Specialty Hospitals Face New Cardiac Billing Codes

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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.

However, opponents object that the payment changes, which went into effect on Oct. 1, don't address the apparent 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.

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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-refer 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. ■

POLICY & PRACTICE

Health Care Rankings

Health care quality improved markedly in many key areas in 2004, but only about 21.5% of the industry now reports publicly on its performance, according to the National Committee for Quality Assurance (NCQA) annual State of Health Care Quality report. Among the 289 commercial health plans that reported their data, average performance improved on 18 of 22 clinical measures although Medicare and Medicaid plans reported smaller gains. Gains in blood pressure control were made in 2004 (up 4.6 points to 66.8%), along with cholesterol control for people with diabetes (up 4.4 points to 64.8%). Fewer patients are enrolled in plans that publicly report their data, due largely to shifting enrollment patterns, the NCQA reported. Enrollment in preferred provider organizations and consumer-directed health plans is up sharply. With few exceptions, these plans tend not to measure or report on their performance. "Today we see a lot of health plans that aren't measuring anything. The right response as a consumer to these plans is simply, don't buy them," said NCQA President Margaret E. O'Kane. "The new mantra for health care purchasers needs to be, 'show us your data.' Why trust your family's health to an organization that operates behind closed doors?" As many as 67,000 deaths have been prevented to date as a result of improvements recorded over the past 6 years.

Public Health Unpreparedness

Many local public health agencies are ill-prepared to learn about and respond to naturally occurring outbreaks of deadly infectious diseases or acts of bioterrorism, a test by the RAND Corporation has found. To conduct the test, researchers posed as local physicians who were reporting fictitious cases of botulism, anthrax, smallpox, bubonic plague, and other diseases to 19 public health agencies in 18 states nationwide. (Agency directors agreed in advance to participate in the test, but did not tell their staff members.) In one case, after listening to a description of the classic symptoms of bubonic plague, a public health worker advised the caller not to worry because no similar cases had been reported. Another caller who reported a botulism case was told: "You're right, it does sound like botulism. I wouldn't worry too much if I were you." The article appeared in the Aug. 30 online edition of Health Affairs.

FDA Commissioner Resigns

After a brief tenure, Lester Crawford, D.V.M., Ph.D., resigned his position as commissioner of the Food and Drug Administration. Dr. Crawford had a 30-year career with the agency, serving as its deputy commissioner and director of the Center for Veterinary Medicine, among other posts. "It is time at the age of 67, to step aside," he said. In a statement, Michael Jacobson, executive director of the Center for Science in the Public Interest said CSPI would "miss Dr. Crawford for his openness, despite various policy disagreements. He was one of the only FDA commissioners who had substantive experience with food safety." Andrew C. von Eschenbach, M.D., who served as the head of the National Cancer Institute, has since been appointed as the FDA's acting commissioner. "As a practicing physician and research scientist, I share in the critical mission of this agency in protecting and promoting the health of the American people," he said in a statement.

A PAC Is Born

The American Academy of Family Physicians has launched FamMedPAC, its political action committee, with the goal of raising $1 million in this election cycle. The idea for the PAC was approved at last year's Congress of Delegates meeting and it got underway in June. At press time, the PAC had raised more than $100,000. All of the contributions will go toward contributions to federal campaigns. Already, the PAC has contributed on a bipartisan basis to five sitting House members, including Rep. Patrick Kennedy (D-R.I.) and Rep. Tim Murphy (R-Pa.), who have cosponsored legislation encouraging the use of health information technology. Issues on the top of the PAC's agenda this year include medical liability reform and a fix to the physician pay formula, according to PAC board member Jim King, M.D., a family physician in Selmer, Tenn. He said that before the PAC was established, the AAFP had hit the limit on what it could accomplish politically. "The PAC takes us to a different level in the political game," Dr. King said. The establishment of PACs within medicine seems to be a growing trend: In 2004, the internal medicine community formed the ACP Services PAC, which was very active during the 2004 election season.

No Free Lunch

Among the many exhibits showcasing pharmaceuticals and technology products at this year's AAFP meeting was one exhibit devoted to urging physicians not to accept free gifts from pharmaceutical reps. No Free Lunch is a group of physicians and other health care providers who say that the promotional efforts of drug companies are unduly influencing physicians. The issue is "much bigger than pens and gifts," said Paul Bergeron, M.D., an internist based in Portsmouth, N.H., who participated in an ethics panel discussion at the American College of Physicians meeting earlier this year. If the pharmaceutical company offers something that benefits patients, such as compliance programs free of charge, that's okay, he said. "What we shouldn't be taking are things that personally benefit the physician. If they pay me $1,000 to talk about a drug at a conference, that's not appropriate."

—Jennifer Lubell