POLICY & PRACTICE

Merck Loses First Vioxx Case

A jury in Texas last month awarded $253 million to the widow of a man who died after taking Vioxx (rofecoxib). The plaintiff charged that the drug maker Merck & Co. failed to warn physicians about the danger posed by Vioxx, that the drug was improperly designed, and that the company's negligence caused the death of the plaintiff's husband, Robert Ernst. Merck executives plan to appeal the verdict on the grounds that the jury was allowed to hear testimony that was both irrelevant and not based on reliable science, the company said. "While we are disappointed with the verdict, this decision should be put in its appropriate context," Kenneth C. Frazier, Merck's senior vice president and general counsel, said in a statement. "This is the first of many trials. Each case has a different set of facts. Regardless of the outcome in this single case, the fact remains that plaintiffs have a significant legal burden in proving causation." The award included $24 million in actual damages and $229 million in punitive damages. But the punitive damages could be reduced to about $2 million, according to Merck, since punitive damages are limited under Texas law.

Chronic Care Pilots

Medicare is launching chronic care pilot projects this year aimed at improving care for people with heart failure and diabetes. The program, called Medicare Health Support, will provide free, voluntary services to about 160,000 Medicare fee-for-service beneficiaries for 3 years. Participating patients will get access to nurse coaches; reminders about preventive care needs; prescription drug counseling; home visits and intensive care management, when needed; and home monitoring equipment to track health status. At press time, eight areas had been selected for the program: Maryland, Oklahoma, Western Pennsylvania, Mississippi, Northwest Georgia, Chicago, Central Florida, and the District of Columbia. "Because early intervention is tremendously important in treating chronic illnesses, we are providing beneficiaries additional tools to help them manage their health more effectively and avoid preventable complications," Health and Human Services Secretary Mike Leavitt said in a statement.

Uninsured Demographics

Although they make up only 15% of the U.S. population, Hispanics comprise nearly 29% of the uninsured in that population, according to the 2004 Medical Expenditure Panel Survey (MEPS) findings from the Agency for Healthcare Research and Quality. More than one in three Hispanics is uninsured, and 25% are covered by public health insurance. In addition, Hispanics constitute 36% of all uninsured children under 18. "These results confirm the urgency of identifying effective policies to expand access to care for all Americans, particularly Hispanics," said AHRQ Director Carolyn M. Clancy, M.D. In other findings, white non-Hispanics made up 65% of the U.S. population and almost 50% of the uninsured. About one in seven whites was uninsured, and 10% had only public insurance. Black non-Hispanics made up almost 13% of the population and almost 15% of the uninsured. Young adults aged 19-24 years were at greatest risk of being uninsured, with 35% having no insurance coverage for the first part of 2004. The report noted the lack of coverage was worst for young Hispanic adults, with 56% uninsured.

When the Price Isn't Right

Brand name pharmaceutical prices continue to increase, far exceeding the rate of general inflation in 2005, according to an AARP "Rx Watchdog Report." More than one-half of the drugs in the sample, 110 of 195, had increases in manufacturer price during the period from Dec. 31, 2004, through March 31, 2005. Taking into account price increases in recent years, the report estimated that a typical older American (who takes three prescription drugs) is likely to have experienced an increase, on average, in the cost of therapy from the year 2000 through March 31, 2005, of $866.16 if the drugs are brand name products used to treat chronic conditions and the full price increases were passed along to the consumer. "We are very disappointed that brand name manufacturers have failed to keep their price increases in line with inflation," said AARP's CEO William Novelli, who promised to educate older consumers on how best to find affordable drugs that suit their needs.

Meth Crisis Continues

The methamphetamine crisis has meant major problems for law enforcement and child welfare workers, according to two new surveys by the National Association of Counties. The first survey, which included responses from 500 local law enforcement agencies, found that 87% reported an increase in methamphetamine-related arrests beginning 3 years ago. More than half the counties said methamphetamine was their largest drug problem, with an estimated one-fifth of jail inmates incarcerated because of meth-related crimes. In the second survey, which involved child welfare officials in more than 300 counties, 40% of respondents reported increased out-of-home placements because of meth addiction in the past year, and nearly two-thirds of officials agreed that the nature of the meth-using parent increased the difficulty of family reunification. "As our surveys confirmed, methamphetamine abuse is a national drug crisis that requires national leadership," Valerie Brown, chair of the association's membership committee, said in testimony to a House subcommittee. "A comprehensive and intergovernmental approach is needed to combat the methamphetamine epidemic."

—Jennifer Silverman

Payment Changes Aimed At Cardiac Hospitals

BY MARY ELLEN SCHNEIDER
Senior Writer

Medicare officials are changing the way hospitals get paid to provide cardiac care in an effort to level the playing field between general hospitals and cardiac specialty hospitals.

Proponents of specialty hospitals are welcoming the move, saying it will show that physician owners aren't skimming the cream off the system and are providing efficient care.

But opponents say the payment changes, which go into effect on Oct. 1, don't address the underlying conflict of interest when physicians refer to hospitals in which they have an ownership interest.

Officials at the Centers for Medicare and Medicaid Services are replacing 9 current cardiovascular diagnosis-related groups (DRGs) commonly billed by specialty hospitals with 12 new DRGs that the agency says will better recognize the severity of illness of the patient. The changes affect DRGs for coronary artery bypass graft surgery, permanent pacemaker implantation, percutaneous vascular procedures, and "other" vascular procedures.

Opponents say the changes don't address the underlying conflict of interest when physicians refer to hospitals in which they have an interest.

In the 2006 Inpatient Prospective Payment System final rule, published in August, CMS said that the changes will address a portion of the "inappropriately higher payments" to specialty hospitals under the current system.

Compared with the current DRGs, the new DRGs have higher average standardized charges for procedures in patients diagnosed with a major cardiovascular condition (MCV), as identified in the ruling, and lower charges for procedures in patients without an MCV diagnosis.

For example, CMS has replaced DRG 107, for coronary bypass with cardiac catheterization, which had average standardized charges of $82,398, with two new DRG codes: New DRG 547 will be used for procedures in patients with an MCV diagnosis carrying a charge of $92,542 (up 12.3%), and new DRG 548 will be used for procedures in patients without an MCV diagnosis, valued at $71,906 (down 12.7%).

The changes to the DRGs are expected to decrease the case-mix index and the resulting payments by an average of 1% among specialty hospitals, according to CMS.

On average, the impact of the changes on any particular hospital group will be small. Urban hospitals are expected to see a 0.1% increase and rural hospitals should see a 0.1% decrease, CMS said.

"We believe these new DRGs are an improvement over the existing DRG structure because they better recognize a patient's severity of illness and, accordingly, permit us to make higher payments for more severely ill patients who require more resources while lowering our payments for less severely ill and less resource-intensive patients," CMS said in its final ruling.

In the meantime, CMS officials are continuing to examine the specialty hospital issue and could propose further changes to the DRG system for fiscal year 2007.

Samuel Wann, M.D., chairman of cardiovascular medicine at the Wisconsin Heart Hospital, said he has no objection to changes that make payments more accurate. "I'm against gaming the system too," he said.

Even if payments for some services decrease, Dr. Wann predicts that his hospital will do fine, because it can rely on efficiency and economies of scale.

Regina Herzlinger, a professor at Harvard Business School who has analyzed the issue of specialty hospitals for a number of years, agrees. The more accurate the reimbursement is, the more institutions that provide cost effective care will thrive, she said.

"My bet is that this will be very good for the specialty hospital." The changes will weed out the less cost effective providers whether they are in general hospitals or specialty hospitals, she said. "They should be competing because they are better and cheaper."

Richard Coorsh, a spokesman for the Federation of American Hospitals (FAH), also supports the reexamination of DRGs as a way to improve the system overall. But he doesn't see it as addressing the main objection that community hospitals have to physician-owned specialty hospitals—self-referral.

FAH has urged CMS to prohibit physician owners of specialty hospitals to self-referral patients.

And FAH is supporting the Hospital Fair Competition Act of 2005 (S. 1002), which was introduced by Sen. Charles Grassley (R-Iowa) and Sen. Max Baucus (D-Mont.). The legislation would among other things prohibit certain physician self-referrals to physician-owned specialty hospitals.

Congress imposed a moratorium on physician-investor referrals of Medicare or Medicaid patients to new specialty hospitals, effectively freezing their development.

That moratorium expired on June 8, but CMS has established a sort of administrative moratorium by halting processing of Medicare participation applications from specialty hospitals until January 2006.

The Grassley-Baucus legislation is a "step in the right direction," Mr. Coorsh said. He said FAH officials are hopeful that it will be acted on before the administrative moratorium expires in January 2006. ■