IMPLEMENTING HEALTH REFORM

The Ban on Physician-Owned Specialty Hospitals

The criticisms of physician-owned specialty hospitals are chiefly that they receive the same tax breaks and insurance payments as do traditional hospitals, but don't provide the same breadth of care (no labor and delivery, no emergency care), and that they are rife with conflicts of interest. Periodically, the federal government has imposed moratoriums on physician ownership, but even so, the number of facilities has grown. Now, a provision of the Affordable Care Act bans the construction of new physician-owned hospitals that do not receive Medicare certification before Dec. 31; existing physician-owned facilities have been prohibited from expanding since the law was enacted on March 23.

Dr. Jack Lewin, CEO of the American College of Cardiology, talks about the upcoming ban on physician-owned specialty hospitals.

OB.GYN. NEWS: What finally moved Congress to approve permanent restrictions on physician ownership?

DR. LEWIN: Strong opposition from hospitals was very effective in protecting their interest. There are legitimate concerns related to specialty hospitals in some communities – for example, where services for low-income patients may be jeopardized by the shifting of high-revenue patients from public and community hospitals to specialty hospitals. This is certainly not a phenomenon everywhere specialty hospitals exist. The contrary position is that specialty hospitals provide services at a higher quality and a competitive cost, which benefit patients. If legitimate problems were caused by the introduction of a hospital into a community, it would be better to address the concern in approving the new facility rather than to create an outright ban, which is all too often simply an anticompetitive effort of the existing traditional hospital.

OB.GYN. NEWS: Critics claim improper referrals and higher procedure rates among their reasons to ban physician-owned hospitals. The ACC is against a ban. What is the argument for physician ownership?

DR. LEWIN: The ACC supports a policy that promotes better medical and clinical quality outcomes and patient satisfaction. There are a number of ways to protect against physician self-interest, self-referral, and overuse of services. The use of ACC registries could readily identify such problems. In many instances, physician investors in these facilities are limited to less than 1% of overall ownership. It is hard to argue that this in itself is an unfair self-interest, in particular when there is no source of funding available to improve the situation in communities where operating rooms are overbooked, understaffed, and ill equipped. In other words, the ACC supports assurances that physician self-interest is not the key factor behind a specialty hospital, but rather that the central issues are the best interests of the patient and community, and the quality of care.

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DR. LEWIN

OB.GYN. NEWS: How can physicians ensure that appropriate and high-quality care is being delivered at specialty hospitals?

DR. LEWIN: More than 2,400 hospitals participate in the ACC's NCDR (National Cardiovascular Data Registry) programs, but by using just a few specialty-hospital registries, we could provide objective feedback and comparisons based on clinical data, rather than on claims data that insurance companies and the government use. Our registries provide most of the U.S. hospitals that offer cardiac care access to data and feedback on quality outcomes, system problems, and rates of complications. If specialty hospitals were required to participate in these registries, most of the concerns could be mediated.

OB.GYN. NEWS: Does the ACC support legal challenges to the coming ban on physician ownership?

DR. LEWIN: The ACC believes that the ban should be lifted and replaced with thoughtful policies that allow for specialty hospitals to improve access, quality, patient satisfaction, and efficiency. These policies could address concerns about self-referral, self-interest, or adverse impacts on other needed community-based hospital services.

OB.GYN. NEWS: What would the ACC propose as an alternative to the ban?

DR. LEWIN: The ban notwithstanding, the way care is provided in the United States will change due to public and market pressures. Community hospitals will continue to need to provide emergency surgeries, general intensive care, and other services as currently provided in the traditional model, but the ACC believes that the best care and services will evolve into specialty units that focus on increased volume and increased quality in cardiology, orthopedics, gynecology, trauma, neurosciences, oncology, and other specialized areas. This will include pediatric as well as inpatient services. If we are serious about promoting the best outcomes, best quality, and patient and physician satisfaction, then this is where we are headed, regardless of the politically inspired ban. ■

DR. LEWIN is CEO of the American College of Cardiology.

POLICY & PRACTICE

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Mortality Trends Diverge

While pregnancy-related deaths dropped around the world, the official number increased early in this decade among U.S. women, according to two reports. Worldwide pregnancy-related deaths dropped by a third during 1990-2008, from 546,000 to 358,000, according to the latest maternal mortality report from the United Nations and the World Bank. "Countries where women are facing a high risk of death during pregnancy or childbirth are taking measures that are proving effective; they are training more midwives, and strengthening hospitals and health [centers] to assist pregnant women," Dr. Margaret Chan, Director-General of the U.N.'s World Health Organization, said in a statement. In the United States, increased reporting of pregnancy deaths put the number of women dying of maternal causes at 495 in 2003 and 540 in 2004, the Centers for Disease Control and Prevention reported. The U.S. figures translate to 12 deaths per 100,000 live births in 2003 and 13 deaths per 100,000 in 2004. In contrast, the worldwide report said that the 2008 rate of maternal death was 290 per 100,000 live births in developing parts of the world. The U.S. increase "largely reflects the use by an increasing number of states of a separate item on the death certificate indicating pregnancy status of the decedent," according to the CDC report. It acknowledged that an increasing number of cesarean sections and maternal obesity could be partly to blame.

Pregnancy Prevention Funded

The Department of Health and Human Services has granted $155 million to states, nonprofit organizations, schools, and universities to support teen pregnancy prevention programs that have been tested and proved effective, the agency said. "This investment will help bring evidence-based initiatives to more communities across the country while also testing new approaches so we can expand our toolkit of effective interventions," HHS Secretary Kathleen Sebelius said in a statement. About $100 million will come from the existing Teen Pregnancy Prevention program, and the rest is from the new Affordable Care Act and the Personal Responsibility Education Program it created.

Planned Parenthood Case Moves On

A criminal case against a Kansas City, Kan., Planned Parenthood clinic is moving forward, after the state's Supreme Court refused to dismiss charges that the clinic conducted illegal late-term abortions and falsified records. The criminal complaint, filed in 2007 by the state's district attorney, includes 23 felonies and 84 misdemeanors, the Kansas City Star reported. The clinic is alleged to have done late-term abortions without finding that they were medically necessary. Planned Parenthood has denied all charges. The district attorney at the time, Phill Kline, had earlier as the state's attorney general launched an investigation into Wichita abortion provider Dr. George Tiller as well as the Kansas City Planned Parenthood clinic. Dr. Tiller went on trial in March 2009 and was acquitted of all charges. He was shot to death 2 months later by an antiabortion activist.

Productivity, Ownership Linked

Billable work per patient appears to be increasing only at physician groups under the "private practice model," but expenses have also grown, according to a Medical Group Management Association study. Over the past 5 years, relative value units per patient rose by 13% at private medical practices but declined nearly 18% at practices owned by hospitals or integrated delivery systems, analysts found. Meanwhile, operating costs for private practices increased by nearly 2% last year, in contrast to a slight decline for practices owned by the larger entities. MGMA attributed part of the increase in expenses for private practices to the cost of implementing electronic health record systems. "In the private practice model, EHR incentives have provided a catalyst for practices to purchase systems and deploy electronic health records, therefore increasing the practice's information technology expenditures," Kenneth Hertz, a principal with MGMA Health Care Consulting Group, said in a statement.

Nursing Expansion Called For

Nurses' roles and responsibilities should change significantly to meet the increased demand for care created by health care reform, according to an Institute of Medicine report that immediately drew criticism from the American Medical Association. The report urged removal of regulatory and institutional obstacles to nurses taking on additional patient-care duties. To handle these new responsibilities, nurses should receive higher levels of training through an improved education system, including a new residency program and additional opportunities for lifelong learning, the institute report said. The AMA took issue with the report's call to expand nurses' scope of practice, saying that nurse practitioners don't have nearly the amount of training and clinical experience that doctors do. "With a shortage of both nurses and physicians, increasing the responsibility of nurses is not the answer to the physician shortage," AMA board member Dr. Rebecca J. Patchin said in a statement.

—Naseem S. Miller