Hospitals Look to Physicians As Partners, Not Employees

BY JOEL B. FINKELSTEIN
Contributing Writer

WASHINGTON — Hospitals are getting smart instead of angry about competition from physicians.

"A lot of care is moving from the hospital to the ambulatory sector, some of which is still under the auspices of the hospital, but increasingly into doctor's offices, into physician-owned ambulatory surgery centers, imaging centers, testing facilities," Dr. Robert Berenson, a senior fellow at the Washington-based think tank of the Urban Institute, said at a press briefing on health care costs sponsored by the Center for Studying Health System Change.

Physicians often set up these centers in part out of frustration with hospital bureaucracy, but also in response to economic pressures, said Adam Feinstein, a managing director at Lehman Brothers where he coordinates the health care facilities research team.

"Physician incomes have been going down. They have been looking to make up for the lost income, and they're competing more aggressively with the hospitals," he said.

Over the past 10 years, the number of ambulatory surgery centers has doubled to approximately 5,000. There are now almost as many surgery centers as there are hospitals in the country. By comparison, there are only about 100 specialty hospitals in the United States, despite all the political attention they get.

Jeff Schaub, who rates acute care hospitals for the international credit rating firm Fitch Ratings, pointed out that when hospital leadership does not focus on "what their physicians are doing and want to do, we have seen dozens of places have their outpatient surgery volumes cut in half because docs have gone out and put up buildings."

To counteract such trends, "what we have seen over the last 5-8 years is tremendous interest on the part of hospitals and systems to do joint ventures with physicians, figuring that they would rather lose half the business than all of it," he said.

Alternatively, some hospitals have tried to integrate physicians into more of the business decisions, hoping to create a more comfortable environment for them to work and minimizing their desire to go off on their own, Mr. Schaub said.

"It is really interesting how things come full circle," said Mr. Feinstein. "Hospitals were letting doctors partner with them back in the mid-1990s, there was a lot of scrutiny over this so everyone stopped doing it, and now here we are again and everyone is doing it."

There are similarities, but some important differences this time around, Mr. Schaub said.

"In the 1990s, everybody was buying practices just because everybody else was buying practices. Now what I see is a much more strategic focus, whether it's service-line related or to head off entrepreneurs splitting off or to focus on a particular geography, hospitals in a lot of markets are being more selective than they were 10 years ago," he said. ■

Most Medicare Part D Plans Cover Common Medications

BY JANE ANDERSON
Contributing Writer

Although formularies under Medicare Part D plans vary widely, nearly all plans cover at least one brand-name drug in many commonly prescribed treatment classes, according to research published in the Journal of the American Medical Association.

The researchers, who looked at Part D plans in California, studied eight treatment classes, including angiotensin-converting enzyme inhibitors, angiotensin II receptor blockers, β-blockers, calcium channel blockers, loop diuretics, selective serotonin reuptake inhibitors, statins, and thiazide diuretics. They looked at how often drugs were included in at least 90% of formularies at copayments of $35 or less without prior authorization.

"Providers can have a difficult time knowing which drug is paid for by Medicare Part D because there are over 1,800 plans and there's a great deal of variation among these formularies," Dr. Chien-Wen Tseng, a researcher at the University of Hawaii and the Pacific Health Research Institute, said in an interview.

But "despite the large number of plans and variation among their formularies, for most of the treatment classes we examined we found one or more drugs that were covered by nearly 100% of Part D formularies," Dr. Tseng said.

Nearly all of these widely covered drugs are generics, according to the study, which also noted that the drugs covered by Part D formularies are likely to change over time as generics become available and as new clinical data are released (JAMA 2007;297:2596-602).

For example, simvastatin (Zocor) and sertraline (Zoloft) became available as generics in 2006. Earlier that year, 71% of formularies had covered simvastatin as a brand name, while 74% covered sertraline as a brand name. But by Dec. 8, 2006, after both drugs had generic equivalents, the study authors found that 93% of the formularies examined covered simvastatin as a generic, while 100% covered sertraline as a generic.

Dr. Tseng said that a Web site that tracks the list of these "widely covered" drugs potentially could help physicians determine which drugs are most likely to be covered and therefore more affordable for patients.

"While the large number of formularies and variation among these formularies is an inconvenience for doctors, it's a real health problem for patients because they may not get the drug they need if it's not covered or too expensive," he said. ■

Mohs Exemption May Go

Medicare *from page 1*

"We really do have some bipartisan support and interest," Dr. Elston said.

By law, CMS officials must adjust physician payments according to the sustainable growth rate (SGR) formula, which calculates physician payments based in part on the gross domestic product.

At press time, bills were being considered in both the House and the Senate to replace the SGR, which physicians consider to be a flawed payment formula that does not adequately account for rising practice costs. The bills would also assure a small positive payment update for the next 2 years, Dr. Elston said.

There is other bad news for dermatologists. It is likely that CMS will eliminate the multiple surgery reduction exemption for Mohs surgery codes. CMS dropped the exemption for Mohs surgery codes back in January and then reinstated it due to objections from medical specialty societies that they were not given a chance to comment on the change.

Loss of the exemption is likely to occur next year and begin to impact Medicare payments in January.

Under the multiple surgery reduction policy, payment for subsequent surgical procedures performed during the same operative session by the same physician is reduced by 50%. This policy would be applied to CPT codes 17311 through 17315, according to the CMS proposed rule. The proposal was expected after the American Medical Association's Specialty Society Relative Value Scale Update Committee (RUC) recommended that Mohs surgery codes not be exempt from the multiple surgery reduction rule.

The action is disappointing but expected, said Dr. Brett Coldiron, clinical assistant professor of dermatology at the University of Cincinnati and the chairman of the AAD's Health Care Finance Committee. "It's counterproductive and disrupts patient care," he said.

Dr. Coldiron encouraged dermatologists to contact CMS and their members of Congress about the need to keep the exemption in place permanently.

The proposed rule also addresses future changes to the voluntary Physician Quality Reporting Initiative (PQRI) that was launched by CMS on July 1. The PQRI program gives physicians a chance to earn up to a 1.5% bonus payment on all of their allowed Medicare charges if they report on certain quality indicators. CMS officials have touted the program as the first step in aligning payments with quality. In its first phase, it is slated to run from July 1 through Dec. 31, 2007.

The proposed rule addresses the continuance of PQRI next year, and outlines new quality measures.

CMS officials are also considering the feasibility of accepting clinical data from electronic health records. The agency will weigh whether to accept data on a limited number of ambulatory care PQRI measures for which data may also be submitted under the current Doctors Office Quality Information Technology Project (DOQ-IT).

The proposed rule also outlines ways the agency would like to test the use of clinical data registries to report PQRI data. The testing, which would begin in 2008, would evaluate methods for physicians to report data to clinical data registries and the registries to submit the data on the physician's behalf to CMS.

For example, the Society of Thoracic Surgeons has a national database registry that collects quality data on cardiac surgeries, including two PQRI quality measures. However, under the current setup for 2007 and 2008, physicians must report these measures separately to CMS through the claims-based reporting process.

CMS officials are proposing to fund the bonus payments for the 2008 PQRI program by using $1.35 billion provided by Congress as part of the Physician Assistance and Quality Initiative Fund. In the proposed rule, CMS stated that the bonus payments were likely to be about 1.5% of allowed Medicare charges, not to exceed 2%.

That decision was criticized by the American Medical Association, which said the $1.35 billion should be used to reduce the projected 2008 physician pay cut.

CMS estimates the $1.35 billion would reduce the projected cut by about 2%.

"The AMA and 85 other physician and health professional organizations sent a letter strongly urging the Administration to use this money to help Medicare physician payments keep pace with increases in practice costs. The Medicare Payment Advisory Commission made a similar recommendation," Dr. Cecil B. Wilson, AMA board member, said in a statement. "CMS has chosen to spend all of the money to provide just 1.5% to 2% to physicians who report on certain quality measures."

The proposed rule also made a number of other policy changes including revising the methodology used to determine the average sales price for Part B drugs purchased in bundling arrangements.

CMS is proposing to require drug manufacturers to report price concessions proportionately to the dollar value of the units of each drug sold under the bundling arrangement. The aim is to ensure that the average sales price better reflects the true costs paid by physicians when purchasing drugs, according to CMS. ■