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Hospitals Cite Worry on Fees in Health Bill

By [ANEMONA HARTOCOLLIS](#)

As Congress struggles to rein in health care costs as part of its sweeping reform efforts, [hospitals](#) in New York City and other urban areas that provide some of the most expensive care are among the primary targets.

The issue pits hospitals in more rural states like Iowa and Minnesota, where spending tends to be lower, against those in areas like New York and Los Angeles, and revolves around a question that has bedeviled the medical establishment for decades: How much money do hospitals need to provide adequate care for patients, especially poor people who have not had regular access to health care.

A provision in the House health care bill, included over the objections of hospitals from New York and other cities, would order a neutral group, the [Institute of Medicine](#), to conduct a two-year study of regional variations in [Medicare](#) spending. The bill requires the institute to recommend changes that would reward "quality and value," and those changes would take effect automatically unless Congress objected by May 31, 2012.

Proponents say the institute's findings could prove crucial to efforts to slow out-of-control costs. They argue that through greater efficiency, Medicare spending could be cut by 15 to 30 percent, and cite researchers at Dartmouth Medical School, who contend that Medicare could save \$1.42 trillion by 2023, and eliminate a looming deficit, by reducing annual growth in per patient spending to 2.4 percent from the national average of 3.5 percent.

The recommendation that New York hospitals fear most is that Medicare should reduce payments to areas where costs grow fastest and increase payments to those who are best at controlling them. They argue that some of the most efficient hospitals are in affluent and rural areas that do not face the same challenges, including higher poverty and cost of living, as New York.

"This line of inquiry is destructive to urban centers," said Dr. Kenneth L. Davis, chief executive at [Mount Sinai Medical Center](#) in New York. "Unless we deal with the problems of poverty in underserved areas, health care will be expensive in urban areas."

The study was so important to the fiscally conservative Blue Dog Democrats that they made it a condition of their support for the [public option health insurance](#) plan. House members from the West and Midwest argued that they had been historically shortchanged by Medicare, which essentially penalized them for providing more efficient care. “This agreement rewards states like Iowa who have put patients and their care first,” Representative Dave Loebsack, Democrat of Iowa, said in a statement after the study provision was finalized.

Two weeks ago, hospitals from New York and other urban areas succeeded in adding language that prevents the institute’s recommendations from reducing payments for medical education, much of which occurs at New York’s large teaching hospitals, or from reducing so-called disproportionate share payments for hospitals that serve large numbers of low-income patients.

The hospitals are watching to see whether the Senate will bring up the issue of geographic disparity in a floor fight. The current Senate bill would penalize doctors who order a high number of tests, but would compare Manhattan doctors with other Manhattan doctors, for example, and not with Iowa doctors, according to Senator [Charles E. Schumer](#), Democrat of New York.

The issue highlights work by researchers at the Dartmouth Medical School’s Institute for Health Policy and Clinical Practice, through its [Dartmouth Atlas of Health Care](#). The atlas has found striking regional differences in the intensity and cost of health care.

At [New York University](#) Langone Medical Center, for example, Medicare spending was \$105,000 per patient during the last two years of life. During the last six months of life, when costs go up still more sharply, patients at the center spent an average of 31 days in the hospital and were visited by 77 doctors.

At Genesis Medical Center in Davenport, Iowa, which the atlas called the state’s most aggressive hospital, Medicare spending was \$40,000 per patient during the last two years, and during the last six months, patients spent 14 days in the hospital and were visited by 29 doctors.

The Dartmouth researchers say that high-cost hospitals — spurred by “volume-based payment systems” — are oriented toward providing more tests, like CT scans and [M.R.I.](#)’s; more surgeries; and more admissions, and that evidence suggests that patient outcomes are better in low-spending regions.

Just lessening the reliance on hospital care, said Dr. Elliot Fisher, the atlas’s primary investigator, would be “a great opportunity for reducing the overall cost of American health care.” He added, “Who wants to go to the hospital if they don’t need to be there?”

Dr. Robert Grossman, dean and chief executive of New York University Langone, said the Dartmouth data failed to take into account patients who survived more than six months, “key

drivers” like local wages, and the complexity of the medical care provided by the hospital. He said that since the Dartmouth data was compiled in 2005, N.Y.U. had made progress in reducing costs.

Dr. Michael L. Langberg, senior vice president for medical affairs at Cedars-Sinai Health System in Los Angeles, wrote in a letter in May to the Senate Finance Committee, “The vast majority of the U.S. population does not live in places that resemble Rochester, Minnesota” — the home of the often-praised [Mayo Clinic](#) — “rural north-central Pennsylvania, or Utah.”

Representative Joseph Crowley, who represents parts of Queens and the Bronx and was one of eight House Democrats, evenly split among rural and urban areas, who negotiated the study compromise, said that with controls for variables like medical education costs and poverty added in, “I actually think this has the potential to be a good deal for New York. The fact is that New York still makes one out of every six doctors in the U.S.”

But hospital officials say that even with those variables explicitly under consideration, the outcome is far from certain. “I don’t dismiss the Dartmouth study out of hand,” said Stanley Brezenoff, chief executive of Continuum Health Partners, parent company for major New York hospitals like [Beth Israel Medical Center](#) and St. Luke’s-Roosevelt Hospitals. “What I’m saying is there may be explanations that go beyond the simple explanation of overutilization.”

But Mr. Brezenoff said he recognized the inevitability of some changes, and was already looking for ways to cut costs associated with frequent readmissions of the same patient, an area in which New York performs badly.

“I now have my people poring over readmissions,” he said. “What we’re discovering are things like individuals don’t take their medications, and you ask yourself what it is that we as a hospital could do to deal with that.”

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