MedPAC Votes to Extend Specialty Hospital Moratorium

BY JENNIFER SILVERMAN
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WASHINGTON — Congress should extend the Medicare Modernization Act's moratorium on the construction of physician-owned specialty hospitals for another 18 months, a federal advisory panel has recommended.

The Medicare Payment Advisory Commission in draft recommendations had set the extension for 1 year, but later changed it to 18 months after commission members decided that more time was needed to study the full impact of these hospitals, often deemed as "cream skimmers" for attracting more profitable patients away from community hospitals.

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MedPAC data indicate that specialty hospitals tend to concentrate on certain diagnosis-related groups (DRGs), treating relatively lower-severity patients within them, and lower shares of Medicaid patients. So far, they've had little financial impact on community hospitals, MedPAC analysts claim.

Commissioners at a recent meeting decided to forgo tougher language that would have eliminated the "whole hospital" exemption, a provision in the self-referral regulations that allows physicians to refer patients to a hospital in which they have an investment interest as long as the interest is in the entire hospital.

Eliminating the exemption "is not the right step to take at this time due to the limited amount of data we have at this point on specialty hospitals and their performance," MedPAC chairman Glenn Hackbarth said.

To date, there's only a small sample of institutions to work on, and "we don't have a strong analytic foundation [on which] to base efficiency. With regard to quality, we haven't looked at that at all," he said. MedPAC should readdress the issue in the future, however, "so that we could craft rules to get us the best competition without compromising clinical judgment," Mr. Hackbarth said.

Existing specialty hospitals and hospitals under development were still eligible for the whole hospital exemption under the 2003 Medicare reform law, but new hospitals were not, effectively placing a moratorium on their construction.

The original moratorium, set to expire in June, would effectively go on until Jan. 1, 2007, if MedPAC's recommendation were adopted.

In a statement, Rick Pollack, executive vice president of the American Hospital Association, commended MedPAC for extending the moratorium. "This decision sends an important message to Congress that physician ownership and self-referral can cause serious conflict of interest concerns," he said.

In other recommendations slated for MedPAC's upcoming report to Congress, commissioners voted on several measures to refine the DRGs used to determine hospital payments to better account for differences in severity of illness among patients:

- The Department of Health and Human Services should base the DRG relative weights on the estimated cost of providing care rather than on charges, and on the national average of hospitals' relative values in each DRG.
- Congress should amend the law to give the Department of Health and Human Services secretary authority to adjust the DRG relative weights to account for differences in the prevalence of high-cost outlier cases. In addition, case-mix measurement and outlier policies should be developed over a transitional period.
- HHS should also have the authority to regulate gainsharing arrangements between physicians and hospitals so that quality of care is protected and financial incentives that could affect physician referrals are minimized. ■

Analgesia Prescribing Errors Seen In Half of Pediatric Discharges

BY SHERRY BOSCHERT
San Francisco Bureau

SAN FRANCISCO — Half of 83 prescriptions for analgesics written for 77 children being sent home from the hospital contained one or more errors, including 2 prescriptions with errors that could have significantly harmed the patients, Benjamin H. Lee, M.D., said at the annual meeting of the American Academy of Pediatrics.

Unbeknownst to the primary medical or surgical physicians who wrote the discharge analgesic prescriptions, investigators from the Johns Hopkins Medical Institutions' (Baltimore) pediatric pain service secretly monitored the prescriptions during the study and rewrote any they considered dangerous, so no children were harmed, said Dr. Lee of Johns Hopkins.

"We were surprised at this potential adverse drug event rate of 2.4%. That's not insignificant in this small patient series," he said, adding, "I don't think this is something that's limited to Johns Hopkins Hospital."

Discharge time is a vulnerable period for inpatients, who lose the safety net of pharmacists, nurses, and multiple physicians who look at medication orders while the patient is hospitalized, he explained. When the patient is sent home with analgesics, a single physician writes the prescription and the discharge orders, which are reviewed usually by a single nurse, with no pharmacists or other providers involved.

The two dangerous prescriptions in the study were for opioids. One included a 10-fold overdose error. The other included instructions for a long-acting medication that could lead a patient to take multiple doses all at once. All patients got prescriptions for opioids at discharge, and 7% also received NSAIDs.

Most of the prescription errors were not clinically significant; the study used a strict definition of error. The two most common causes of errors, however, illustrate problems that could lead to patient harm: a lack of any identification of weight or weight-based dosing in the prescription, and incomplete information about dispensing of the medication.

For patients weighing less than 40 kg, no weight was recorded on 45% of analgesic prescriptions. Investigators found discrepancies between the written prescriptions and the discharge data form in 10% of cases. Physicians wrote an incorrect name or patient identifier in 4% of analgesia prescriptions.

A separate study is underway to see if using a computerized prescription-writing program that includes weight-based dosing for pediatric patients will reduce errors and improve patient safety, Dr. Lee said.

The current results echo those of a similar study by Dr. Lee and his associates of errors in 122 prescriptions written for 75 patients in the hospital's day surgery unit, which included mostly adults, with some pediatric patients. They found an error rate of 57% including potentially dangerous errors in 2.5%.

"If this is happening at a tertiary-care hospital with a lot of oversight, with providers who are very comfortable taking care of critically ill patients, this is probably a phenomenon that extends to other institutions and other settings," Dr. Lee said. ■

Full-Time Work No Protection From Accruing Medical Debt

BY JOYCE FRIEDEN
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WASHINGTON — Medical debt is more common among families with full-time workers than among families whose members work part-time, according to University of Iowa researchers at the annual meeting of the American Public Health Association.

"Medical debt can result in credit problems and force people to file for bankruptcy," said Matthew Levi, a graduate research assistant in the department of community and behavioral health at the university. "These problems can be worsened if an individual stops going in for care and using prescription drugs because untreated problems can prevent a person from returning to work. People with medical debt also report increased levels of stress and anxiety."

The researchers looked at Urban Institute data from interviews with more than 1,400 residents, some done in person and some by phone. Subjects were located either in low-income areas of Des Moines or in surrounding Polk County.

More than one-third of households with children reported medical debt—but without correlation to the child's health status.

Data came primarily from a single question in the survey asking whether the subject or their spouse was paying off any medical debt, although a few other responses also were included.

Surprisingly, people with full-time jobs were more likely to report medical debt, said Anne Wallis, Ph.D., of the department of community and behavioral health at the university. "We suspect this reflects having full-time employment, but without health insurance, or with inadequate health insurance."

Families with private health insurance were more likely to report medical debt than families without such insurance. However, this result may have been due to the way data were collected, since Medicaid data were reported separately. "So [it may just show] that families with private health insurance are not adequately insured," Dr. Wallis said.

Another surprising finding had to do with the household incomes of people reporting medical debt. "We see almost an upside-down 'U' shape where, with increases in income, up to a point, people are more likely to have medical debt," Dr. Wallis said. "They're less likely to have Medicaid or some other type of coverage, and more likely to be among the working poor." Respondents on welfare also were more likely to have medical debt, she added.

More than one-third of households with children reported medical debt—but without correlation to the child's health status, Dr. Wallis said. "Where parents reported their child's health as being poor, 100% reported medical debt, in addition to 50% who reported debt if their child's health was fair," she said. "But even when the child's health was good or excellent, medical debt approached 40%."

The researchers did not find a lot of differences in the amount of medical debt reported when comparing the ages of children in the house; however, there was a dip in the percentage of debt reported by families with preschool-aged children. "We're not re ally sure what that's about, [but] a lot of children in this sample are Head Start children, so they would be receiving some services and referrals," Dr. Wallis noted. ■