Hospice Costs Rise Amidst For-Profit Providers

BY ALICIA AULT
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WASHINGTON — Staggering growth in the popularity of hospice services—and in the rise of for-profit hospice providers—has caught the attention of the Medicare Payment Assessment Commission.

At their recent meeting, MedPAC commissioners debated the potential impact of rising hospice costs on the Medicare program. The hospice benefit began in 1983 with the idea that it would cost Medicare less to provide hospice than conventional end-of-life treatment, which is usually delivered in the hospital, said MedPAC staff member James Mathews, Ph.D.

But there is some evidence indicating that hospice use may actually result in higher spending, said Dr. Mathews.

According to MedPAC's analysis of Medicare claims data, hospice spending tripled from 2000 to 2007, when Medicare spent $10 billion on hospice services. The mean length of hospice stay increased 30% from 2000 to 2005. It's not clear why length of stay is increasing, although data have shown that some illnesses—such as Alzheimer's disease and ischemic heart disease—tend to result in longer stays, said Dr. Mathews.

One explanation may be that hospice care tends to be more expensive at the beginning and the end of the service; interim days are more profitable, so there is an incentive to lengthen stay, he said.

But it appears that much of the growth in costs and length of stay is due to the huge increase in for-profit hospice facilities in the market. From 2000 to 2007, very few nonprofit hospices entered the market, while the for-profit sector grew 12% a year, Dr. Mathews said. There were a little more than 1,600 for-profit hospices in 2007, compared with about 1,200 nonprofit and 400 government-run facilities, according to the MedPAC analysis.

In addition, the analysis determined that profit margins are also much higher at for-profit hospice facilities. In 2005, the last year in the analysis, for-profit margins were about 12%, while nonprofits had negative margins. MedPAC also found that hospices that entered the market since 2000 had higher margins—and these were mostly for-profit operations.

Some hospices, only about 9%, are subject to a cap that limits the length of stay, but even those facilities have found a way to profit from Medicare, said Dr. Mathews.

"Clearly, people see an opportunity—a financial opportunity—here," commented MedPAC chairman Glenn Hackbarth, a health care consultant based in Bend, Ore. He said that the commission needed to find a way to keep the hospice program from spiraling out of control.

Commissioner Jack Ebeler suggested that Medicare "may need blunter instruments for slowing the growth," but also added that the health program should not do anything to lose "an extraordinarily valuable benefit."

MedPAC vice chairman Robert Reischauer, Ph.D., suggested that Medicare payment could be refined to buy more appropriate care. "It strikes me that there's probably an easy way to do this," said Dr. Reischauer, who is also president of the Urban Institute. ■

LAW & MEDICINE

Expert Witnesses Under Fire

BY MILES J. ZAREMSKI, J.D.

The notion of peer review typically arises in the context of an academic paper being reviewed by an author's colleagues—sitting as his or her peers—to determine whether the paper is of publishable quality. Another example would be a summer art show or fair, where artists tender their works to juries of suitably qualified experts. The notion of peer review has even been carried over to the presidential race, where pundits and participants are discussing the role and purpose of "superdelegates" in determining who the candidates will be for the general election.

The concept of peer review is equally if not more significant in the world of health care, where medical care and treatment, typically in a hospital setting, are the subjects of review by those who sit on what are known as peer review committees. Sometimes, however, peer review in the health care setting is abused and warped to a degree never envisioned by legislators who enacted such legislation.

Two examples of this phenomenon, now percolating their way through state legal systems, warrant attention. They are *Joseph Kamelgard, M.D. v. the American College of Surgeons* (Circuit Court of Cook County, Ill.), and *Charles Yancey, M.D. v. American Academy of Ophthalmology, et al.* (4th Judicial District., Hennepin County, Minn.).

In the Kamelgard case, Dr. Kamelgard, a well-regarded bariatric surgeon from New Jersey, testified as a medical expert for the very first time in a medical malpractice lawsuit litigated in federal court in Brooklyn, N.Y. The plaintiff was a resident of New York and was cared for at a hospital in Staten Island. The defendant was a physician who, according to court records, had been named previously in multiple professional liability cases. The jury decided in favor of the defendant physician.

The defendant physician never challenged the testimony Dr. Kamelgard gave in court. But later, the defendant filed a complaint with the American College of Surgeons (ACS), accusing Dr. Kamelgard of allegedly testifying falsely regarding relevant standards of care and his knowledge of them. Following an extensive investigation over several months, the ACS decided to charge Dr. Kamelgard with violating its rules in this regard. Shortly before a hearing on the charges was scheduled to proceed, lawyers intervened on Dr. Kamelgard's behalf. Weeks later—but still before damages had been sustained by Dr. Kamelgard—the ACS dropped the case; no explanation was ever given.

What is disturbing about this is that, despite Dr. Kamelgard's requests, the ACS refused to provide him with a copy of the complaint lodged against him, the identity of his accuser, or even the names of the three members of the ACS deemed qualified as bariatric surgeons to review the complaint and present their findings to the college, which then charged Dr. Kamelgard with violating ACS rules.

Dr. Kamelgard filed a petition seeking the identities of these three members. The ACS responded by asserting that what was being sought was protected by the state's Medical Studies Act (MSA), its peer review statute.

According to court filings, the ACS admitted that no practice of medicine occurred in Illinois, that testifying equates to the practice of medicine, and that by testifying there Kamelgard practiced medicine in New York (though New York's statute defining medical practice does not include testifying). But even though he was not licensed in Illinois and had no connection to the state except belonging to the ACS headquartered there, the ACS wrote while the MSA is not a negotiated or bargained-for term when a physician joins it as a member, when any member does become a member, he or she agrees to be bound by Illinois law, including the application of the MSA. ACS also asserts that it only needs to show it is headquartered in Illinois before using the MSA. The ACS has over 74,000 members worldwide, so it suggests by this case that Illinois law governs its conduct.

In the Minnesota case, Dr. Yancey sued a Dr. Weis, and his expert, a Dr. Hardten, for defamation as a result of their filing an ethics complaint against him with the American Academy of Ophthalmology (AAO). At the time the ethics charge was filed, a malpractice case was ongoing in which Yancey was the expert medical witness for the plaintiff, with Weis as a defendant. Yancey also asserted the AAO violated its own rules when it handled the complaint lodged against him, including not keeping the matter confidential.

Initially, a jury had returned a verdict for $3 million in favor of the plaintiff. The case was going to be retried on damages with Yancey again offering testimony; however, a day before this was to occur, the AAO served on him the ethics charge Weis and Hardten had filed. The underlying malpractice case was, as with Kamelgard, the first lawsuit in which Yancey ever testified as a medical expert.

According to his lawyer, Yancey claimed the ethics charge was an attempt to force him to alter his testimony in the underlying case, and thereafter chill his ability to testify in other, subsequent cases that may have come his way. The defendants moved to dismiss Yancey's complaint and, in the alternative, for the summary judgment.

In the Kamelgard case, which is pending in Illinois but now on appeal, it remains to be seen whether an Illinois court will opine on how the ACS believes the Illinois statute should be used. The Yancey case is also still pending.

It is well recognized that state peer review statutes—each state and the District of Columbia have one—were put in force with the ultimate purpose of maintaining and improving quality health care within a state. This purpose is achieved by keeping privileged from discovery the products of a peer review committee. (The exception to this is when certain cases are litigated in federal court.)

However, the Yancey and Kamelgard cases show there is an attempt to redefine peer review statutes to include judging expert testimony within the practice of medicine. Such statutes were also not intended to apply solely because an organization is headquartered in a particular state without any health care rendered there, or to chill an expert from further testifying during the course of a legal proceeding.

At the same time, these cases demonstrate a penchant among professional medical organizations to muzzle health care providers from testifying to other than what these entities believe is appropriate.

Granted, there are those among the physician ranks who don't belong in a courtroom offering expert testimony. However, the Kamelgard and Yancey cases are examples of the Damoclean swords professional societies may now think they can wield in order to prevent physicians from offering legitimate expert medical testimony.

If you are a physician wishing to consult or testify, don't be dissuaded from doing so—as long as you review all medical records properly and thoroughly, you are well credentialed, and you are familiar with all applicable medical standards by way of background, experience, and training. In addition, consult not only with your own organizations as to their standards and policies on testifying, but enquire of the lawyer who retains you as to what your state law requires of experts who testify in legal cases. ■

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