

# Medicare Minutes

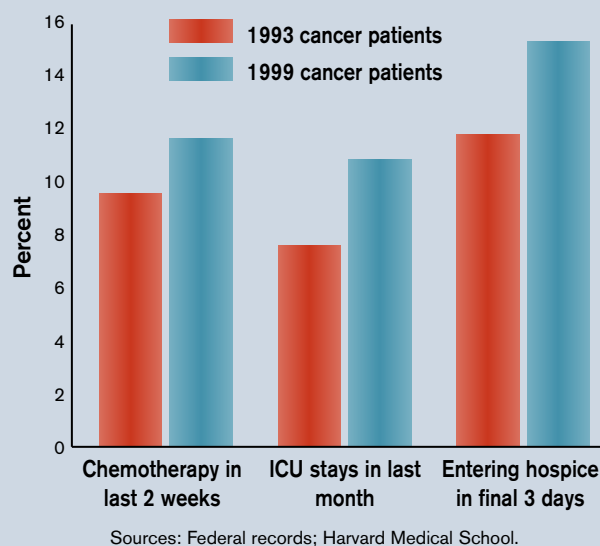
## Review of Medicare Records Finds End-of-Life Medicare Patients Receiving Futile, Costly Care

According to a federally funded study presented on June 2, 2006, at the Annual Meeting of the American Society of Clinical Oncology in Atlanta, differences in how hospitals care for end-of-life cancer patients indicate serious problems with quality of care and point toward unnecessary spending by Medicare. Led by Dr. Craig Earle of the Dana-Farber Cancer Institute and Harvard Medical School, the study showed that the number of people receiving chemotherapy and other aggressive but futile forms of treatment at the end of life is on the rise (Figure 1). According to a review of 215,488 Medicare records of people who died of cancer in the 1990s, nearly 12% of cancer patients who died in 1999 received chemotherapy during the last 2 weeks of life compared with 10% in 1993. Admissions to hospital intensive care units in the last month of life increased from nearly 8% in 1993 to 11% in 1999, while emergency room visits rose from 24% to 28%, respectively, during the same period. The study further suggested that the percentage is probably even higher today. Aggressive anti-cancer treatment for patients at the end of life gives false hope and puts people through exhausting and costly ordeals when there is no chance of cure, indicating that many patients are not benefiting from hospice care and other palliative care services.

This report comes on the heels of a recent study by the Center for the Evaluative Clinical Sciences (CECS) at Dartmouth Medical School, which calls for overhauling how the nation manages chronic illness, and proposes

that hospitals take leadership in redesigning how they care for the chronically ill. The Dartmouth Atlas Project studied the records of 4.7 million Medicare enrollees who died from 2000 to 2003 and had at least 1 of 12 chronic illnesses. The study demonstrated that within this patient population, Medicare could have realized substantial savings—\$40 billion or nearly one-third of what it spent for

**Figure 1. Increase in the number of cancer patients who are receiving aggressive but futile care at the end of life, as indicated by a review of Medicare records**



the care of these patients over the 4-year study period—if all US hospitals practiced at the high-quality/low-cost standard set by the Salt Lake City region. According to Principal Investigator John E. Wennburg, MD, MPh, lower utilization of acute care hospitals and physician visits could actually lead to better results for patients and prolong the solvency of the Medicare program.

Both reports speak clearly to the need to overhaul the way end-of-life care is managed. There is a need for physicians to redirect resources away from acute care to helping terminally ill patients die with dignity and in comfort outside of hospitals, for example, in home health and hospice care settings. Academic medical institutions and federal agencies,

such as the National Institutes of Health, should perform patient-level studies to produce detailed evidence that defines the most efficient clinical practices, for example, whom to hospitalize, when to schedule a revisit, or when to refer to a medical specialist, home health agency, or hospice.

## Several Physician Voluntary Reporting Program (PVRP) Performance Measure CPT Codes in CR4183 Modified

As a result of additional input received by CMS from medical specialty societies, several PVRP performance measure CPT codes in CR4183 have been modified. In addition, CPT Category II codes are now available for certain measures. The changes are reflected in CR5036. For additional information, view the MLN Matters article at: [www.cms.hhs.gov/MLNMattersArticles/downloads/MM5036.pdf](http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5036.pdf).

Additional information about the program also can be found at: [www.cms.hhs.gov/PVRP](http://www.cms.hhs.gov/PVRP). You may want to visit this Web page periodically for updates. CMS will soon post the 1-page worksheets developed specifically for certain specialties to assist in reporting relevant information to the PVRP.

## Officials Confirm Medicare Will Have Fewer Drug Plans in 2007

Earlier reports that the Medicare Drug Program will include fewer plans next year have been confirmed by Department of Health and Human Services Secretary Mike Leavitt. Secretary Leavitt told insurance executives that market forces have helped lower drug prices and will enable a reduction in the number of plans next year. Leavitt made this announcement at a recent meeting sponsored by America's Health Insurance Plans (AHIP), a national

trade association representing nearly 1300 member companies that provide health benefits to more than 200 million Americans.

Calling the initial version of the drug benefit "Medicare Part D 1.0," Leavitt told executives that "Part D 2.0" would reflect the need for simplification and standardization in the program.

Also in attendance, CMS Administrator Mark McClellan stated that, "Some plans are definitely proving to be more popular than others," and that there is "some consolidation." He added, "I suspect we are going to see some more of that, particularly from plans that haven't generated a large level of enrollment."

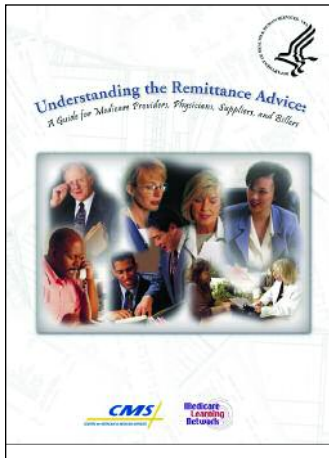
However, CMS might not be leaving it entirely up to market forces to reduce plan offerings. In late February, CMS sent a memo to insurers, requesting feedback on a proposal to limit insurers with Medicare drug plans to offering 1 "basic" benefit plan and 1 "enhanced" benefit plan in each region. For this year's coverage, insurers were allowed to sponsor up to 3 plans per region.

During the meeting, Leavitt cited elimination of "separate applications for every plan" as an example of how to simplify the program in the future. In addition, it was reported that although drug plans' customer service has been improving, it has a ways to go yet. Plans still need to do a better job of responding to inquires from beneficiaries and pharmacists, and pay pharmacists faster, particularly those in rural areas. As a result, CMS is increasing the monitoring of plans' call centers and their speed at processing beneficiary and pharmacist concerns and is designing performance measures to track those functions.

## Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers

*The RA Guide* has been updated and is now available online through the Medicare Learning

Network's publication page located on the CMS Web site at: [www.cms.hhs.gov/MLNProducts/downloads/RA\\_Guide\\_Full\\_03-22-06.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf). This comprehensive publication



provides practical information on the types, uses, components of, and standardized codes sets used on the RA, as well as how to read the Standard Paper Remittance Advice and the Electronic Remittance Advice using PC-Print software (for institutional providers who receive RAs from Fiscal Intermediaries or Regional Home Health Intermediaries)

and Medicare Remit Easy Print software (for professional providers who receive RAs from Carriers or Durable Medical Equipment Medicare Administrative Contractors [DMACS], formerly known as Durable Medical Equipment Regional Carriers [DMERCs]). The guide also includes a number of helpful resources, including field indexes (for institutional and professional RAs), an acronym list, and a glossary. In addition to the online version of *The RA Guide*, it will soon be available in print and on CD-ROM. CMS will announce the availability of these products as they become available.

## Update on the Medicare Pharmacist Phone Line

During implementation of Medicare Part D, CMS provided a special contact phone line for pharmacists to assist in determining plan enrollment and low-income subsidy (LIS) co-pay status. This pharmacist line (866-835-7595) provided direct access to Medicare call service representatives (CSRs).

Beginning June 24, 2006, when pharmacists call the 1-866 pharmacist line, they will be directed to the standard 1-800 Medicare interactive voice response system. Medicare CSRs will continue to be available through this sys-

tem, providing the same information and service for pharmacists as they did before.

## Medicare Posts Pricing Information to Ease Comparisons

In an effort to help consumers compare the price and quantity of health care, CMS has publicly posted pricing and quality information for 30 of the most commonly performed hospital procedures, such as heart operations and hip and knee replacements. The data show what Medicare pays for the 30 procedures in each county, not at any particular hospital within a county. However, it does have hospital-specific information on how many procedures of each type were performed at a particular hospital. This should give consumers a better idea of how experienced a hospital might be with treating patients with their specific ailment.

The move comes as employers and others who pay the nation's \$1.9 trillion health care tab encourage patients to be more like savvy shoppers when it comes to medical care, currently a difficult prospect because so little comparative information on cost and quality is available. That the federal government, the nation's largest purchaser of health care, is posting such information on its CMS Web site is important, employer groups say.

CMS officials say that releasing the data is a first step in what they hope will be a broad effort by both the government and the private sector to publish price and quality information. In the private sector, a few insurers have made limited cost and quality information available to their members. According to Health and Human Services Secretary Michael Leavitt, "Our ultimate vision is that patients will be able to compare hospitals and physicians on cost, quality and consumer satisfaction." Data expected to be released later this year will include countywide cost ranges for various procedures paid for by Medicare in outpatient surgery clinics and doctors' offices. The pricing data can be found at [www.cms.hhs.gov/HealthCareConInit/](http://www.cms.hhs.gov/HealthCareConInit/). **MPM**