for an overwhelming three quarters of all personal medical spending in the United States.

No Surprise: Uninsured Take The Biggest Hit

The study analyzes data from 1997 to 2006 using access to care measures from the National Health Interview Survey for non-elderly adults having at least one of the following 7 major chronic conditions: heart disease, hypertension, stroke, diabetes, asthma, emphysema and cancer. Comparisons were then made within this group between those who were uninsured, publicly insured through Medicaid, and privately insured.

Hoffman and Schwartz found that large differences in access to care between uninsured and insured adults with chronic conditions, which existed in 1997, grew even wider in 2006. The study also indicates that the proportions of Medicaid enrollees and privately insured people having problems getting care are similar, and both of these proportions are much lower than the proportion of the uninsured who experienced problems getting care, after adjusting for social and health differences among the different groups.

Regular monitoring and continuity in care are important tools in managing a chronic condition effectively. However, the study shows that the percentage of uninsured adults with a chronic condition who reported not having a usual source of care grew from 29 percent to 34 percent between 1997 and 2006. By 2006, more people in this group were not seeing medical specialists. In contrast, among the privately insured, access to providers improved but was unchanged for Medicaid recipients.

A Gloomy Picture For Drug Costs

Overall, the rising costs of healthcare along with the economic recession and slow growth in wages adversely affected both the insured and uninsured with chronic conditions. And the reliance on costly prescription drugs to treat chronic illnesses only adds to the financial strain.

People in all three insurance categories reported having unmet needs for prescription drugs because of cost. Among the privately insured with chronic conditions, the percentage of people reporting this problem of access nearly doubled from 5 percent in 1997 to 9.5 percent in 2006. For the uninsured, these percentages grew from 25 percent to 33 percent, and for those on Medicaid, the percentages grew from 5 percent to 8 percent by 2006. Prescription drugs are playing an increasingly important role in chronic condition management so this finding is particularly disconcerting, according to the study’s authors.

Older Americans

Time To Step Up Preparations For Baby Boomers In Long-Term Care

LTC must plan change now before boomers’ needs outpace providers’ abilities.

Experts to long-term care: All hands on deck — the baby boomers are coming! 2011 marks the start of a drastic increase in the population of older Americans. That’s the year boomers start to turn 65. And between 2005 and 2030, the number of older Americans will almost double, according to a recent study.

Unfortunately, that study (from the Institute of Medicine) also warns that physicians and other caregivers lack training and expertise in caring for geriatric patients. This creates an impending healthcare crisis as the number of older patients with more complex health needs increasingly outpaces the number of healthcare providers with the knowledge and skills to adequately care for them.

Fundamental changes in the healthcare system need to take place, and greater financial resources need to be committed to ensure seniors can receive high-quality care, the study, Retooling for an Aging America: Building the Health Care Workforce, urges. Right now, the nation is not prepared to meet the social and healthcare needs of elderly people, study authors warn.

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significant regulatory changes that have burdened providers in recent years,” the Academy said in an e-mail to its members. It then encouraged members to submit comments to the Centers for Medicare & Medicaid Services “if you feel the implementation date should be pushed to a later time.”

But CMS says any further delay could start working against the industry’s favor. “We recognize that the transition to ICD-10 will require some up-front costs, but each year of delay would create additional costs, both because of the limitations of ICD-9 and because of the need to employ the greater precision that ICD-10 codes provide to support value-based purchasing of healthcare and other initiatives,” acting administrator Kerry Weems said.

ICD-9 Can’t Last Forever, CMS Says

The ICD-9-CM code sets were adopted in 2000 under authority provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These code sets were designed for administrative transactions to report diagnoses and inpatient hospital procedures.

Why the upgrade to ICD-10? ICD-9-CM codes emerged almost 30 years ago, and industry leaders believe they are now outdated because of their limited ability to accommodate new procedures and diagnoses. ICD-9-CM contains only 17,000 codes, and experts expect it to start running out of available codes next year. On the other hand, the proposed ICD-10 code sets contain more than 155,000 codes, thus accommodating many more diagnoses and procedures. The additional codes will also help implement electronic health records, because they will provide more details in the electronic transactions.

And get ready for two sets of ICD-10 codes. The proposed rule would adopt the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) for diagnosis coding and the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) for inpatient hospital procedure coding. The new codes would replace the ICD-9-CM Volumes 1 and 2, and the ICD-9-CM Volume 3, for diagnosis and procedure codes, respectively.

Updated Electronic Transaction Standards Come Hand-In-Hand

In a separate proposed regulation, HHS is also pushing adoption of the updated X12 standard, Version 5010, and the National Council for Prescription Drug Program standard, Version D.0, for electronic transactions, according to HHS.

“The greatly expanded ICD-10 code sets will enable HHS to fully support quality reporting, pay-for-performance, bio-surveillance and other critical activities,” said HHS Secretary Mike Leavitt. “Conversion to ICD-10 is essential to development of a nationwide electronic health information environment, and the updated X12 transaction standards are a critical step in the implementation of these new codes.”

The latest versions of current HIPAA electronic transaction standards require the use of the ICD-10 code sets for claims, remittance advice, eligibility inquiries, referral authorization and other widely used transactions. The currently adopted standard, Version 4010/4010A1 of the American Standards Committee X12 group, cannot accommodate the much larger ICD-10 code sets.

Under the updated transaction standards proposed rule, compliance with Version 5010 (healthcare transactions) and Version D.0 (pharmacy claims) would be required by April 1, 2010. In this same rule CMS also proposes a standard for the Medicaid pharmacy subrogation transaction. Medicaid pharmacy subrogation is the process by which state Medicaid agencies recoup funds for payments they have made for pharmacy services for Medicaid recipients in cases where another third party payer has primary financial responsibility. CMS would require compliance two years after the effective date of the final rule, except for small health plans, which would have an additional year to adjust.

CMS will accept comments on its rules until 5:00 p.m. Eastern time on Oct. 21. Both rules are at www.cms.hhs.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp.
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Experts Recommend Variety Of Solutions

The study advocates better training in geriatrics for the healthcare workforce, as well as improving recruitment into the field and exploring new models of care. And a recent Commonwealth Fund/Modern Healthcare Opinion Leaders Survey found that more than three quarters of healthcare experts surveyed would like to see a long-term-care benefit added to Medicare.

Survey respondents also listed ensuring adequate financing and a workforce able to meet the needs of the nation’s aging population as a top priority for long-term-care.

Good news for now: the Centers for Medicare and Medicaid Services recently announced that Medicare reimbursement to nursing homes will increase by $780 million in 2009. The agency will also put a hold on a proposed recalibration of Medicare SNF payment rates for pending further study.

“This announcement is a huge success for America’s nursing homes and the millions of people they serve,” said American Association of Homes and Services for the Aging president & CEO Larry Minnix.

Industry players are also pleased that CMS decided to reconsider the proposed changes. When CMS first proposed changes in the way Medicare payment rates are calculated, AAHSA warned that the proposal would make a faulty payment system worse and would reduce funds needed for quality care at a time when costs are rising rapidly.

Outcomes

CMS/HHS Pumps Up Consumer Data On Hospital Care

Hospital Compare Web site reveals more about mortality rates and other key info.

Healthcare consumers today have a lot more information at their disposal to choose high-quality medical providers — and the U.S. Department of Health & Human Services is stepping up the consumer’s ability to compare local hospitals.

The Centers for Medicare & Medicaid Services’ Hospital Compare consumer Web site recently underwent some significant additions, said an Aug. 20 CMS press release.

The site’s improvements included the addition of a mortality measure for pneumonia and publicly reported measures for hospital care of children. Previously, Hospital Compare had provided only quality information based on hospitalizations of adult patients.

Earlier this year, Medicare added patient satisfaction information to the Web site. With these additions, the total goes up to 26 “process of care” measures, three “outcome of care” measures, two children’s asthma care measures and 10 “patient experience of care” measures, CMS said. Hospital Compare also contains information about the number of certain elective hospital procedures provided to patients and what Medicare pays for those services.

“CMS’s goal for updating and enhancing the Hospital Compare Web site is to provide usable and accurate information about hospital performance to providers and communities that will encourage hospitals to excel in the quality of care they provide,” said CMS acting administrator Kerry Weems.

The agency is particularly proud of its individual hospital mortality scores. “The 30-day Medicare mortality data will strengthen quality improvement partnerships in hospitals by encouraging better handoffs and communication,” said Carolyn M. Clancy, M.D., the Agency for Healthcare Research and Quality’s director.

Quality Of Care On The Ups With Mortality Reporting

Reporting hospital performance has done more than simply inform consumers; it may be improving quality of care too. Last summer, CMS began reporting the 30-day mortality measures of heart failure and heart attack, and since then, CMS has seen national improvement on mortality rates for heart attack. The rate of 30-day heart attack mortality dropped from 16.3 percent reported in 2007 to 16.1 percent reported in 2008, according to the release.

Variance among hospitals in their rates was less, too. There are no hospitals whose heart attack mortality rates were low enough to classify them as “worse than the U.S. national rate” under CMS’s mortality rate classification system.

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Outcomes, continued from previous page

The mortality outcome measures are risk-adjusted and take into account previous health problems to “level the playing field” among hospitals, CMS assured. The measures are also intended to help ensure accuracy in performance reporting.

Consumers Get More Details On Stats

In addition to new information about pneumonia mortality, the Hospital Compare Web site will allow consumers and hospitals to dig deeper than just the information of the mortality measures for each hospital. Consumers will be able to compare the hospital’s mortality rate vis-à-vis the U.S. national rate.

This new data includes each hospital’s risk-standardized mortality rate, an estimate of the rate’s certainty (also known as the interval estimate) and the number of eligible cases for each hospital.

This information will also serve as a benchmark where Medicare beneficiaries and other consumers can determine — on a year-by-year basis — whether their hospital providers are improving for these important outcome measures.

The children’s asthma care measures CMS recently added are relievers for inpatient asthma and systemic corticosteroids for inpatient asthma. By including these measures, CMS and the Hospital Quality Alliance begin providing the public with information about the quality of children’s care in hospitals, including in pediatric hospitals, for the first time, the release said.

Could all this be a trickle-down effect? President Bush issued an Executive Order in 2006 that directed federal agencies that sponsor or subsidize healthcare commit to “four cornerstones” of value-driven healthcare: ensuring transparent quality and price information, interoperable health information technology, incentives for high-quality and efficient healthcare delivery.

In Brief

CMS ‘Cooked The Books’ And Reported Inaccurate Error Rate

The Centers for Medicare & Medicaid Services may have boasted that it slashed inappropriate spending in 2006, but the agency allegedly overlooked nearly $2.8 billion in improper Medicare spending, according to a late-breaking new report.

On Aug. 21, the New York Times reported that the OIG will soon issue a document indicating that CMS “told outside auditors to ignore government policies that would have accurately measured fraud.” If the auditors had properly reviewed the records, they would have found about $2.8 billion more in improper spending by DME suppliers, the Times article indicates.

Congress members are outraged by what they refer to as CMS’ attempt to “cook the books.” Look to Medicine & Health in the coming weeks for more information when the OIG issues its final report on the subject.