Specialty Hospitals Getting Mixed Reviews

BY MARY ELLEN SCHNEIDER
Senior Writer

WASHINGTON — Physicians and policy makers are divided on how to level the playing field on physician-owned specialty hospitals.

While the Medicare Payment Advisory Commission (MedPAC) is considering reforms that would eliminate some of the financial incentives to launch specialty hospitals, the American Medical Association in turn wants to preserve the competition that these hospitals provide.

At press time, MedPAC was preparing to vote on draft proposals that would refine the diagnosis-related groups (DRGs) used to determine hospital payments to better account for differences in severity of illness among patients.

MedPAC also is deciding whether to recommend the elimination of the whole hospital exemption for all new hospitals and develop criteria for grandfathering existing ones. If adopted, this would prohibit physicians from referring patients to new hospitals, both single specialty and full-service hospitals, in which they have an ownership stake. And MedPAC commissioners are weighing whether to allow the Department of Health and Human Services to regulate gainsharing arrangements between physicians and hospitals.

Gainsharing has the potential benefit of better aligning hospital and physician financial incentives, but could be structured to have fewer risks than outright physician ownership of hospitals, said Ariel Winter, a MedPAC analyst who presented the draft recommendations to the commission last month.

"My big concerns here are about an unlevel playing field," said MedPAC Chairman Glenn M. Hackbarth.

The challenge for MedPAC is to devise a way to have competition among hospitals under a payment system that is fair to everyone and that benefits patients, Mr. Hackbarth said.

Under the Medicare Modernization Act, the commission was charged with conducting an analysis of cardiac, orthopedic, and surgical specialty hospitals focusing on costs and the payment system. MedPAC is scheduled to issue a report to Congress in March.

The Medicare reform law also placed an 18-month moratorium on the self-referral, "whole hospital" exemption for new specialty hospitals. The moratorium, which is set to expire in June, doesn't include existing hospitals or those under construction. The whole hospital exemption allows physicians to refer patients to a hospital in which they have an investment interest as long as the interest is in the "whole hospital."

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Ralph W. Muller, a MedPAC member and CEO of the University of Pennsylvania Health System, said he wants to see a payment system that will reward hospitals for providing care to the full spectrum of patients, rather than provide incentives for selecting patients whose conditions might be less severe.

But Francis J. Crosson, M.D., a MedPAC member and executive director of the Permanente Federation in Oakland, Calif., said simply removing the whole hospital exemption could potentially eliminate the ability of some physicians to create an environment that fits their practice style.

He suggested that the commission should explore ways to separate the two major motives for physician ownership of hospitals—profits and having a say in hospital governance.

Refinements of the DRG system should be sufficient to curb any cherry-picking of patients, Randolph B. Fenninger, of the American Surgical Hospital Association, told MedPAC members. But he objected to any recommendation to eliminate the whole hospital exemption or continue the current moratorium. Hospital officials have commented that the emergence of specialty hospitals has been a "wake-up call" and caused them to improve services, he said. "To take away the ability of physicians to invest in these hospitals is a call to go back to sleep," Mr. Fenninger said.

Mr. Fenninger added that the grandfathering clause will not work. The investments in specialty hospitals will be rendered valueless very quickly, he said.

A similar debate took place at the AMA's interim meeting in late 2004, when delegates approved a board report encouraging competition among health facilities as a means of promoting high quality, cost-effective care.

Surgical specialties in particular voiced support for the specialty hospitals, while other delegates warned of the repercussions. "These hospitals take highly profitable patients and ship them out of the community hospitals. They don't have to support less profitable areas, such as pediatric units," Daniel Heinemann, M.D., a family physician from South Dakota, said during committee debate.

"They're a threat to our physicians and a threat to hospitals in our state." In addition, "there has not been a huge increase in quality care because of these hospitals."

Russell Kridel, M.D., a delegate from the American Academy of Facial Plastic and Reconstructive Surgery, countered that clinical care would be better off if left to the community hospitals. "Shouldn't we all do what we do best?" he said.

The report also opposed efforts to extend the moratorium. ■

Jennifer Silverman, Associate Editor, Practice Trends, contributed to this report.

Tort Reforms That Go Beyond Caps Backed

BY MARY ELLEN SCHNEIDER
Senior Writer

ALEXANDRIA, VA. — Traditional tort reform measures like damage caps won't address some of the fundamental problems with the medical liability system, experts said at a meeting on patient safety and medical liability sponsored by the Joint Commission on Accreditation of Healthcare Organizations.

To deal with the current malpractice situation, the medical community needs to address the reasons why people sue—injuries, unmet expenses, and anger, said Lucian L. Leape, M.D., of the department of health policy and management at the Harvard School of Public Health, Boston.

"The main reason most people sue is because they are angry at the physician," Dr. Leape said.

But the current system and the most commonly proposed reforms, such as damage caps, don't address the need to increase disclosure of errors to patients or incentivize physicians to offer apologies, he said.

In the current tort system, filing a lawsuit is often the only way that patients feel they can get information about what happened to them or impose a penalty on the physician, said Michelle Mello, Ph.D., also of the department of health policy and management at the Harvard School of Public Health. But this process often fails to secure an admission of responsibility or an apology, she said.

Traditional reforms such as caps would undercompensate seriously injured patients and increase administrative costs, Dr. Mello said. But they would not help deter medical malpractice, she said.

Damage caps also fail to address the poor correlation between medical injury and malpractice claims, she said. Instead of focusing on caps, the medical community needs to consider an administrative compensation system to replace torts.

The malpractice system is "blocking efforts at patient safety," said Troyen A. Brennan, M.D., professor of medicine at Harvard Medical School, Boston, and professor of law and public health at the Harvard School of Public Health.

A new system should be established to separate compensation for injuries from deterrence, he said. In order to do that, liability for negligence has to be eliminated, and reporting has to be made based on patient injury.

"You have to enable open and honest reporting," Dr. Brennan said.

And physicians have to realize that reporting patient injury is part of their professional responsibility, he said.

Currently, some physicians do not disclose errors or injuries. It's a rational economic response to their rising premiums and fear of being sued, he said, but it's not an ethical response. ■