Pittsburgh Regional Healthcare Initiative

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Naida Grunden, editor

Second in a series

More reimbursement stories

We've been gratified by a great response to the examples of payment policies that are not "pro-patient" published in last month's PRHI Executive Summary*. Policymakers are calling to say that these examples are helping them understand the issues more clearly. And partners are calling with more examples. They include:*

- Clinical breakthroughs present financial dilemmas "at the point of patient care." New clinical treatments with promising outcomes often face barriers or complex and varying conditions for reimbursement by payers. For one promising agent–Erbitux–hospitals face a $30,000-$40,000 gamble per patient. If they administer it, but find that complex and varying payment rules among payers weren't met in a particular instance, they must assume that cost.
- In another case, new injectible heparin agents that allow patients recovering from deep vein thrombosis (DVT) to go home from the hospital days earlier than usual 5 days. These treatments are not covered for Medicare patients at home (though they will be with the new Medicare Rx bill in 2006). Many patients do not have prescription coverage for Lovenox ($400-800 per patient.) The incentive is for the patient to stay in the hospital to avoid that expense. At least one local hospital has chosen to give the Lovenox to dozens of these patients who are otherwise ready for discharge. The hospital's costs and reimbursement "even out" under the DRG system, but they question why incentives aren't better aligned.
- A State moratorium on the approval of additional skilled nursing facility beds in some communities is resulting in longer hospital stays and inconvenience to patients and caregivers. As in many cases, the efforts of one entity to control costs result in a cost shift to others.
- Patients are frequently transferred from hospitals to specialty acute-care facilities in the late evening or at night. This is less than ideal for patient care, because of staffing levels (i.e. whether the pharmacy is fully staffed, the presence of medical staff) and other factors. Currently, under federal regulations, payments are calculated based on a census of patients at midnight. If the census were conducted at 6 PM, there would be an incentive to transfer patients at a "pro patient" time.
- Community health education and screening programs provided by hospitals are not reimbursed by payers. They are provided as part of charitable mission, but are not acknowledged as value-creators by the payment system.

Of course, the question remains whether we are going to act as a community and nation to address the problem, and how. Look for provocative "straw person" thoughts in future issues.

We need your thoughts as well! Please send them to:
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