Some favor a pay-for-performance system, allowing states to get grants based on their measured progress.

By Jennifer Silverman
Associate Editor, Practice Trends

Washington — Rewarding states based on a new way to cover more uninsured Americans, Henry J. Aaron said at the annual meeting of the National Governors Association. Following up on a trend that already has affected the physician community, Mr. Aaron proposed a “pay-for-perform- ance” system, where states could receive federal grants based on their “actual- ized measured progress of increasing the number and proportion of state residents covered by health insurance.”

The federal grants would be set to cov- er medical costs associated with extending coverage.

“Any state that succeeded in boosting a fraction of its population [covered by] health insurance would receive federal support. The states that made no such progress would receive nothing,” noted Mr. Aaron, who is a senior fellow for eco- nomic studies at the Brookings Institution.

The federal government should first de- fine a standard for health insurance cov- erage, Mr. Aaron said, suggesting that the minimum be “similar to the actuarial val- ue of the Federal Employees Health Ben- efits Program.” His plan also would include a “first, do no harm” standard, prohibiting states from materially eroding coverage for the cur- rent Medicaid population.

“Even now, Medicaid is substantially less costly than private insurance of the same scope. Still, state costs for long-term care [are] on track to rise relentlessly as baby boomers age.”

This means that states need continued financial protection from adverse trends— and not a cap on federal support.

“(States also) need flexibility to mod- ernize Medicaid but within the limits that maintain the per capita protection of the most vulnerable populations in our na- tion,” Mr. Aaron said.

Within these broad guidelines, states should be encouraged to pursue any ap- proach that would increase the propor- tion of state residents with health insur- ance coverage, he continued. Depending on local conditions and political prefer- ences, individual states could use refundable tax credits or vouchers to pro- mote individual insurance.

Individual states could also facilitate new insur- ance groups by allowing churches, unions, and the like to create association health plans; extend Med- icaid or the State Children’s Health Insurance Pro- gram; impose employer mandates; or try to create an intrastate single-payer plan.

“In the absence of these options would be manda- tory,” he said.

Another panelist, Stuart M. Butler, Ph.D., vice president, domestic and eco- nomic studies at the Brookings Institution, suggested that members of Congress enact a policy “toolbox” that would make a range of ideas avail- able to individual states, on a voluntary basis.

Under such an approach, state law- makers could propose an initiative for preserving coverage, selecting certain elements from the toolbox, and negotiating with the U.S. Health and Human Services department on appro- priate waivers to pull such an option together, Mr. Butler explained.

In an attempt to maintain and extend the functional equivalent of Medicaid dur- ing these very tight budget times, states could utilize an enhanced federal refundable tax credit from the policy toolbox, using additional federal funds to create pur- chasing alliances or pools, Mr. Butler ex- plained.

“The real key is to make sure that Medi- care populations are protected, encour- age innovations through the states [and] rewarding pay-for-performance successes by the states, to reach these goals,” he added.

Physician-Owned Specialty Hospitals Under Scrutiny

By Mary Ellen Schneider
Senior Writer

The Medicare Payment Advisory Commission has recommended that Congress extend the morato- rium on the development of new physi- cian-owned specialty hospitals, but its chairman urged members of Congress not to close the door on these hospitals before the potential benefits can be fully investigated.

“Frankly, the status quo in our health care system is not great,” MedPAC chair- man Glenn Hack- barth testified at a hearing of the Sen- ate Finance Commit- tee on specialty hos- pitals last month. “We’ve got real qual- ity and cost issues.”

MedPAC members are concerned about the potential conflict of interest in physician-owned specialty hospitals, Mr. Hackbarth said, but they are not prepared to recommend outlawing them until they see evidence on whether specialty hospitals offer increased quality of care and efficiency.

And policymakers do not yet have the answers to those questions, he said.

Sen. Chuck Grassley (R-Iowa), chair- man of the Senate Finance Committee, and Sen. Max Baucus (D-Mont.), the com- mittee’s ranking Democrat, are drafting legislation that will set Medicare policy on specialty hospitals.

Mr. Grassley said that he will rely on the MedPAC findings as he crafts the leg- islation. He is also awaiting the final results of a study on quality of care at specialty hospitals from the Centers for Medicare and Medicaid Services.

Officials at CMS presented preliminary findings from that study at the hearing. CMS was charged under the Medicare Modernization Act of 2003 with examining referral patterns of specialty-hospital physician owners, assessing quality of care and patient satisfaction, and examining differences in the uncompensated care and tax payments between specialty hos- pitals and community hospitals.

Based on claims analysis, the prelimi- nary results show that quality of care at cardiac hospitals was generally at least as good and in some cases better than the quality of care at community hos- pitals. Complication and mortality rates were also lower at cardiac specialty hos- pitals even when ad- justed for severity of illness.

However, because of the small number of discharges, a statistically significant as- sessment could not be made for surgical and orthopedic hospitals, said Thomas A. Gustafson, Ph.D., deputy director of the Center for Medicare Management at CMS.

Patient satisfaction was high at cardiac, surgical, and orthopedic hospitals, Dr. Gustafson said, due to amenities like larg- er rooms and easy parking, adding that pa- tients had a favorable perception of the clinical quality of care they received at the specialty hospitals.

But Sen. Baucus expressed skepticism about the findings and how the study was conducted. He urged caution in using the results of the CMS study as a basis for policymaking. In its report to Congress, MedPAC rec- ommended that the moratorium on construc- tion of new specialty hospitals be ex- tended another 18 months—until Jan. 1, 2007.

While MedPAC stopped short of rec- ommending that Congress ban new spe- cialty hospitals, the panel did recommend payment changes that would remove in-centives for hospitals to treat healthier but more profitable patients.

First, the panel recommended that the secretary of Health and Human Services refine the current diagnosis-related groups (DRGs) to better capture differ- ences in severity of illness among Medicare patients. The panel also advised the HHIS secretary to base the DRG rela- tive weights on the estimated cost of pro- viding care, rather than on charges. And MedPAC recommended that Congress amend the law to allow the HHIS secretary to adjust DRG relative weights to account for differences in the prevalence of high-cost outlier cases.

These changes would affect all hospitals that see Medicare patients and increase the accuracy and fairness of payments, Mr. Hackbarth said.

In addition, MedPAC tried to address physicians’ concerns that they do not have a say in the management of community hospitals, by recommending that Con- gress allow the HHIS secretary to permit arrangements between physicians and hospitals. Gainsharing aligns financial incentives for physicians and hospitals by allowing physicians to share in the cost savings realized from de- livering efficient care in the hospital.

But even with these changes, Mr. Hack- barth said MedPAC members still have concerns about the impact of physician ownership on clinical decision making.

And members of the Senate Finance Committee also raised questions about the appropriateness of physician self-referral.

“When it comes to physician ownership of specialty hospitals, I’m not sure the playing field is level,” Sen. Baucus said.

Physicians are the ones who choose where patients will receive care, he said. He compared the physician owners of specialty hospitals to coaches who choose the starting lineup for both teams.

Advocates for specialty hospitals, in- cluding the American Medical Associa- tion and the American Surgical Hospital Association, are lobbying Congress to end the moratorium, saying it will allow competition and won’t hurt community hospitals.

But opponents are asking Congress to close the federal self-referral–law ex- emption that allows physicians to invest in the “whole hospital” rather than a sin- gle department.

Sen. Baucus said that surgical specialty hospitals, which on average have only 14 beds, look more like hospital departments than full-service hospitals. “This loophole may well need closing,” he said.