Health-care Reform and Chest Physicians

With the Supreme Court ruling essentially upholding health-care reform as originally proposed, our series of articles on this topic is very germane and pertinent. This month’s article is especially relevant to our members, since it covers the scope of changes expected in the fields of pulmonary, critical care, and sleep medicine. Our specialty will, most definitely, be affected in a meaningful way. In the most recent 10-year projection, the actuaries of the Centers for Medicare & Medicaid Services (CMS) project that health-care spending will nearly double to $4.4 trillion by 2018. Drs. Curt Sessler, Regent-at-Large, and Steven Simpson, Chair of the Critical Care NetWork, discuss the reporting of outcomes, following of evidence-based guidelines, and development of performance metrics that are now being instituted. They emphasize patient-focused research to define practice parameters. The practice of sleep medicine has undergone substantial change. As the number of laboratory-based sleep studies and CPAP prescriptions skyrocketed in the late 1990s and the first decade of 2000, insurers started taking a hard look at their costs. In 2008, the Centers for Medicare & Medicaid Services (CMS) began to allow home sleep testing to diagnose sleep apnea. When the anticipated rush on home sleep testing did not materialize, third party payers in parts of the Northeast hired utilization management companies to “decide” if a patient referred for a sleep study could undergo home sleep testing instead. In the areas where this has been enforced, in laboratory polysomnographies have been reduced by 50%. With increasing focus on cost-effectiveness and outcomes, this trend will likely continue to sweep across the rest of the country, probably resulting in fewer sleep laboratories and a surge of polysomnography technologists. Sleep centers that embrace home sleep testing may be “ahead” of the game. Increasing focus on outcomes, rather than point care, may also affect sleep laboratory accreditation. Sleep laboratory accreditation offered by the American Academy of Sleep Medicine (AASM), the Joint Commission (JC), and other entities centered on testing and treatment in a safe, controlled environment by trained staff. But the push now is to improve outcomes related to the health of patients. Recently, CMS accepted a PQRS (Physician Quality Reporting System) initiative directed at

Health-care Reform: Is Anyone Listening?

The centerpiece for health-care reform is the Patient Protection and Affordable Care Act of 2010, which holds a number of implications for chest physicians. Key provisions of the Act include expanding insurance coverage to reduce the number of uninsured Americans, emphasizing preventive care, building a more robust primary care base, and placing greater value on delivery of high quality care—including more accountability for practitioners. Dr. Suhail Raoof has asked members of the College who have special expertise in critical care, sleep, and pulmonary medicine to share their ideas about what health-care reform means for chest physicians.

Critical Care

With regard to critical care medicine and its practitioners, the Act does not directly tackle key critical care issues, such as end-of-life care, disaster preparedness, and workforce shortages. However, efforts to reduce the high cost of ICU care—an estimated 15% of US GDP—are likely to play an important role in attempts to balance the health-care budget. There has been steady growth in organized efforts and incentives to provide high quality health care in the past decade. The demonstration of successful statewide programs, such as for the near-elimination of hospital-acquired bloodstream infections in ICU patients ( Pronovost et al. N Engl J Med. 2006;355(12):1225), has illustrated the clinical value and cost-savings of such programs, and there is a strong emphasis on expanding these efforts in the Act. Components that will have a direct impact on critical care include expansion of quality metrics, including support for innovative and pilot programs; increased reporting requirements on quality measures; imposition of penalties for nonreporting of quality measures (in 2015); and expansion of accountable care organizations (ACO)—voluntary organizations of providers who are accountable for quality and costs. It is clear that ICU care will be an attractive target for quality measures.

Quality care is driven by patient-focused research. Critical care specialists are in key positions in performing clinical and comparative effectiveness research, such as early goal-directed therapy for severe sepsis and lung protective ventilation for ARDS. The Act emphasizes the need for and supports the funding of comparative effectiveness research, presenting an opportunity for researchers. ICUs are at the center of the safety net for patients who experience devastating illness or injury, events that disproportionately impact the poor and uninsured. Expanding the number of Americans with health insurance is likely to influence ICU patient mix, as well as reimbursement. Similarly, elimination of preexisting condition exclusions and lifetime insurance coverage limits should promote better care for patients with serious chronic illnesses and reduce the risk for financial devastation for patients with prolonged critical illness. Greater use of preventive services and better access to care will likely reduce the use of EDs, and, thus, ICU admissions, for management of preventable progression of chronic disease to acute life-threatening illness. While the greatest benefit will be for our critically ill patients, it is widely held that providers and institutions, including many safety net ICUs now caring for large numbers of uninsured patients, will benefit from the Act as a result of improved payer mix. However, the anticipated reduction in Medicare reimbursement and the uneven acceptance of the Act across the states will impact this assumption.

Sleep Medicine

In advance of implementation of the Patient Protection and Affordable Care Act, sleep medicine has already undergone substantial change. As the number of laboratory-based sleep studies and CPAP prescriptions skyrocketed in the late 1990s and the first decade of 2000, insurers started taking a hard look at their costs. In 2008, the Centers for Medicare & Medicaid Services (CMS) began to allow home sleep testing to diagnose sleep apnea. When the anticipated rush on home sleep testing did not materialize, third party payers in parts of the Northeast hired utilization management companies to “decide” if a patient referred for a sleep study could undergo home sleep testing instead. In the areas where this has been enforced, in laboratory polysomnographies have been reduced by 50%. With increasing focus on cost-effectiveness and outcomes, this trend will likely continue to sweep across the rest of the country, probably resulting in fewer sleep laboratories and a surge of polysomnography technologists. Sleep centers that embrace home sleep testing may be “ahead” of the game. Increasing focus on outcomes, rather than point care, may also affect sleep laboratory accreditation. Sleep laboratory accreditation offered by the American Academy of Sleep Medicine (AASM), the Joint Commission (JC), and other entities centered on testing and treatment in a safe, controlled environment by trained staff. But the push now is to improve outcomes related to the health of patients. Recently, CMS accepted a PQRS (Physician Quality Reporting System) initiative directed at
sleep apnea (www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/pqrs/). This was developed by a task force working with the AMA, the ACCP was a participating partner (www.chestnet.org/accp/quality-improvement/aquire/pqrs/). Unfortunately, this is not yet available in a registry. In this regard, some aspects of sleep medicine that lack well-documented beneficial treatment outcomes (eg, chronic hypnagogic for insomnia, pharmacologic treatment of periodic limb movements) may become not reimbursable. It is imperative for sleep medicine to develop more of these outcome measures for the other sleep disorders and to incorporate outcome measurements into sleep center accreditation standards, if not, the specialty as a whole may be left out of ACO models, and care for patients with sleep disorders may fall to the care of primary care doctors who typically get little training in sleep medicine.

Another example of such a challenge is in the patient-centered medical home. As this concept is further developed, the relationships and communication between sleep specialists and primary care providers will be critical. Sleep medicine has some unique tools including CPAP monitoring, home testing, and actigraphy that could be appealing to primary care practitioners. Trying to stay in these conversations on a local level will be key to remaining a viable specialty.

A final challenge for sleep medicine will be interfacing with the electronic health record (EHR). Sleep studies and CPAP downloads are digital and logically should interface with EHRs. AP downloads are digital and health record (EHR). Sleep studies and packaging with the electronic viably should interface with EHRs.

Health information technology (EHR) systems will soon become interoperable. Some of these include physicians, hospitals, pharmacies, nursing homes, and payers.

Pulmonary practices should consider opportunities for clinical integration with hospitals and extended care facilities. Bundling of payments between hospitals and physicians for inpatient services may be enacted as soon as 2013. Clinical integration between hospitals and physician groups can take several forms, including physician employment and a professional service agreement (PSA) between a hospital and a medical practice. Hospital administrations vary regarding their preference for ownership vs relationships in which medical groups remain independent. Hospitals seeking physician ownership tend to prioritize primary care practices before addressing subspecialty practices. Pulmonary practices should focus on demonstrating their value to hospitals. Avoidance of readmissions can be supported by rapid outpatient access and by the initiation of pulmonary rehabilitation programs in extended care facilities (ECFs). The practice culture must gain the ability to shift the focus of its compensation model from productivity to cost savings and quality outcomes.

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