Specialty Hospitals Face Congressional Scrutiny

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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.

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 policy making.

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 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. ■

POLICY & PRACTICE

Tweaking the Geographic Adjusters

Medicare's geographic adjusters for setting physician fees are valid in their fundamental design, but their methods need refinement, the Government Accountability Office reported. Geographic practice cost indices (GPCIs) are used to raise or lower Medicare physician fees depending on whether local practice costs are above or below the national average. They are based on physician work, practice, and malpractice expenses. The adjusters play a useful role by protect physicianing fees in low-cost areas from dropping to levels that could be considered unfair relative to fees in high-cost areas. On the other hand, the wage data used are not current, and the malpractice data used are incomplete, GAO said. The adjusters also seem to have little bearing on whether physicians decide to locate in rural areas, as factors other than a paycheck come into play.

'Rent-A-Patient' Fraud

Hundreds of patients from across the country had unnecessary and sometimes dangerous surgical procedures that led to the submission of tens of millions of dollars in fraudulent medical claims, according to a $30 million lawsuit filed by 12 Blue Cross and Blue Shield Plans. The suit was filed against nine California-based outpatient surgery clinics, seven medical management companies, and 34 individuals, in a Los Angeles federal district court. The Blues Plans allege that paid recruiters enlisted patients to travel to the surgical centers and undergo "needless and sometimes hazardous" surgical procedures and treatments. In return, the patients received cash payments or cosmetic surgery, and the providers submitted fraudulent insurance claims. These "rent-a-patient" tactics have resulted in significant financial losses to insurers and employee benefit plans since 1999, according to the suit.

A Plan to Reform Medicaid

Governors were unable to reach a consensus with lawmakers on Medicaid reform at their annual meeting, but they're pushing their own plan to modernize the program. In the report, "Medicaid in 2005: Principles and Proposals for Reform," the National Governors Association recommended simplifying state plan and waiver standards and processing requirements, and allowing states to adopt policies that encourage Medicaid beneficiaries to direct their own care and share in any associated cost savings. Medicaid should also update its formula for calculating state-specific federal matching rates, while Medicare law should be amended so the federal government assumes specific responsibility for low-income Medicare-Medicaid dual eligibles, the governors said.

Discount Cards: Not Created Equal

Some discount medical cards provide value, but others have serious drawbacks such as high-pressure sales tactics, exaggerated claims of savings, inaccurate promotions, or difficulty finding participating physicians, a survey by the Commonwealth Fund concluded. The cards promise discounts for a wide range of providers, including physicians and hospitals, as well as for lab work, surgical procedures and other services. Some discount card firm are seeking to reform the market through a trade association and voluntary code of conduct. But the cards aren't regulated, so "legislative action is needed that gives state insurance departments the authority and resources to have direct oversight of the discount medical card industry," the survey authors said. Researchers tested 5 of 27 cards advertised in the Washington, D.C. area by undergoing the application process, seeking health care services from participating providers, then canceling the cards.

Conflict-of-Interest Rules Targeted

People with direct financial conflicts of interest should not be put on Food and Drug Administration advisory committees, a coalition of public interest groups has recommended. Financial conflicts undermine "the public's faith in the fairness and credibility of the panel's work," the Center for Science in the Public Interest, the National Women's Health Network, the U.S. Cochrane Center Consumer Coalition, and eight other groups said in a letter to Acting FDA Commissioner Lester Crawford, D.V.M., Ph.D. The groups cited the FDA advisory committee that recently reviewed the safety of cyclooxygenase-2 inhibitors, noting that 10 of the 32 members had direct financial conflicts. In addition to prohibiting scientists, physicians, and clinicians with relevant conflicts of interest from serving on advisory committees, the groups also recommended that people with any industry ties make up no more than half of a committee.

Assault on Salt?

The federal government's refusal to reveal data that it used to develop its recommendation to reduce salt intake with the goal of preventing strokes has drawn fire from the salt industry. The Salt Institute, representing salt manufacturers, sued the Department of Health and Human Services, claiming HHS refused to release the studies supporting its 2002 recommendation that Americans cut salt intake as a way to avoid hypertension and stroke. The failure to release the information was a violation of the federal Information Quality Act, the suit alleges. Under the act, parties who feel that the government is withholding information have the right to appeal to the agency in question; the institute, along with the U.S. Chamber of Commerce, did just that, but the appeal was denied. HHS says the suit is not valid because there is no provision in the act for a judicial review of a denied appeal; the court agreed and dismissed the suit. The chamber and the institute are appealing that decision.

—Jennifer Silverman

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