Alternatives for States to Improve Health Coverage

Some favor a pay-for-performance system, allowing states to get grants based on their measured progress.

BY JENNIFER SILVERMAN
Associate Editor, Practice Trends

WASHINGTON — Rewarding states based on quality is one way to cover more uninsured Americans, Henry J. Aaron said at the annual meeting of the National Governors Association.

Following up on a trend that already has affected the physician community, Mr. Aaron proposed a "pay-for-performance" system, where states could receive federal grants based on their "actual measured progress of increasing the number and proportion of state residents covered by health insurance."

The federal grants would be set to cover much or all of the costs associated with extending coverage.

"Any state that succeeded in boosting a fraction of its population [covered by] health insurance would receive federal support. The states that made no such progress would receive nothing," noted Mr. Aaron, who is a senior fellow for economic studies at the Brookings Institution.

The federal government should first define a standard for health insurance coverage, Mr. Aaron said, suggesting that the minimum be "similar to the actuarial value of the Federal Employees Health Benefits Program."

His plan also would include a "first, do no harm" standard, prohibiting states from materially eroding coverage for the current Medicaid population.

"Even now, Medicaid is substantially less costly than private insurance of the same scope. Still, state costs for long-term care [are] on track to rise relentlessly as baby boomers age."

This means that states need continued financial protection from adverse trends—and not a cap on federal support.

"[States] also need flexibility to modernize Medicaid but within the limits that maintain the per capita protection of the most vulnerable populations in our nation," Mr. Aaron said.

Within these broad guidelines, states should be encouraged to pursue any approach that would increase the proportion of state residents with health insurance coverage, he continued. Depending on local conditions and political preferences, individual states could use refundable tax credits or vouchers to promote individual insurance.

States need 'flexibility to modernize Medicaid but within the limits that maintain the per capita protection of the most vulnerable populations ...'

Individual states could also facilitate new insurance groups by allowing churches, unions, and the like to create association health plans; extend Medicaid or the State Children's Health Insurance Program; impose employer mandates; or try to create an intrastate single-payer plan.

None of these options would be mandatory, he said.

Another panelist, Stuart M. Butler, Ph.D., vice president, domestic and economic policy studies, the Heritage Foundation, Washington, suggested that members of Congress enact a policy "toolbox" that would make a range of ideas available to individual states, on a voluntary basis.

Under such an approach, state lawmakers could propose an initiative for preserving coverage, selecting certain elements from the toolbox, and negotiating with the U.S. Health and Human Services department on appropriate waivers to pull such an option together, Mr. Butler explained.

In an attempt to maintain and extend the functional equivalent of Medicaid during these very tight budget times, states could utilize an enhanced federal refundable tax credit from the policy toolbox, using additional federal funds to create purchasing alliances or pools, Mr. Butler explained.

The real key is to make sure that Medicaid populations are protected, "encouraging innovations through the states [and] rewarding pay-for-performance successes by the states, to reach these goals," he added. ■

Physician-Owned Specialty Hospitals Under Scrutiny

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 recommended payment changes that would remove incentives for hospitals to treat healthier but more profitable patients.

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.

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.

But opponents are asking Congress to close the federal self-referral–law exemption that allows physicians to invest in the "whole hospital" rather than a single department.

Sen. Baucus said that surgical specialty hospitals, which on average have only 14 beds, look more like hospital departments than full-service hospitals. "This loophole may well need closing," he said. ■

NEXT ISSUE

Endometriosis Pain

The FDA has approved subcutaneous nedroxyprogesterone acetate for the treatment of endometriosis-related pelvic pain.

Pages 60a—60b