Congress Scrutinizes Specialty Hospitals

BY MARY ELLEN SCHNEIDER
Senior Writer

The Medicare Payment Advisory Commission has recommended that Congress extend the moratorium on the development of new physician-owned specialty hospitals, but its chairman urged members of Congress not to close the door on these hospitals before the potential benefits can be fully investigated.

"Frankly, the status quo in our health care system is not great," MedPAC chairman Glenn Hackbarth testified at a hearing of the Senate Finance Committee on specialty hospitals last month. "We've got real quality and cost issues."

MedPAC members are concerned about the potential conflict of interest in physician-owned specialty hospitals, Mr. Hackbarth said, but they are not prepared to recommend outlawing them until they see evidence on whether specialty hospitals offer increased quality of care and efficiency.

'When it comes to physician ownership of specialty hospitals, I'm not sure the playing field is level.'

And policymakers do not yet have the answers to those questions, he said.

Sen. Chuck Grassley (R-Iowa), chairman of the Senate Finance Committee, and Sen. Max Baucus (D-Mont.), the committee's ranking Democrat, are drafting legislation that will set Medicare policy on specialty hospitals.

Sen. Grassley said that he will rely on the MedPAC findings as he drafts the legislation. He is also awaiting the final results of a study on quality of care at specialty hospitals from the Centers for Medicare and Medicaid Services.

Officials at CMS presented preliminary findings from that study at the hearing. CMS was charged under the Medicare Modernization Act of 2003 with examining referral patterns of specialty-hospital physician owners, assessing quality of care and patient satisfaction, and examining differences in the uncompensated care and tax payments between specialty hospitals and community hospitals.

Based on claims analysis, the preliminary results show that quality of care at cardiac hospitals was generally at least as good and in some cases better than the quality of care at community hospitals. Complication and mortality rates were also lower at cardiac specialty hospitals even when adjusted for severity of illness.

However, because of the small number of discharges, a statistically significant assessment could not be made for surgical and orthopedic hospitals, said Thomas A. Gustafson, Ph.D., deputy director of the Center for Medicare Management at CMS.

Patient satisfaction was high at cardiac, surgical, and orthopedic hospitals, Dr. Gustafson said, due to amenities like larger rooms and easy parking, adding that patients had a favorable perception of the clinical quality of care they received at the specialty hospitals.

But Sen. Baucus expressed skepticism about the findings and how the study was conducted. He urged caution in using the results of the CMS study as a basis for policymaking.

In its report to Congress, MedPAC recommended that the moratorium on construction of new specialty hospitals be extended another 18 months—until Jan. 1, 2007.

While MedPAC stopped short of recommending that Congress ban new specialty hospitals, the panel did recommend payment changes that would remove incentives for hospitals to treat healthier but more profitable patients.

First, the panel recommended that the secretary of Health and Human Services refine the current diagnosis-related groups (DRGs) to better capture differences in severity of illness among Medicare patients. The panel also advised the HHS secretary to base the DRG relative weights on the estimated cost of providing care, rather than on charges. And MedPAC recommended that Congress amend the law to allow the HHS secretary to adjust DRG relative weights to account for differences in the prevalence of high-cost outlier cases.

These changes would affect all hospitals that see Medicare patients and increase the accuracy and fairness of payments, Mr. Hackbarth said.

In addition, MedPAC tried to address physicians' concerns that they do not have a say in the management of community hospitals, by recommending that Congress allow the HHS secretary to permit "gainsharing" arrangements between physicians and hospitals.

Gainsharing aligns financial incentives for physicians and hospitals by allowing physicians to share in the cost savings realized from delivering efficient care in the hospital.

But even with these changes, Mr. Hackbarth said MedPAC members still have concerns about the impact of physician ownership on clinical decision making.

And members of the Senate Finance Committee also raised questions about the appropriateness of physician self-referral.

"When it comes to physician ownership of specialty hospitals, I'm not sure the playing field is level," Sen. Baucus said.

Physicians are the ones who choose where patients will receive care, he said. He compared the physician owners of specialty hospitals to coaches who choose the starting lineup for both teams.

Advocates for specialty hospitals, including the American Medical Association and the American Surgical Hospital Association, are lobbying Congress to end the moratorium, saying it will allow competition and won't hurt community hospitals. ■

POLICY & PRACTICE

State Sets COX-2 Restrictions

Louisiana physicians now must document a specific medical need in order to prescribe cyclooxygenase-2 inhibitor (COX-2) drugs to Medicaid patients. Starting last month, Medicaid is filling COX-2 prescriptions only when medical need for these medications over an alternative pain reliever, such as ibuprofen, can be demonstrated. "This is an aggressive, responsible approach to patient safety that will ensure better health outcomes for our Medicaid recipients," Fred Cerise, M.D., secretary of the Louisiana Department of Health and Hospitals, said in a statement. Under the new policy, a Medicaid patient cannot have a prescription for any such drug filled without documented medical justification from the prescriber. Kaiser Permanente recently made a similar move when it placed a 6-month moratorium on the dispensing of valdecoxib (Bextra) because of safety concerns.

Milk's Role in Children's Bone Health

Physical activity and a healthy diet do more to build strong bones in children and young adults than drinking milk does, according to research published in the March issue of Pediatrics. "To build strong bones and healthy bodies, children need exercise, sunshine, and a diet rich in fruits and vegetables that helps them maintain a healthy body weight," Amy Lanou, Ph.D., the lead author of the study and nutrition director of the Physicians Committee for Responsible Medicine, said in a statement. But the analysis was dismissed by the National Dairy Council and the International Dairy Foods Association as "an opinion piece by three representatives of an animal rights organization that has only a 5% physician membership." The groups said the study authors ignored decades of research endorsing dairy's role in bone health. They also pointed to consensus in the scientific and medical community, including the current calcium policy statement of the American Academy of Pediatrics.

Pay-for-Performance Principles

Any pay-for-performance program should offer voluntary physician participation and foster the relationship between physician and patient, the American Medical Association asserted in a new set of principles for such programs. Such programs should also use accurate data and fair reporting, provide program incentives, and ensure quality of care, the AMA stated. If done improperly, "some so-called pay-for-performance programs are a lose-lose proposition for patients and their physicians, with the only benefit accruing to health insurers," AMA Secretary John H. Armstrong, M.D., said in a statement. Both public and private-sector groups have started offering incentive payments to physicians based on performance appraisals. Before taking on such reforms, however, Congress should try to fix Medicare's flawed payment formula, according to recent AMA testimony.

Cost of New Drug Benefit

National health care spending costs will remain stable during the next 10 years, though public programs will account for half of total spending, in part because of the new Medicare Part D prescription drug benefit, according to a report by the Centers for Medicare and Medicaid Services. The agency claims the drug benefit—which kicks in next January—is expected to "significantly" increase prescription drug use and reduce out-of-pocket spending for older patients without causing any major increase in the health care spending trend. However, the new benefit will result in a significant shift in funding from private payers and Medicaid to Medicare. Medicare spending is projected to grow almost 8% in 2004 and 8.5% in 2005, because of several changes in the program under the Medicare Modernization Act, such as positive physician updates and higher Medicare Advantage payment rates.

Clinical Trial Registry Legislation

Sen. Chuck Grassley (R-Iowa) and Sen. Christopher Dodd (D-Conn.) have introduced legislation to require drug makers to register clinical trials about prescription medicines. The bill is similar to legislation Sen. Dodd introduced in the last Congress, but it stipulates that www.clinicaltrials.gov be maintained as a registry for patients and physicians seeking information about ongoing clinical trials for serious or life-threatening diseases and requires the Food and Drug Administration to make internal drug approval and safety reviews publicly available. Pharmaceutical trade groups have already pledged to use a voluntary clinical trials registry and results database by mid-2005.

Views on Physician-Assisted Suicide

More than half of physicians in a national survey say they believe it's ethical to assist a patient in committing suicide. Approximately 57% of the 1,000 physicians surveyed in the national poll said it was ethical, and 39% said it was unethical. In addition, 41% of the physicians surveyed would endorse the legalization of physician-assisted suicide under a wide variety of circumstances, 30% support its legalization in a few cases, and 29% oppose legalizing it in all cases. Although many physicians supported physician-assisted suicide as public policy, the results were mixed when it came to whether they would personally assist a suicide. The survey was conducted by HCD Research, a marketing and communications research company, and the Louis Finkelstein Institute for Religious and Social Studies.

—Mary Ellen Schneider