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Drug Sales Bring Huge Profits, And Scrutiny, to Cancer Doctors

Insurers and Experts See High Costs and Conflicts

By REED ABELSON

Among cancer doctors, it is called the chemotherapy concession. At a time when overall spending on prescription drugs is soaring, cancer specialists are pocketing hundreds of millions of dollars each year by selling drugs to patients — a practice that almost no other doctors follow.

The cancer specialists can make huge sums — often the majority of their practice revenue — from the difference between what they pay for the drugs and what they charge insurers and government programs. But some private health insurers are now studying ways to reduce these profits, and the issue is getting close attention in Congress.

Typically, doctors give patients prescriptions for drugs that are then filled at pharmacies. But cancer doctors, known as oncologists, buy the chemotherapy drugs themselves, often at prices discounted by drug manufacturers trying to sell more of their products, and then administer them intravenously to patients in their offices.

The practice also creates a potential conflict of interest for these doctors, who must help patients decide whether to undergo or continue chemotherapy if it is not proving to be effective, and which drugs to use.

Cancer specialists have successfully resisted most government efforts to take the drug concession away, arguing that they need the payments to offset high costs in the rest of their practices. An attempt by the Clinton administration to change reimbursement practices was strongly opposed by doctors, and by George W. Bush, who was then governor of Texas, among others. But support for change is growing, and some changes are beginning to take place.

"This has gotten out of hand," said Dr. William C. Popik, the chief medical officer for Aetna, which is exploring different approaches to the concession, including taking it away in some regions.

Health insurers say they can buy these drugs much less expensively themselves and have the drugs shipped directly to doctors' offices. Some also want to keep better track of how the drugs are used.

Critics say the money these doctors make from selling medicine is contributing to the nation's high health care bills and adding to the waste and inefficiency in the health care system.

Medicare, which does not cover most prescription drugs, does pay doctors about $6.5 billion a year for drugs they personally administer, largely cancer drugs. Under the current system of determining what the appropriate prices for these drugs are, the government is paying, by some estimates, more than $1 billion over what the drugs actually cost. Many private insurers say they are also overpaying for these drugs.

In some cases, patients may even be paying a much larger co-payment for the drug than a cancer doctor is paying to buy it. Some patients paid

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about $150 out of pocket for Toposar, a cancer drug, for example, while doctors appear to have paid closer to $60 after various discounts from Pharmacia, the manufacturer, according to the Minnesota attorney general, who is suing Pharmacia, accusing it of pricing fraud.

The General Accounting Office, which studied federal payments for cancer drugs in late 2001, discovered that doctors, on average, were able to get discounts as high as 86 percent on some drugs. Doctors paid less than $3 for a single dose of leucovorin, for example, while patients paid them around $3.50 out of a total reimbursement of about $17.50.

"We think it's a bad system that creates bad incentives that creates bad medicine," said Robert M. Hayes, president of the Medicare Rights Center, a consumer group, who testified before Congress last fall on the issue.

Dr. Thomas J. Smith, an associate professor of oncology at the Medical College of Virginia Commonwealth University, has estimated that oncologists in private practice typically make two-thirds of their practice revenue from the chemotherapy concession.

The concession echoes the system in Japan, where doctors make money by dispensing drugs. Drug spending per capita in Japan is among the highest in the world, higher than in the United States.

"This is our little corner of Japan," said Joseph P. Newhouse, a health policy professor at Harvard, who has been asked by the government to look into how the Medicare reimbursement system may affect how doctors prescribe chemotherapy.

The concession may also lead some doctors to recommend chemotherapy when patients may not benefit. In a 2001 study of cancer patients in Massachusetts, conducted by a team of researchers led by Dr. Ezekiel J. Emanuel of the National Institutes of Health, the authors found that a third of those patients received chemotherapy in the last six months of their lives, even when their cancers were considered unresponsive to chemotherapy. Those findings strongly suggested overuse of chemotherapy at the end of life.

"We know there is not all appropriate use," said Dr. John Gillespie, medical director of Blue Cross Blue Shield of Western New York.

But oncologists say they are only trying to respond to their patients' wishes. And they say they need the profits from the drugs to make up for high costs in the rest of their operations. They say they spend enormous sums to have the facilities and employees that enable patients to receive chemotherapy outside a hospital, under close supervision.

"It seems to be a wash right now," said Dr. Larry Norton, an oncologist at Memorial Sloan-Kettering Cancer Center in New York and a former president of the American Society of Clinical Oncology. He and his colleagues argue that oncologists treat patients who demand more care and therefore have higher expenses.

"We're just trying to break even," Dr. Norton said.

Oncologists also argue that patients may suffer if doctors do not buy chemotherapy drugs directly. They point to a case in Kansas City, Mo., in which a pharmacist was sentenced in December to 30 years in prison for diluting chemotherapy drugs he then sold to doctors who administered the drugs in their offices. Dr. Norton argued that the case illustrated why he and his colleagues were worried. "Some potential problems could arise," he said.

The health plans, and some of the specialty pharmacies that sell to both doctors and insurers, say this concern is unfounded.

Earlier this month, Representative Pete Stark, Democrat of California, introduced legislation that would slightly increase what Medicare pays oncologists for their services and bring doctors closer to what the drugs actually cost. The government is also looking into how the concession is affecting prescribing patterns.

Oncologists began selling drugs directly more than a decade ago, after they persuaded insurers that it would be less expensive to administer the drugs in their offices than in hospitals. This was part of a trend of doctors' being paid much more to perform services and treatments in their offices than in hospitals. (Some other specialists, like urologists, also profit from chemotherapy drugs, but they administer them only to some of their patients.)

Over the course of the 1990's, oncologists have been able to rely on the sale of chemotherapy drugs as an important source of revenue. They are now among the best-paid doctors, surpassing obstetricians and general surgeons, according to data from the Medical Group Management Association. In 2001, the median compensation for an oncologist in a large practice was $274,000. While compensation for specialists has increased 19 percent, on average, since

Oncologists say drug profits offset other expenses.

1997, oncologists' compensation has risen slightly more than 40 percent.

Dr. Norton dismisses the notion that cancer doctors' compensation has risen faster because of income from chemotherapy drugs. "Oncologists are extremely busy," he said, because more people have cancer and more treatments are available.

But the idea that these doctors make money from the drugs worries some. "All the evidence suggests that doctors do respond to money," said Dr. Susan D. Goold, an associate professor at the University of Michigan Medical School.

Some oncologists acknowledge that the current system creates a perverse incentive. The potential for conflicts of interest "is troubling," said Dr. Edward L. Braud, the president of the Association of Community Cancer Centers, whose members treat more than half of the nation's cancer patients.

Drug Profits

Oncologists can make substantial profits on chemotherapy drugs that they administer and sell to patients directly.

Drug costs and reimbursements *Figures are for each standard dose*

DRUG	APPROXIMATE PRICE PAID BY DOCTORS	APPROXIMATE REIMBURSEMENT*	MARGIN
Rituximab	$387	$455	$68
Docetaxel	245	298	53
Paclitaxel	146	172	26
Dolasetron mesylate	16	43	27
Leucovorin calcium	3	18	15

Source: General Accounting Office *"From Medicare and patient copayments*

The New York Times

In several prominent cases, drug companies have also been accused of using discounts to influence doctors. For example, in the Minnesota lawsuit, brought last year, Pharmacia is accused of having "induced physicians to purchase its drugs, rather than competitors' drugs, by persuading them that the wider 'spread' on the defendant's drugs would allow the physicians to receive more money, and make more of a profit, at the expense of the Medicaid program and Medicare beneficiaries."

Pharmacia said it could not comment because the matter was still in litigation.

But others say doctors are solely motivated by what their patients want — a chance, no matter how slim, of living longer or suffering less. Dr. Norton, for one, dismissed the idea that oncologists would be motivated to give too much care or the wrong kind, and said undertreatment is a much greater risk.

Some insurers are getting oncologists to forgo profits from chemotherapy drugs, often by paying the doctors more for administering them. While oncologists may not make as much under the new system, and some have objected vehemently, it is "palatable," said Dr. Abraham Rosenberg, an oncologist in South Florida, where the new system is prevalent.

Last year, inspired by Florida's example, the Blue Cross Blue Shield plan in western New York began negotiating new contracts with oncologists.

The UnitedHealth Group is also in discussions with doctors in New York and expects to begin a pilot program this year. It plans to give oncologists a choice: they can allow UnitedHealth to buy the drugs at a lower price and pay the doctors for administering chemotherapy, or they can accept a lower payment for the drugs if they continue to buy them. The plan is also talking with doctors in cities including Cleveland and Dallas.

Aetna is trying different approaches. In the Northeast, the insurer wants to reimburse doctors at prices that are much closer to what the doctors are actually paying, while in the Southeast and Southwest, it is looking to buy the drugs directly.

Richard H. Friedman, the chief executive of the MIM Corporation, which operates a specialty pharmacy that supplies chemotherapy drugs to doctors, predicted that the chemotherapy concession may not last. The health plans, he said, "are all starting to take a much harder look."

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How One Hospital Benefited From Questionable Surgery

By KURT EICHENWALD

OPERATING PROFITS

Mining Medicare

Could it possibly be, Dr. Patrick Campbell wondered, that doctors at his hospital in Redding, Calif., were cracking open the chests of perfectly healthy people?

Dr. Campbell, an internist, first suspected trouble in Redding Medical Center's cardiology program soon after joining the hospital in 1993, according to papers obtained by federal investigators. That year, one of his patients underwent open-heart surgery even after the surgeon told Dr. Campbell the procedure was unnecessary. Two years later, another patient received a coronary bypass, though the cardiologist's report said it was not necessary.

Then there were the numbers — tens of thousands of diagnostic tests, thousands of surgical coronary procedures. The totals seemed more likely for a major university medical center than for a hospital in a rural community of about 90,000 people.

Dismayed, Dr. Campbell brought his concerns to Stephen E. Corbeil, the hospital's chief executive at the time. Though Dr. Campbell declined to comment on the meeting and Mr. Corbeil did not return telephone calls, the papers obtained by federal investigators indicate that the administrator's response was succinct: The young internist, he said, should mind his own business.

Ultimately, Dr. Campbell's concern proved to be everyone's business. Last week, the hospital's owner, Tenet Healthcare, agreed to pay $54 million to the government to resolve accusations that Redding Medical doctors conducted unnecessary heart procedures and operations on hundreds of healthy patients. Tenet did not admit any wrongdoing and agreed to cooperate with further investigations.

As disturbing as the accusations may be, there would have been a logic to what a patient called Redding's ''little house of horrors'' — a logic born of the twisted finances of American health care, which may have made the hospital less willing to hear concerns about two of its highest-billing doctors.

Until federal agents raided Red-

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ding last fall, Tenet's business model was based on maximizing the dollars it could collect from Medicare, the nation's biggest buyer of health care. And Medicare's complex formulas — the template for private insurers, as well — reward some kinds of health care more richly than others, and few more richly than cardiac care.

So it was that two heart doctors at Redding — Dr. Chae Hyun Moon, the chief cardiologist, and Dr. Fidel Realyvasquez, its top cardiac surgeon — became immensely powerful, people who worked there said. Tenet promised investors growing profits, and at Redding, these people said, that required steady growth in cardiac care.

Together, Dr. Moon, who also sat on the hospital's board, and Dr. Realyvasquez directed the California Heart Institute, the cardiac program that Redding had started in the 1970's, and it proved to be a bonanza.

'We were constantly being pushed to bigger budgets, and there was no way to do it without the heart institute,'' one former Redding administrator said. ''People were terrified that Moon would go on vacation, because of the effect a few days would have on the hospital's financial performance.''

While few doubt the hospital would have responded to explicit evidence of problems in the heart program, like high death rates, the financial pressures created a disincentive to pursue less specific suspicions, people who worked at Redding said.

And there were many suspicions. Besides Dr. Campbell, more than half a dozen doctors, along with medical technicians and patients, expressed concerns to multiple administrators, according to people interviewed and records obtained by investigators. There were also questions of competence: one former executive said that two years ago, a representative of the company whose ultrasound machine Dr. Moon relied on for many of his diagnoses warned that he was misusing it.

But the hospital never conducted the peer reviews that might have confirmed the critics' doubts.

''I sometimes just shake my head at the American system, where the financial intent is almost cleverly designed to create mischief,'' said Uwe Reinhardt, a Princeton University health care economist. ''For administrators, it creates a conflict of interest when they're trying to deliver the numbers at the same time that doctors are saying the hospital is doing too much cardiac surgery.''

Tenet's $54 million settlement with the government — the largest ever for accusations of billing federal health programs for unnecessary care — means that the company will not face criminal or civil charges. But the company has been upended by the scandal, the first in a series of events to raise questions about the company's finances. Numerous executives, including Jeffrey C. Barbakow, its longtime chief executive, have resigned, and its stock has lost almost three-quarters of its value.

A criminal investigation of Drs. Moon and Realyvasquez is continuing, though no charges have been filed. Their work at the heart institute has been suspended, and Dr. Moon has surrendered his medical license pending resolution of the matter. Lawyers for each of them say that, while other doctors' opinions about their decisions may differ, neither did anything illegal.

''Certainly physicians can and do have differences of opinion,'' said Matthew Jacobs, a lawyer in Sacramento representing Dr. Moon. ''But to base a fraud prosecution on such differences with no other evidence of fraud just doesn't work.''

Malcolm Segal, a lawyer for Dr. Realyvasquez, said that his client's decisions to operate were justified. ''Dr. Realyvasquez is an outstanding, well qualified surgeon,'' Mr. Segal said. ''He did everything he was supposed to do and believes that when he provided the surgery to the patients, it was needed.''

For its part, Tenet says that as part of its settlement with the government, it has imposed new checks and balances to ensure that no future problems could occur at Redding. Harry Anderson, a Tenet spokesman, said the company's new management had agreed to heighten monitoring and education programs ''to rebuild the reputation and services of Redding Medical Center so it may continue to serve that community for years to come.''

Meanwhile, there are hundreds of former patients of the two doctors who now must wonder whether there was any reason for their operations. They are like Shirley B. Wooten, 78, who sought care last year for back and arm pain. After several tests, she was told she needed emergency bypass surgery, which was conducted by Dr. Realyvasquez. Complications followed, and Mrs. Wooten, who loved to attend dances with her husband, Bob, and take long driving trips around the California countryside, can no longer write or walk steadily. An independent expert has deemed the surgery unnecessary, and she is suing.

''I had to quit my job to take care of her,'' Mr. Wooten said. 'Our lives came to a screeching halt after that surgery, I'll tell you.''

Push for Higher Profits

By the winter of 1998, Redding Medical Center was virtually bursting at the seams. A conference room was converted into a patient care area. The emergency room was running over capacity.

''We were beyond full,'' one former administrator said. ''We were flying.''

That fiscal year, officials said, the hospital exceeded its budget for pretax profit by almost 50 percent, bringing in more than $50 million. And then at a budget meeting with senior Tenet officials, the order came down: Do better next year.

''We said 'We don't know how to do it unless we have extra capacity,' '' the former administrator said. ''They were pushing for what I thought was ridiculous financial results.''

Tenet agreed to invest millions of dollars to complete rapidly the construction of a five-story addition to the hospital. People in town came to call it ''the tower,'' a symbol of how a once sleepy hospital, founded by a single local physician in 1945, had truly entered the big time.

The project only heightened Redding's dependence on Dr. Moon and the California Heart Institute. The son of a family practitioner, Dr. Moon told associates that his decision to become a doctor had been dictated to him by God when he was a boy. He graduated in 1972 from the Medical College at Yonsei University in Seoul, and completed his internship and residency at Metropolitan Hospital in New York.

After setting up practice in Redding in the early 1980's, Dr. Moon rapidly developed a reputation for aggressively pursuing evidence of coronary disease. He also was known for being quick to recommend a cardiac catheterization, in which a small tube is passed through a blood vessel to examine how a patient's heart is working.

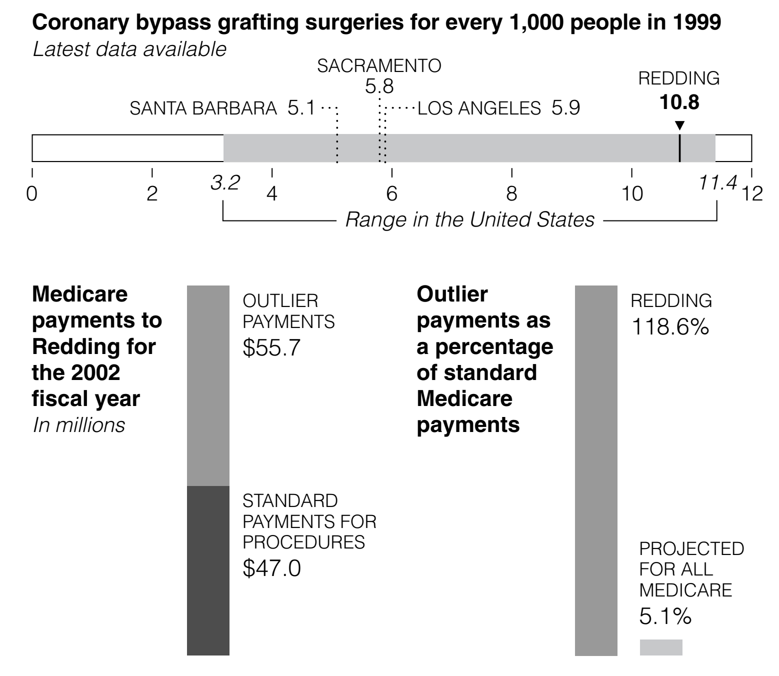
''His philosophy has always been if you know the anatomy of the diseased heart, you are going to be able to make informed decisions,'' said Dr. Bruce Kittrick, an internist at Redding who does not believe the accusations against Dr. Moon. ''That is what made him really investigate anatomically most of the people he took care of.''

That willingness to conduct catheterizations and other invasive procedures also helped fuel Dr. Moon's success within Redding Medical Center. Over time, he became one of the hospital's biggest money-makers, conducting more than 35,000 catheterizations during his years there, which other cardiologists say is easily many times the number that they would expect in such a time frame.

In the last fiscal year he collected more from Medicare than all but one other cardiologist in Northern California, figures compiled by the program show, billing for almost $4 million in the 12 months ended June 30,

Red Flags at Redding

Redding Medical Center, a small regional hospital in Northern California, became a prolific heart surgery center. An unusually high percentage of the reimbursements it received from Medicare were outlier payments, which are usually given as additional reimbursements for treating the sickest people.



Sources: Dartmouth Atlas of Healthcare; Centers for Medicare and Medicaid Services

The New York Times

2002. In that year, Medicare records show, he billed for 876 catheterizations for the left side of the heart, at least four times the number performed by any of his colleagues in Northern California.

By the early 1990's, Dr. Moon's success gave him enormous power in the organization. At one point, according to several Redding doctors, a former administrator and investigative records, Dr. Moon earned the reputation for having been instrumental in persuading Tenet to dismiss one of Redding's chief executives. The event, which became the stuff of hospital legend, only increased Dr. Moon's influence, said one former administrator.

''No one would ever want to take him on,'' he said. ''Moon was Redding Medical Center, and he knew it.''

Indeed, Dr. Moon became fond of making that point himself. ''Who is Redding Medical Center?'' he said in a recorded presentation in the mid-1990's. And then, participants said, Dr. Moon pointed to himself.

Administrators' pay grew if Redding's profits exceeded Tenet's expectations, so the financial performance of Dr. Moon, Dr. Realyvasquez and their cardiac program was reviewed intently.

As part of a companywide procedure, Redding's chief financial officer prepared a report each month describing important events affecting the hospital's returns.

''They noticed everything,'' one former administrator recalled. ''If Moon's numbers were off a little bit, they asked about it.''

In turn, Redding did all it could to keep its heart specialists happy. The hospital began an advertising campaign, with mailings and billboards that used tombstones and other images invoking death to persuade Redding residents to be checked for heart disease. It paid nurses to dictate charts for Dr. Moon, who colleagues and former administrators said made little time for record keeping. It sponsored golf tournaments to promote the heart institute, and sometimes offered Dr. Moon use of its helicopter to fly to the golf course, administrators and doctors said.

The doctors also received particular attention from senior Tenet executives, particularly Thomas Mackey and Neil Sorrentino, according to former Redding executives, doctors and documents obtained by investigators. Mr. Mackey was ultimately the chief operating officer of Tenet, while Mr. Sorrentino was the head of its California hospitals.

Topping it off were the financial rewards. Former Redding administrators said that, around 1997, Dr. Realyvasquez demanded and was given a lucrative contract, paying him huge sums of money.

''He told us the number he wanted, and we had to work backwards to figure out a way to get it to him,'' one administrator said.

Normal checks and balances did not seem to apply to Dr. Moon, Redding physicians said. He was not only head of the cardiology program but also a hospital director. And though he was not board certified in cardiology or internal medicine — a credential he dismissed as insignificant — he was also head of the hospital's Cardiology Care Committee, in charge of conducting peer review of his own program's quality of care.

Court records say that committee rarely, if ever, met.

Others Saw Trouble Signs

Across town, Redding's chief rival, Mercy Medical Center, also took admissions from Dr. Moon. But the staff there was far less impressed with him.

In 1996, one of his patients at Mercy, Charles K. Brown, a 67-year-old man from Anderson, Calif., suffered a stroke while Dr. Moon was performing a catheterization and soon died. Staff members in Mercy's catheterization lab complained to the hospital's medical division, saying that Dr. Moon's care had fallen below appropriate standards.

According to court records, the staff members said that Dr. Moon left the hospital while the patient was unstable, leaving nurses without clear instructions. A review of the medical chart found no indication that Dr. Moon had taken basic preparatory steps to ensure that Mr. Brown was well enough for the procedure, according to written findings of the medical division.

As a result, the medical division ruled that Dr. Moon would have to be monitored by another doctor.

''Leaving the nurses to deal with the complication was inappropriate and a serious quality of care issue,'' read a letter to Dr. Moon from the medical division. 'You will not jeopardize patient safety.''

Dr. Moon objected, saying in a letter that he had alerted Mr. Brown's other doctors to his problems and had been assured they were handling his care. The division revised its decision, saying that the monitoring would be limited to two cases and that a letter would be placed in his file. Dr. Moon struck back, announcing in an advertisement in the local newspaper that he would no longer admit patients to Mercy. He then sued the hospital, claiming defamation and financial harm. The suit was later dismissed.

About the same time, Dr. Campbell, the internist, brought his concerns about Redding Medical Center's heart program to Mr. Corbeil, then the hospital's chief executive.

Dr. Campbell arrived at Redding in 1993 and quickly benefited from Dr. Moon's influence; the cardiologist helped him and three other doctors form a group practice, and pledged that Tenet would provide more than $100,000 toward the group's start-up costs.

The same year, Dr. Campbell's worries about the heart center began.. Dr. Moon recommended that a patient, Mary Rosburg, receive immediate coronary surgery, according to papers obtained by federal investigators. A surgeon working with Dr. Realyvasquez telephoned Dr. Campbell, vehemently arguing that no surgery was needed. Dr. Moon's view prevailed, and the once-reluctant surgeon performed the operation. Ms. Rosburg died from complications several months later.

In 1995, another of Dr. Campbell's patients, Emma Jean Montgomery, came under the care of Dr. Moon's team. An associate of Dr. Moon informed Dr. Campbell that the patient had severe coronary disease and needed immediate surgery, which Dr. Realyvasquez performed. Afterward, when Dr. Campbell reviewed the medical chart, he found none of the evidence of serious heart problems that Dr. Realyvasquez had described, according to records obtained by federal investigators.

Dismayed, Dr. Campbell took Ms. Montgomery's records to another local cardiologist, Dr. Roy Ditchey, who was astounded to hear that the patient had undergone surgery, according to information obtained by federal investigators.

It was then that Dr. Campbell approached Mr. Corbeil, but the administrator dismissed his concerns, papers obtained by the investigators say. Dr. Campbell, who still practices in Redding, has since filed a suit on behalf of the government, under the federal whistle-blower statute, which remains under seal.

When faced with credible concerns about a program, health care experts said, it is commonplace in the hospital industry to bring in an outside group to conduct a review.

''Most hospital administrators are very responsible,'' said Evelyn Baram-Clothier, executive director of the American Medical Foundation for Peer Review and Education. ''I have administrators who call us to review departments just to be sure they're O.K.''

In the fall of 1996, Mr. Corbeil was succeeded by Kenneth Rivers. The following spring, according to court documents and records obtained by federal investigators, a group of doctors including Dr. Campbell, Dr. Kittrick and two others approached him to discuss the cardiac program.

According to the papers, Dr. Kittrick spoke for the group and asked for an independent peer review of the cardiology program, to determine if the catheterizations were reliable. Mr. Rivers replied that he would have to ask Tenet's lawyers whether such a study would violate patient confidentiality, the records say.

No such study was ever done, according to doctors at the hospital.

As new administrators arrived, the same pattern was repeated. According to court papers and other records, Dr. Roy Pick, a local cardiologist, approached Mr. Rivers's successor, Stephen Schmidt, and Mr. Schmidt's replacement, Hal Chilton, the current chief executive. Each time, Dr. Pick, who had reviewed the records of some of Dr. Moon's patients, raised concerns about the heart program and asked for an independent peer review. None was undertaken.

Dr. Pick and Mr. Chilton did not return calls seeking comment. A phone number for Mr. Schmidt, who has since retired, could not be located. Phone numbers found through a computer search for Mr. Phillips, Mr. MacKay and Mr. Sorrentino were all disconnected.

Dr. Thomas Drakes, a board-certified oncologist who worked at Redding for two decades and taught at the University of California at Davis, said he, too, raised his concerns with Mr. Schmidt, with little result.

''Here I am, a guy on his staff who has some credibility, and I go to Schmidt and tell him he's going to have a '60 Minutes' episode on your hands here if you don't do something,'' Dr. Drakes said. ''He just said, 'Don't worry about it.' ''

But, by 2002 the secrets at Redding Medical Center were about to burst into public view.

Differing Diagnoses

Last year, the Rev. John Corapi decided, at 55, to have a cardiac stress test at Redding. He passed the test, but Dr. Moon still suggested a trip to the catheterization lab.

While Father Corapi, a Roman Catholic priest, was still on the table, Dr. Moon broke the news: He needed an emergency triple bypass. According to Father Corapi, the doctor said he had three dissecting arteries, a critical condition. Still, Dr. Moon suggested waiting for surgery until the next week, when Dr. Realyvasquez returned.

Anxious, Father Corapi said that he telephoned a friend in Las Vegas, Joseph F. Zerga, an accountant who had close contacts with a cardiac unit at a local hospital. He persuaded Father Corapi to come to Nevada for the emergency surgery.

But when he got to Las Vegas, the heart specialists were confused. ''While I was being processed in, the cardiologist there said, 'Excuse me, what are we bypassing?' '' said Father Corapi, who, like Dr. Campbell, has filed a whistle-blower suit.

Back in Redding, Father Corapi and Mr. Zerga met with hospital officials, who said that two cardiologists had reviewed the records and agreed with Dr. Moon's findings, though they declined to name the doctors. ''I expected the hospital to be extremely concerned over this situation,'' Mr. Zerga said. ''But they weren't.''

When further discussions with the hospital proved unsatisfactory, Mr. Zerga contacted the Federal Bureau of Investigation. Within days, agents found their way to Robert G. Simpson, a lawyer in Redding for whom Dr. Moon had recommended a four-way bypass last summer. Mr. Simpson had challenged Dr. Moon's diagnosis after getting a second and a third opinion. Mr. Simpson has since been interviewed by federal investigators and is now representing numerous patients suing Redding.

Four months after being contacted about Father Corapi, federal agents raided the hospital.

For Tenet, it was as if the roof were suddenly falling in.

Near the time of the Redding raids, the company was hit with other financial body blows that raised the same question: Was Tenet really as successful as it had long appeared? Or had it just profited from multiple methods — including unnecessary surgery at Redding — of gaming the Medicare system?

On Oct. 28, Kenneth Weakley, an analyst with UBS Warburg, reported that Tenet was heavily dependent on special Medicare payments for particularly sick patients. These ''outlier'' payments accounted for about 24 percent of Tenet's base Medicare payments for overnight stays, Mr. Weakley wrote, triple the amount three years earlier.

That same day, the federal Department of Health and Human Services notified Tenet that it would be auditing its hospitals to see if the company had been improperly manipulating its outlier payments. The company failed to disclose the information publicly for more than a week, later saying it had waited until it had more specifics. (The overpayment allegations were not covered by the $54 million settlement.)

As the events unfolded, the nature of the outlier problem became clear. Tenet hospitals had been rapidly increasing their retail charges — amounts actually paid by very few people who have procedures without insurance. But those numbers are used in determining outlier amounts. In essence, Medicare was paying Tenet more for treating sicker people, when in fact all Tenet was doing

was charging higher prices.

Under pressure from investors, Tenet in early November disclosed that it received $763 million in outlier payments in the 2002 fiscal year, much of it from 11 hospitals that had ramped up retail charges. Seven of those 11 hospitals are in California.

Among that group is Redding Medical Center. According to federal data, outlier payments to Redding were off the charts. Medicare projected that it would pay 5.1 percent of its total standard payments for inpatient care at all hospitals to outliers. At Redding, in fiscal 2002, the payments instead reached 118.6 percent, or $55.7 million.

Indeed, the problems at Redding seem to infuse the repeated scandals at Tenet. Two of the company's biggest allies of Dr. Moon and Dr. Realyvasquez were soon gone. Mr. Mackey, the company's chief operating officer, left in November amid reports that he was an architect of the company's pricing strategy. Then, in March, Mr. Sorrentino, head of the company's California hospital operation, also departed.

As the scandals unwound, with pricing strategies changing and the cardiac program suspended, Redding's finances fell apart.

According to data filed with the State of California, total net patient revenue at Redding for the first quarter of this year (the latest data available) dropped almost in half from the period last year, falling from $61.1 million to $31.2 million. All told, more than 75 percent of that decline came from the drop in Medicare payments, which fell by $23 million.

Indeed, the numbers at Redding raise questions about how problems at the hospital could have been missed. The state filings show, in the 12 months ended June 30, 2002, Redding Medical Center generated pretax net income of $94 million, more than any other of Tenet's 40 hospitals in California. Just down the street, the larger Mercy Medical Center reported pretax net income of about $5 million in the same period.

''When those types of numbers get reported back to the home office, does everyone stay willfully blind and declare a holiday, or does someone say, 'Let's postpone the celebration and take a hard look at these,' '' said Neil Getnick of Getnick & Getnick, which specializes in business integrity counseling. ''Part of business integrity is creating reasonable expectations amongst shareholders of what kind of profits you can achieve, and what we have seen with Tenet indicates that the company departed from that basic model.''

In that, analysts say, is the essence of the problem. Different hospitals can be run more efficiently, but ultimately, health care is a commodity; the science available at one hospital is the same across the street. The industry itself is more than a century old. Yet Wall Street expects and rewards double-digit earnings growth from hospital companies, something analysts say is unsustainable.

''The hospital industry is by its very nature a mature industry,'' said Mr. Reinhardt, the Princeton economist. ''It is not a high-margin business. It can't be a growth industry like some Internet company. That is just unreasonable.''

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Industry Fights to Put Imprint on Drug Bill

By SHERYL GAY STOLBERG and GARDINER HARRIS

In the thick of the 2000 presidential campaign, executives at Bristol-Myers Squibb, one of the nation's largest drug companies, received an urgent message: donate money to George W. Bush.

The message did not come from Republican campaign officials. It came from top Bristol-Myers executives, according to four executives who say they donated to Mr. Bush under pressure from their bosses. They said that they were urged to donate the maximum — $1,000 in their own name and $1,000 in their spouse's — and were warned that the company's chief executive would be notified if they failed to give.

Bristol-Myers said no one was forced to donate. But elsewhere in the drug industry, the message about the election was much the same. At some companies, officials circulated a videotape of Vice President Al Gore railing against the high price of prescription drugs. A torrent of contributions for Mr. Bush and other Republicans resulted. And the money kept flowing, right through the elections of 2002.

Those donations may soon pay off handsomely for the pharmaceutical business. Four years ago, a Democrat was in the White House and the industry was bitterly fighting a prescription drug proposal that it said would have led to price controls. Today, a Republican-controlled Congress is preparing to send a Republican president a measure with a central provision — the use of private health plans to deliver Medicare prescription drug benefits — that is tailor-made to the industry's specifications.

The story of how pharmaceutical manufacturers helped shape the Medicare drug benefit is, in part, that of a calculated decision by a lucrative industry to throw its financial weight behind one political party — with $50 million in campaign contributions over the last four years, the vast majority to Republicans. It is also the story of a dogged, mostly unseen campaign that included a small army of lobbyists in Washington and a network of industry-financed groups, which carried the drug makers' message to the public.

Throughout, the industry had a single goal: to defeat any legislation

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that would let Medicare negotiate steep discounts on the prices of medicines for its 40 million beneficiaries.

Instead, if there had to be a prescription drug benefit, industry executives agreed that it should be administered by the private sector, where insurance companies would negotiate on their own, without Medicare's influence. That is precisely what will occur if bills passed by the House and Senate are reconciled and a law is signed by President Bush. Both measures envision taxpayers spending $400 billion over the next 10 years on the drug benefit alone, with banking government officials from even seeking volume discounts.

"The drug lobby has just emasculated Congress with tons of money," said Representative Pete Stark of California, the senior Democrat on the health subcommittee of the House Ways and Means Committee, whose Republican leaders wrote the House Medicare bill. "They bought themselves a deal."

But Republicans say that their legislation will lead to discounts and that the industry gave up as much as it got.

"I think the drug industry would rather not have any bill," said Senator Charles E. Grassley, the Iowa Republican who, as chairman of the Senate Finance Committee, is a driving force behind the legislation. "But they know there is going to be a bill because of public demand for it, and I think they are just swallowing hard."

For the manufacturers, the stakes could hardly be higher. The United States, the last industrialized country with unregulated drug prices, provides half of the industry's revenues, up from less than a third a decade ago, and most of its profits. And the elderly are its best customers. Some companies estimate that up to half of their sales in the United States are for prescription drugs bought by the elderly. Pfizer alone sells medicines to treat cholesterol, blood pressure and arthritis problems that brought in $17 billion last year — nearly all from Medicare-eligible patients.

Some companies, like Merck, are pressing hard for the legislation, while others are lukewarm. A number of drug executives say they fear that the proposed benefit is so skimpy that Congress will be forced over time to improve it — a move that will eventually lead to price controls. One described the measure as "deeply flawed."

Yet even those drug executives with reservations say they will not stand in the legislation's way. A spokesman for the Pharmaceutical Research and Manufacturers of America, an industry trade group, said that passing a Medicare drug benefit "remains the top priority."

"I kind of hate to say the industry got what it wanted," said Ian Spatz, vice president for public affairs at Merck. "But I think it's a fair solution that does give people access to our medicines, and does it in a way that is least likely to lead to price controls."

The Beginnings

RE-EXAMINING MEDICARE
The Drug Industry's Muscle

Clinton Plan Spurred Industry Into Action

It was the White House — the Clinton White House — that provided the impetus for the drug makers' long-running campaign to shape the public discussion about a Medicare drug benefit.

Late in his second term, Mr. Clinton proposed giving elderly Americans some relief from the cost of prescription drugs. Knowing that a benefit administered by Medicare would never pass muster with Republicans, he called for Medicare to contract with private pharmaceutical benefits managers, or P.B.M.'s — one per region of the country — to manage drug purchases for the government.

The drug industry hated the idea. Private benefits managers had gained a foothold in many positions of considerable power just a few years earlier, and drug makers were stunned by their ability to drive down prices and even shift sales to competitors' pills.

So the drug makers took a page from the insurance industry's successful Harry and Louise advertising campaign, which helped defeat the Clinton health care plan in 1994.

This time, an arthritic bowler named Flo was featured in a $30 million ad campaign. "I think the drug industry would rather not have any bill," said Senator Charles E. Grassley, the Iowa Republican who, as chairman of the Senate Finance Committee, is a driving force behind the legislation. "But they know there is going to be a bill because of public demand for it, and I think they are just swallowing hard."

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The Contributions

A Push for Money, Mostly for the G.O.P.

Republican campaign officials were keenly aware of the drug industry's growing anxiety about how a drug benefit might be set up.

In a letter dated April 9, 1999, Jim Nicholson, then the Republican National Committee chairman, wrote to Charles A. Heimbold Jr., then the chief executive of Bristol-Myers, to discuss plans for a coalition to lobby for issues important to drug companies.

"We must keep the lines of communication open if we want to continue passing legislation that will benefit your industry," Mr. Nicholson wrote in the letter, which has since become public as part of litigation on campaign finance rules.

He encouraged Bristol-Myers — already a major donor to Republicans — to give $250,000 to join the national committee's Season Pass program, which offered donors "premier seating" at a number of events. Mr. Gilmartin said: "We decided that getting seniors access included the risk of price controls."

On Capitol Hill, meanwhile, Senator Edward M. Kennedy, Democrat of Massachusetts, was quietly reaching out not just to Mr. Gilmartin, but to Gordon Binder, then the president of the industry's largest group.

"It was apparent to me that if they were going to lock it, nothing was going to be achieved," Mr. Kennedy said. "I've been around here long enough to know that was the case. So the question was whether you could find any common ground."

The administration officials also had talks with industry officials, hoping for a compromise. But when news of conciliatory moves between drug makers and Democrats became public, some Republicans and a few industry executives were furious. Executives at several companies suspected that Mr. Gilmartin supported a drug benefit because he had hopes that Medco, a Merck pharmacy benefits subsidiary, would land a crucial role in buying drugs.

"Having the whole benefit run through a couple of P.B.M.'s — especially if one were Merck-Medco — could be a disaster," said one industry executive, speaking on condition of anonymity. Another, at a different pharmaceutical company, said, "Gilmartin wrapped himself in some clever rhetoric of private-sector solutions, and it used to drive us crazy."

Merck has since spun off Medco, and Mr. Gilmartin said that his support of a Medicare drug benefit had nothing to do with Medco.

In the end, the talks between the drug industry and Democrats went nowhere. The industry pinned its hopes on the election of Mr. Bush, who supported a Medicare drug benefit, so long as it was administered through the private sector. In early 2000, the pharmaceutical industry announced it would do the same.

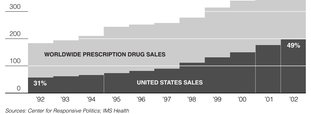
"When Bush came out for it, that nailed it," one industry executive said. "Where else are we going to go?"

Drug companies have increased their political contributions, particularly to Republicans . . .

ELECTION CYCLE	DRUG COMPANIES' CONTRIBUTIONS (millions) DEMOCRATS	REPUBLICANS	INDUSTRY RANK*
1990	$1.5	$1.7	27
1992	3.4	4.5	22
1994	3.3	4.3	20
1996	4.5	9.0	16
1998	4.5	8.4	17
2000	8.3	18.3	13
2002	6.6	20.3	11

*Among more than 80 industries.

. . . as the United States market has become increasingly important to the industry.



Sources: Center for Responsive Politics; IMS Health

The New York Times

said the company's huge contributions resulted in part from aggressive internal solicitations. Each said they were told that a list of those who did not contribute would be given to Mr. Heimbold.

"The need to gather in money to provide green power for our Washington activities was spelled out in excruciating detail to all company officers," one of these executives said.

A spokeswoman for Mr. Heimbold, now the United States ambassador to Sweden, said she had no comment.

Federal election law bars companies from using coercion to force someone to make a political contribution. A spokesman for Bristol-Myers, John Skule, said yesterday that while "we ask for active participation in the political process," no one was forced to donate, and the company "takes very seriously its duty" to comply with election laws.

"There was not one person in the company who lost their job because they didn't donate," Mr. Skule said.

The push to gather money for Republicans was prevalent throughout the drug industry during the 2000 campaign. With Vice President Gore saying that drug makers were gouging the elderly, the industry contributed $29 million to candidates and parties during the campaign, 79 percent of it to Republicans, according to the Center for Responsive Politics.

More important, the industry bought $56 million in TV commercials and radio ads, more in radio, newspaper and direct-mail ads. The ads assured voters that Republican lawmakers were fighting for a Medicare drug benefit. Drug makers also gave the United States Chamber of Commerce $10 million more to run ads under its name. Months before the election, House Republicans passed a bill along the industry's preferred lines.

The bill never gained traction in the Democratic-controlled Senate. And when Mr. Bush was the election, the drug makers celebrated. As one industry executive said, "There were a lot of high-fives around here."

The Victories

A New Congress And a New Outlook

Having a Republican in the White House, however, was not enough to bring elderly people the relief they were clamoring for. In the two years after the 2000 election, a Medicare drug benefit remained bogged down in partisan politics on a divided Capitol Hill.

The drug industry contributed $26 million in the 2002 election, again mostly to Republican candidates. And it again spent millions on television ads in crucial districts around the country — this time telling voters that Republican incumbents had been fighting to add prescription drugs to Medicare.

"What they did, which was so clever, was run ads in Republican districts saying, 'Thank Congressman X for coming up with a prescription drug program for seniors,' " said Senator John McCain, Republican of Arizona, who railed against this year's Medicare bill, saying it favored drug makers while providing the elderly scant relief. "They were helping these guys get re-elected who had done nothing."

Afterward, the drug industry claimed credit for several crucial victories that helped keep Republicans in charge of the House — and, more important, helped them win back the Senate. Once again, industry executives celebrated on election night.

"Having both houses of Congress Republican-controlled was great," one drug lobbyist said. "Like in Monopoly, when you get to add hotels."

By the time the 108th Congress convened in January 2003, drug makers no longer faced the danger of a benefit administered by Medicare. Lobbyists for consumer groups knew not to bother trying. "The whole question of Medicare being the direct purchaser was off the table at the beginning of this Congress," said John C. Rother, the chief lobbyist for AARP, the organization representing retired people.

Changes within the drug industry also increased the likelihood of a drug benefit delivered through the private sector. Merck's spinoff this year of Medco assuaged much of the concern in the industry that any bill would give Merck an unfair advantage.

With the framework of a privately delivered benefit already settled, industry lobbyists went to work on the details. A critical issue was ensuring that Medicare administrators could not press directly for discounts. Both the House and Senate bills have language barring Medicare officials from interfering "in any way with negotiations" between insurers and drug companies.

The industry also won a provision in the House bill that puts Medicare in charge of drug benefits for the elderly poor. That would strip the responsibility from state Medicaid programs, which have begun to rein in costs by limiting purchases of high-price drugs.

In addition, several drug companies pressed lawmakers to include provisions that would allow patients to appeal insurers' decisions to deny coverage for certain drugs, and they fought an amendment to the Senate bill, offered by Senator Hillary Rodham Clinton, Democrat of New York, that would have included money for studies comparing drugs' cost-effectiveness.

"It seems to me if we are going to move toward a market mechanism — which I have a lot of questions about — markets thrive on information, and this is information which is largely within the province of the drug companies," Mrs. Clinton said.

Her amendment failed, receiving just 43 votes. That was no surprise to Senator Clinton, or to others who voted against the Senate bill, including Senator McCain. "There's no doubt in my mind that the drug industry got everything it wanted and more," he said. "It perhaps should be called the 'Leave No Lobbyist Behind Bill.' "

In fact, the industry did not win every battle. Both the House and Senate bills contain provisions that would speed generic drug approvals — a move the manufacturers of brand-name drugs oppose.

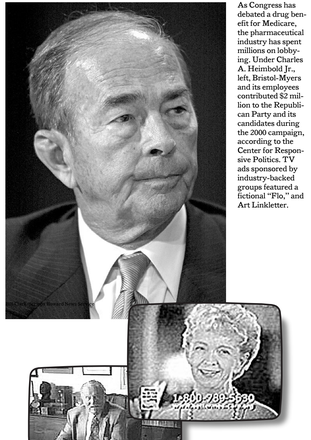
And in the House, a provision that would make it easier for Americans to import cheap drugs from Canada and Europe passed, despite intense industry lobbying against it. Later, the industry persuaded 53 senators to sign a letter saying they oppose the provision. The matter must now be settled in conference.

While the lobbyists worked behind closed doors, the industry financed citizens' groups to bring its message to the public. One such group was the United Seniors Association, whose national spokesman, Art Linkletter, took to the airwaves this spring, congratulating lawmakers who voted to add prescription drugs to Medicare. Gone was the strident campaign featuring Flo, the bowler. Mr. Spatz, of Merck, said there was no need.

"Back then it was really about opposing President Clinton's proposal," he said. "This wasn't about opposing anything. This was about supporting something."

The industry's silence could change, of course, as the House and Senate reconcile their bills. But so far, the behind-the-scenes strategy seems to have been successful. Industry opponents see the low public profile as evidence of the drug makers' satisfaction.

"The dog is not barking," said Bill Vaughan, a lobbyist for Families USA, a consumer group. "I think the dog got what it wanted."



As Congress has debated a drug benefit for Medicare, the pharmaceutical industry has spent millions on lobbying. Under Charles A. Heimbold Jr., left, Bristol-Myers and its employees contributed $2 million to the Republican Party and its candidates during the 2000 campaign, according to the Center for Responsive Politics. T'V ads sponsored by industry-backed groups featured a fictional "Flo," and Art Linkletter.

The New York Times

NEW YORK, SATURDAY, SEPTEMBER 13, 2003

Patients in Florida Lining Up For All That Medicare Covers

By GINA KOLATA

BOCA RATON, Fla. — It is lunchtime, and the door to Boca Urology's office is locked. But outside, patients are milling about, calling the office on their cellphones, hoping the receptionist will let them in. To say they are eager hardly does them justice.

''We never used to lock the door at lunch, but they came in an hour early,'' said Ellie Fertel, the office manager. ''It's like they're waiting for a concert. Sometimes we forget to lock the door and they come in and sit in the dark.''

Yet few have serious medical problems, let alone emergencies. ''It's the culture,'' said Dr. Jeffrey I. Miller, one of four urologists in the practice.

Doctor visits have become a social activity in this place of palm trees and gated retirement communities. Many patients have 8, 10 or 12 specialists and visit one or more of them most days of the week. They bring their spouses and plan their days around their appointments, going out to eat or shopping while they are in the area. They know what they want; they choose specialists for every body part. And every visit, every procedure is covered by Medicare, the federal health insurance program for the elderly.

Boca Raton, researchers agree, is a case study of what happens when people are given free rein to have all the medical care they could imagine. It is also a cautionary tale, they say — timely as Medicare's fate is debated in Congress — for it demonstrates that what the program covers and does not cover, and how much or how little it pays, determines what goes on in a doctor's office and why it is so hard to control costs.

South Florida has all the ingredients for lavish use of medical services, health care researchers say, with its large population of affluent, educated older people and the doctors to accommodate them. As a result, Dr. Elliott Fisher, a health services researcher at Dartmouth Medical School, said, patients have more office visits, see more specialists and have more diagnostic tests than almost anywhere else in the country. Medicare spends more per person in South Florida than almost

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RE-EXAMINING MEDICARE
The Reimbursement Game

Continued From Page A1

anywhere else — twice as much as in Minneapolis, for example.

But there is no apparent medical benefit, Dr. Fisher said, adding, ''In our research, Medicare enrollees in high intensity regions have 2 to 5 percent higher mortality rates than similar patients in the more conservative regions of the country.''

Doctors say that Medicare's policies are guiding medical practice, with many making calculated decisions about whom to treat and how to care for them based on what Medicare covers, and how much it pays.

''The bottom line is that the stuff that reimburses well is easier to get done,'' Dr. Carl Rosenkrantz, a Boca Raton radiologist, said.

Thomas A. Scully, administrator of the Centers for Medicare and Medicaid Services, said he knew the situation all too well.

''We have a system that does nothing to look at utilization,'' Mr. Scully said in a telephone interview. ''If you send in a bill and you are legitimate, we pay it.''

The effect shows up in the way doctors deal with office visits, for example. Medicare in Boca Raton pays $52.46 for a routine visit, in which a doctor sees a patient with no new problem. That is not enough, doctors say; it costs about $1,500 a day to run an office there, they explain. Payrate and fees in other states are different, adjusted for cost of living, but doctors say, and Mr. Scully agrees, that they are generally inadequate. Doctors who try to make a living seeing only Medicare patients for routine visits, he said, ''have a very rough time.''

Medicare bases its payments on a system in which each kind of service is assigned a ''relative value,'' Mr. Scully said. To increase the payment for routine office visits and stay within its budget, Medicare would have to decrease the relative value of other services.

A committee of doctors meets each year to suggest relative values, he said, but ''the most aggressive and active groups tend to be the specialists.''

''Year after year,'' Mr. Scully went on, ''the specialists come in and make a very strong argument for higher reimbursements. There's eventually a squeeze on the basic office visit.''

In many areas of the country, private insurers pay more for office visits than Medicare does, so doctors can essentially subsidize their Medicare patients.

''If we just saw Medicare patients and didn't see anyone with regular insurance, we wouldn't be able to pay the bills,'' said Dr. James E. Kurtz, an internist at Chatham Crossing Medical Center in Pittsboro, N.C.

Elsewhere, many doctors are refusing to see Medicare patients. ''Some counties in Washington have no doctors who take new Medicare patients,'' Dr. Douglas Paauw, a professor of medicine at the University of Washington, said.

Doctors in South Florida do not have a choice. Private insurers there pay the same as Medicare or less, and so many old people live in the area that if doctors want to practice, they must accept them. But how to make a living?

One way, Dr. Robert Colton, an internist in Boca Raton, said, is to see lots of patients, spending just a few minutes with each and referring complicated problems to specialists.

Dr. Colton did that for a while, seeing as many as 35 patients a day. A typical busy internist, he said, would see 20 patients a day. ''I felt like a glorified triage nurse,'' he said.

''If you try to handle a complex problem, it slows you down,'' Dr. Colton said. ''You have to sit down with the family, meet with the patients, talk to them. If you say you have coughing and you are short of breath and your knee hurts, I might have sent you to two different specialists.''

The goal, Dr. Rosenkrantz said, is to move the patients on. ''The worst thing that can happen is for someone to walk into your office and say, 'I have an interesting case for you.' Financially, you'd be dead.''

Even seeing patients in the hospital can become an exercise in time management, Dr. Rosenkrantz said. ''We have doctors who do rounds at 4 a.m.''

A second driving force behind medical care in Boca Raton is the demands of patients. They want lots of tests and specialists, they refer themselves to specialists, they ask for and get far more medical attention from specialists than many doctors think is reasonable or advisable.

''This Medicare card is like a gold card that lets you go to any doctor you want,'' Dr. Colton said. ''I see it every day. When there's no control on utilization, it's just the path of least resistance. If a patient says, 'My shoulder hurts, I want an M.R.I., I want to see a shoulder specialist,' the path of least resistance is to send them off. You have nothing to gain by refusing.''

Patients here say they have mixed emotions. They complain about rushed primary care doctors but readily admit that they seek multiple specialists and multiple procedures.

The primary care doctors are often irritatingly busy, patients say. ''In waiting rooms sometimes they are standing against the wall,'' said Marvin Luxenberg, a retired lawyer who lives in nearby Boynton Beach. Then, he said, ''when you get in to see the doctor, you get just three or four minutes of time.''

Dr. Colton says he found a way to give his patients more time. He joined a ''concierge'' practice, in which patients pay an annual fee in addition to the normal charges for medical services. Dr. Colton's group, MDVIP, charges patients $1,500 a year and limits the number of patients each doctor sees.

But not everyone wants to pay that kind of fee. Many patients just spend their time in specialists' offices. Each specialist handles a different aspect of their care, with no one coordinating it.

Specialists get no more than primary care doctors for an office visit, but they provide tests and procedures that demand higher Medicare reimbursements. Doctors say those payments allow them to stay in business, especially if they provide the procedures in their own office.

Medicare pays the doctor and the facility where a procedure is done. For a nuclear stress test, for example, the doctor gets about $200 and the facility gets about $1,200.

''Doctors have incorporated these tests as much as possible into their offices so they can gain from the facility fee,'' Dr. Thomas Bartzokis, an interventional cardiologist in Boca Raton, said.

Patients say they have lots of specialists, and lots of tests. Asked how many doctors he saw, Leon Bloomberg, 83, a patient of Dr. Miller, thought for a minute and looked at his wife, Esther.

''Between us, we have 10 or 12,'' Mr. Bloomberg said, including a pain specialist and a neurologist for his neuropathy, a cardiologist for his heart condition, ''a pulmonary man'' for his asthma, a rheumatologist for his arthritis and Dr. Miller for his prostate. Mrs. Bloomberg has her own doctors, including ones for heart disease and for diabetes. ''We have two to four or more doctors' appointments a week,'' Mr. Bloomberg said.

It is easy to find all these specialists, he said. ''You get recommendations at the clubhouse, at the swimming pool. You go to a restaurant here and 9 times out of 10, before the meal is over, you hear people talking about a doctor or a medicine or a surgery.'' And of course there are the other patients in all those waiting rooms. Mr. Bloomberg even recommends specialists to his own doctors.

But some patients say they are frustrated by what they call a waste of resources. ''The doctors are raping Medicare,'' said Louis Ziegler, a retired manufacturer of flight simulators who lives in Delray Beach.

Mr. Ziegler recalled going to a doctor for a chronic problem, a finger that sometimes freezes. All he wanted was a shot of cortisone. But he got more, much more: ''I had diathermy, I had ultrasound, I had a paraffin massage. I had $600 worth of Medicare treatments to get my lousy $35 shot of cortisone.''

Dr. Colton, the internist here, is frustrated, too.

''The system is broken,'' he said. ''I'm not being a mean ogre, but when you give something away for free, there is nothing to keep utilization down. And as the doctor, you have nothing to gain by denying them what they want.''

More Care, Not Better Care

Higher Medicare spending does not necessarily translate into better care, according to a study in the Annals of Internal Medicine last February.

MORE RESOURCES The highest-spending regions have more specialists, surgeons and hospital beds per capita than the lowest-spending regions.

MORE SERVICES, WORSE OUTCOMES Medicare enrollees in the highest-spending regions get more services than those in the lowest. But they also have slightly higher risks of death.

Sources: Dr. Elliott S. Fisher, Dartmouth Medical School; Annals of Internal Medicine

The New York Times

The New York Times

NEW YORK, SUNDAY, OCTOBER 26, 2003

Generous Medicare Payments Spur Specialty Hospital Boom

By REED ABELSON

INDIANAPOLIS — The hospitals here — hospitals across the United States, for that matter — covet patients like Robert E. Wilson. Mr. Wilson, 79, has had two open-heart operations, five angioplasties, three cardiac catheterizations and an implanted defibrillator. Just last month, he checked into the Heart Center of Indiana to get his first stent, a tiny bit of wire scaffolding that helps keep arteries open.

Mr. Wilson's primary health insurance is Medicare, and Medicare pays generously for cardiac care — so generously that hospitals and doctors scramble after the business.

The Heart Center, a 60-bed hospital that cost $60 million and boasts not just the most sophisticated new imaging technology but an executive chef and what it calls ''room service,'' opened last December. Indeed, all four major hospital groups in Indianapolis are investing in new heart hospitals, collectively spending $215 million on multistory buildings with catheterization labs and bedside computers.

Cranes have been raised over construction sites in places like Milwaukee, Phoenix and Houston, too, with money flowing into new hospitals specializing not just in cardiac care, but in other well-reimbursed specialties like orthopedics and surgery. In a report this month, the General Accounting Office, the investigative arm of Congress, counted at least 26 specialty hospitals under construction across the country.

Medicare — which pays for some $100 billion of inpatient hospital care annually, and sets the pattern for many private insurers, as well — is not the sole driver of this investment. But health executives say that Medicare's payment system for hospitals, with its emphasis on procedures and its weak ties to the actual costs of providing care, exerts a strong influence on which medical needs in a

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RE-EXAMINING MEDICARE

A Broken-and-Mended Race

Continued From Page 1

community are met.

Amid the building boom here in Indianapolis, some hospitals are laying off employees or scaling back programs, like psychiatric care, that are less generously reimbursed. Preventive care and case management, health experts add, get short shrift.

''The incentives are terribly misaligned,'' said Samuel B. Nussbaum, a doctor and former hospital executive who is now the chief medical officer of Anthem, a large health insurer here.

Creating Excess Demand

A study of Indianapolis health care last year concluded that the construction of so many new heart hospitals could create excess demand for treatment rather than produce better cardiac care.

''Improving clinical quality did not appear to be a driving force for new facilities or services,'' said the report, by the Center for Studying Health System Change, a nonprofit research group. ''Given these market conditions, provider competition could, alternatively, result in higher use rates and costs.''

In Washington, lawmakers rushing to complete a compromise bill that would establish a Medicare prescription drug benefit are now turning their attention to the growth of specialty hospitals. The Senate version of the Medicare bill would make it harder for doctors to invest in and refer patients to such hospitals, and full-service hospitals are lobbying hard for the provision.

Hospitals will typically not disclose how much they profit from a particular procedure, like a coronary bypass or angioplasty. And Medicare — with little information about the cost of treatment — cannot say, either. But one full-service medical center that is leading the lobbying campaign against specialty hospitals, Sioux Valley Hospital in South Dakota, estimates that it makes nearly $3,200 for a typical coronary bypass under Medicare, while it loses almost $1,800 treating a case of simple pneumonia and $2,500 on a patient with kidney failure.

Cardiac procedures ''are absolutely our highest margin business,'' said Becky Nelson, the president of Sioux Valley, who estimates that they account for 13 percent of the hospital's patient volume but 28 percent of its profits. Costs and payment levels vary so widely around the country that Dr. John Birkmeyer, a surgeon who studies health care at Dartmouth Medical School, estimates that some hospitals may make nearly $20,000 on a coronary bypass.

In Indianapolis, there is recognition that reimbursement levels have influenced hospitals' behavior.

''We're working on a payment system that has been jerry-rigged so many times, we've been looking for the loopholes,'' said Jack C. Frank, an executive at Community Health Network, which opened the Indiana Heart Hospital this year in partnership with local doctors.

Hospital Building Boom

Just 20 minutes southeast of the Heart Center of Indiana, Mr. Frank's $60 million center says it is the nation's first all-digital heart hospital, using electronic patient records to track care. Roughly 45 minutes to the south, construction is well under way on the latest — and most expensive — competitor here, the St. Francis Cardiac and Vascular Care Center, expected to cost about $65 million when it opens next year.

Even some of the people building the hospitals worry that Indianapolis may not be able to support them all, though heart disease is the leading cause of death among Indiana residents.

''It can't work,'' said Daniel F. Evans Jr., the chief executive of Clarian Health Partners, whose Clarian Cardiovascular Center is the most modest of the undertakings, at $30 million, and the only one built within a full-service hospital.

Executives, of course, vigorously defend the decisions to build their own facilities. Heart hospitals, they say, help pay for money-losing cases, like accident victims or patients with congestive heart failure.

''Cardiac care has been a source of some margin, which has been very important in subsidizing some services,'' said Robert J. Brody, the chief executive of St. Francis Hospital and Health Centers.

Nothing in the Medicare legislation before Congress would directly alter the hospital payment system. But advocates, mainly Republicans, for provisions aimed at encouraging more beneficiaries to enroll in private health plans say that bigger plans would have more leverage to negotiate better prices.

''The prices are being fixed'' by the government, said Thomas A. Scully, who runs Medicare as administrator of the government's Centers for Medicare and Medicaid Services. Local insurance companies would be much better at deciding how to pay doctors and hospitals to deliver quality care, he said.

Payment System Is Dated

The current system was adopted in 1983, in an effort by the federal government to control costs. Until then, Medicare basically reimbursed hospitals for their costs of delivering care, an arrangement that offered them no incentive to keep hospital stays short. The new plan established fixed prices for treating a specific disease or performing a given procedure. Some cases might cost more and some less, but the price Medicare paid was supposed to represent the average.

As a cost-control mechanism, the system has been largely successful. The problem, say hospital executives and industry analysts, is that after 20 years, the payments are out of whack: Medicare frequently pays too much for some kinds of care and too little for others.

To take account of the rapid changes in medicine, like new technologies and treatments, Medicare collects data on hospital charges — essentially list prices for everything from a cardiac catheterization to bypass surgery to treatment for pneumonia. The agency then tweaks prices relative to one another, updating its payment schedule once a year.

But charges often bear little relation to a hospital's actual costs, any more than a car's sticker price directly indicates what it costs to build the car. And hospitals rarely, if ever, lower their charges, say industry analysts, even when their costs fall significantly.

''Administered price systems tend to break down over time,'' said Joseph P. Newhouse, a Harvard University professor of health policy who is a member of the Medicare Payment Advisory Commission. ''If you're overpaid, everybody smiles on the way to the bank, and you may induce more services.''

Just how overpaid is unclear. Many hospitals lack the accounting systems to determine their exact expenses for specific procedures. Hospitals also have tremendous discretion in allocating expenses across departments, let alone procedures.

In the case of a coronary bypass, for example, hospital charges increased nearly 30 percent from 1993 to 2001, even as the average hospital's duration decreased to 9 days from nearly 12 days, according to data from the Healthcare Cost and Utilization Project of the Agency for Healthcare Research and Quality, a government group in Rockville, Md.

Profitability Varies Widely

What seems certain is that there are wide variations in the profitability of different hospital services under Medicare. Mark Wietecha, who directs health care consulting for Kurt Salmon Associates, estimates that the profit margin for surgery, including cardiovascular cases, is about 15 percent for some hospitals, compared to just 2 percent for gastrointestinal care.

''People build their business plans and facilities on these profitabilities,'' he said.

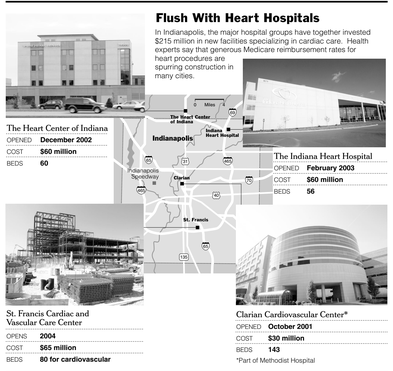
In Indianapolis, the rush to build heart hospitals is leading to what appears to be significant duplication of services.

Heart transplants are offered only by St. Vincent and Clarian, which is affiliated with Indiana University, but many services are available at all four heart hospitals. In fact, St. Vincent's new heart hospital, the Heart Center of Indiana, competes directly with its parent hospital for patients. And some doctors at Clarian who have invested in the Heart Center are sending profitable cases there, according to Mr. Evans, Clarian's chief executive, working on only the most difficult — and expensive — cases at his hospital.

The construction boom here was influenced by the threat of a new competitor, the MedCath Corporation, a for-profit chain with 11 heart hospitals in nine states that opened discussions with some local doctors. To avert MedCath's entry into the market, Community Health and St. Vincent made deals of their own with doctors to build facilities.

Hospital executives here are quick to agree that more needs to be done to help people stop smoking or lose weight — steps that could help prevent the diseases they make money treating. ''Our reimbursement is all around acute care,'' said Sister Sharon Richardt, a St. Vincent executive. ''I think where the flaw is we need to keep people well. We need to start reimbursing for prevention.''

But Medicare was created nearly four decades ago to prevent the financial catastrophe that often occurred when an older person suffered a heart attack or when a disease like cancer was diagnosed. Payments are therefore ''episodic'' rather than intended to encourage hospitals and doctors to prevent disease or coordinate care, said Dr. Gerard F. Anderson, a former federal health official who helped develop the system and now teaches at the Johns Hopkins Bloomberg School of Public Health.



Patients Can Lose

Patients like Corinne Walker, an 83-year-old Indianapolis woman who suffers from congestive heart failure, are not always well served. In late 2000, she developed cellulitis, a serious bacterial infection, in her legs, and spent months in three hospitals. No one bothered talking to her personal doctor, Ms. Walker said. To her, it seemed as if the people treating her virtually ignored her heart condition, although it contributed to her cellulitis.

''They were working on my legs, period,'' Ms. Walker said. Only after she was sent home, with a nurse orchestrating her care, was she finally able to get better, Ms. Walker said.

In Indianapolis, the treatment of chronic conditions ''has fallen through the cracks,'' acknowledged Mr. Frank, the Community Health Network executive. With long hospital stays and few options for aggressive intervention, congestive heart failure is a particularly money-losing diagnosis, executives say; the Sioux Falls hospital says it loses $1,200 on the average case.

Even so, there is little constituency — outside a circle of policy analysts — for overhauling a payment system that produces such results.

Many hospitals have figured out how to make the most of the status quo. Tenet Healthcare has been formally accused of abusing the system by which Medicare pays for the most expensive cases. But hospitals generally try to fit their care into the most lucrative billing codes.

''In fact, you see a great deal of gaming going on,'' said David Butz, a health economist at the University of Michigan.

Lawmakers, meanwhile, focus on small fixes to the system. With cuts in spending on cancer or heart disease politically unpalatable, they tend, under lobbying pressure, to expand coverage or increase payments.

Impetus to refine the existing system has also been blunted by the unwillingness of Congress to better analyze the cost of care, policy analysts say. Some experts say that Medicare's administrative expenses — 2 to 3 percent of its overall budget — have been kept too low.

Armed with more information, they say, Congress could realign the incentives to cut costs and improve care.

''We have a limited budget,'' Dr. Christopher M. Callahan, the director of the Indiana University Center for Aging Research, said. ''From a public health perspective,'' he added, the question is: ''Where would those dollars best be spent?''

The New York Times

NEW YORK, FRIDAY, DECEMBER 5, 2003

Hospitals Say They're Penalized By Medicare for Improving Care

Payment System Is 'Perverse,' an Executive Says

BY REED ABELSON

SALT LAKE CITY — By better educating doctors about the most effective pneumonia treatments, Intermountain Health Care, a network of 21 hospitals in Utah and Idaho, says it saves at least 70 lives a year. By giving the right drugs at discharge time to more people with congestive heart failure, Intermountain saves another 300 lives annually and prevents almost 600 additional hospital stays.

But under Medicare, none of these good deeds go unpunished.

Intermountain says its initiatives have cost it millions of dollars in lost hospital admissions and lower Medicare reimbursements. In the mid-90's, for example, it made an average profit of 9 percent treating pneumonia patients; now, delivering better care, it loses an average of several hundred dollars on each case.

"The health care system is perverse," said a frustrated Dr. Brent C. James, who leads Intermountain's efforts to improve quality. "The payments are perverse. It pays us to harm patients, and it punishes us when we don't."

Intermountain's doctors and executives are in a swelling vanguard of critics who say that Medicare's payment system is fundamentally flawed.

Medicare, the nation's largest purchaser of health care, pays hospitals and doctors a fixed sum to treat a specific diagnosis or perform a given procedure, regardless of the quality of care they provide. Those who work to improve care are not paid extra, and poor care is frequently rewarded, because it creates the need for more procedures and services.

The Medicare legislation that President Bush is expected to sign on Monday calls for studies and a few pilot programs on quality improvement, but experts say that it does little to reverse financial disincentives to improving care.

"Right now, Medicare's payment system is at best neutral and, in some cases, negative, in terms of quality — we think that is an untenable situation," said Glenn M. Hackbarth, the chairman of the Medicare Payment Advisory Commission, an independent panel of economists, health care executives and doctors that advises Congress on such issues as access to care, quality and what to pay health care providers.

In a letter published in the current edition of Health Affairs, a scholarly journal, more than a dozen health care experts, including several former top Medicare officials, urged the program to take the lead in overhauling payment systems so that they reward good care.

"Despite a few initial successes, the inertia of the health system could easily overwhelm nascent efforts to raise average performance levels out of mediocrity," they wrote. "Decisive change will occur only when Medicare, with the full support of the administration and Congress, creates financial incentives that promote pursuit of improved quality."

Medicare's top official is quick to agree that the payment system needs to be fixed. "It's one of the fundamental problems Medicare faces," said Thomas A. Scully, who as the administrator of the Centers

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for Medicare and Medicaid Services has encouraged better care by such steps as publicizing data about the quality of nursing home and home-health care and by experimenting with programs to reward hospitals for their efforts.

But the steps taken so far have been small, and many experts say that rather than paying for more studies, Congress should start making significant changes to the way doctors and hospitals are paid.

"They're splashing at the shallow end of the pool," said Dr. Arnold Milstein, a consultant for Mercer Human Resource Consulting and the medical director for the Pacific Business Group on Health, an association of large California employers. He would like to see as much as 20 percent of what Medicare pays doctors and hospitals linked to the quality of the care they provide and their efficiency in delivering treatment.

Two decades ago, Medicare led a revolution in health care. By setting fixed payments for various kinds of treatment – a coronary bypass or curing a case of pneumonia or replacing a hip – rather than simply reimbursing doctors and hospitals for whatever it cost to deliver the care, it encouraged shorter hospital stays and less-expensive treatments.

But today, many health care executives say, Medicare's payment system hinders attempts to improve care. Dr. James, the Intermountain executive, said he wrestled with the situation every day.

By making sure its doctors prescribe the most effective antibiotic for pneumonia patients, for example, and thereby avoiding complications, Intermountain forgoes roughly $1 million a year in Medicare payments, he estimated. When a pneumonia patient deteriorates so badly that the patient needs a ventilator, Intermountain collects about $19,000, compared with $5,000 for a typical pneumonia case. And while it makes money treating the sicker patient, Dr. James said, it loses money caring for the healthier one.

Nor is Intermountain rewarded for sparing someone a stay in the hospital – and for sparing Medicare the bill. Shirley Monson, 74, of Ephraim, Utah, said that she expected to be hospitalized when she developed pneumonia last year. Instead, Sanpete Valley Hospital, part of Intermountain, sent Mrs. Monson home with antibiotics, and she recovered over the next two weeks. Such visits produce just token payments for hospitals.

In addition to losing revenue each time it avoids an unnecessary hospital stay, Intermountain is penalized for treating only the sickest patients, Dr. James said. Medicare's payments for pneumonia are based on a rough estimate of the cost of an average case and assume a hospital will see a range of patients, some less sick – and therefore less expensive to treat – than others. But because Intermountain now admits only the sickest patients, its reimbursements fall short of its costs, Dr. James said, resulting in an average loss this year of a few hundred dollars a case.

Similarly, averting hospital stays for congestive heart patients by prescribing the right medicines costs Intermountain nearly $4 million a year in potential revenues, according to Dr. James. And every adverse drug reaction Intermountain avoids deprives it of the revenue from treating the case.

"We are really rewarded for episodic care and maximizing the care delivered in each episode," said Dr. Charles W. Sorenson Jr., Intermountain's chief operating officer.

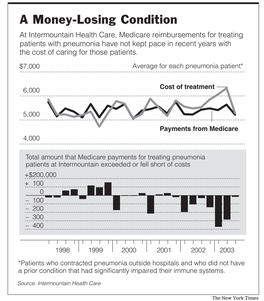
Like the vast majority of the nation's hospitals, Intermountain is a nonprofit organization, and executives here say financial penalties do not damp their desire to provide the highest-quality care, which they see as their central mission. But Intermountain, which operates health plans and outpatient clinics in addition to its hospitals, says it needs to keep hospital beds filled and make money where it can to subsidize unprofitable services and pay for charity care.

Outside of Medicare, Intermountain often benefits from its quality initiatives, executives said, because it gets to pocket much of the savings they produce. For example, Intermountain has generated about $2 million annually in savings by reducing the number of deliveries that women choose to induce before 39 weeks of pregnancy – and thereby reducing the risk of complications to the mother or baby. According to Dr. James, almost all that money has been spent on other kinds of care.

Hospital executives elsewhere say that they, too, have come up against the cold reality of the Medicare payment system. Partners HealthCare, the Boston system that includes Massachusetts General and Brigham and Women's Hospitals, has taken steps to reduce the number of unnecessary diagnostic tests it conducts at outpatient radiology centers, though executives know that smarter care will cut into their revenues.

"That's where you're smack up against the perverseness of the system," said Dr. James J. Mongan, chief executive of Partners.

Medicare's payment policies have stymied efforts in the private sector to improve care, as well.



For example, the Leapfrog Group, a national organization of large employers concerned about health issues, has tried to encourage more hospitals to employ intensivists – specialists who oversee the care provided in intensive-care units. Though studies show that such doctors significantly improve care, Medicare does not pay for them, and employers and insurers are having difficulty persuading some hospitals to take on the added expense.

"It's going to be very hard to compete with the incentives and disincentives in Medicare," said Suzanne Delbanco, the group's executive director.

Others argue that hospitals and doctors should not be paid extra for doing what they should be doing in the first place.

Helen Darling, the executive director of the National Business Group on Health, a national employer group, said Medicare instead should take a firmer stance in demanding quality. The program had a significant effect, she noted, when it said that only hospitals meeting a minimum set of standards could be reimbursed by Medicare for heart transplants.

"The payment system drove quality," Ms. Darling said.

Medicare itself is taking some other tentative steps, including an experiment that pays certain hospitals an extra 2 percent for delivering the highest-quality care, as measured, for example, by administering antibiotics to pneumonia patients quickly and giving heart attack patients aspirin. But some hospital industry executives question whether that is enough money to offset the costs of improving care.

"It can only be a motivator if you really have an incentive," said Carmela Coyle, an executive with the American Hospital Association, who noted that hospitals on average are paid only 98 cents for each dollar of Medicare services they provide.

Mr. Scully, the Medicare administrator, defends the experiment, saying that the agency's goal is to determine if it is using the right measures to reward quality. "If this works, we'll do a bigger demonstration," he said.

But many policy analysts and employer groups want Medicare to do more. "Today, Medicare needs to step out front," said Peter V. Lee, chief executive of the Pacific Business Group on Health, who argues that how hospitals and doctors are paid is a critical component of motivating them to improve care. "There needs to be money at play."

The New York Times

NEW YORK, WEDNESDAY, DECEMBER 31, 2003

An Operation to Ease Back Pain Bolsters the Bottom Line, Too

By REED ABELSON and MELODY PETERSEN

A complex operation called spinal fusion has emerged as the treatment of choice for many kinds of unrelenting back pain. A quarter million of the procedures, in which metal rods are screwed into the spine to stabilize it, were performed this year in the United States, three times as many as a decade ago.

But a number of researchers say there is little scientific evidence to show that for most patients, spinal fusion works any better than a simpler operation, the laminectomy. And laminectomies get patients out of the hospital and back to their daily routine much faster. Some people, experts add, would be better off with no surgery at all. Even doctors who favor fusions say that more research is needed on their benefits.

In the absence of better data, critics in the field point to a different reason for the fusion operation's fast rise: money.

Medicare can pay a surgeon as much as four times more for a spinal fusion, some doctors say, as for a laminectomy, an operation in which some bone is removed from the spine to relieve pressure on the spinal cord and nerves. Hospitals also collect two to four times as much, a gulf that

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a huge role in shaping American health care, from the kinds of hospitals that get built to the amount of chemotherapy drugs that cancer doctors prescribe.

"The reality of it is, we all cave in to market and economic forces," said Dr. Edward C. Benzel, a spine surgeon who is chairman of the Cleveland Clinic Spine Institute. Though doctors, as a rule, should favor the least complicated treatment — with surgery being the last resort — Dr. Benzel estimated that fewer than half of the spinal fusions done today were probably appropriate. He described the current system of paying doctors as "totally perverted."

Doctors and hospitals are not the only players with a financial stake in fusion operations. Critics blame the companies that make the hardware for promoting more complex fusions without evidence that they are significantly more effective. Some sort of hardware is used in almost 90 percent of lower-back fusions, Mr. Mendenhall said, compared with fewer than half in 1996. Between Medicare and private insurers, the national bill for the hardware alone has soared to $2.5 billion a year, he said.

"A lot of technological innovation serves shareholders more than patients," he said.

The hardware makers acknowledge giving surgeons millions of dollars in consulting fees, royalty payments and research grants, but say the money promotes technical and medical advances that improve back care.

"We can't innovate to help patients without these physician relationships," said Bob Hanvik, a spokesman for Medtronic, the Minneapolis company that is the biggest maker of spinal hardware. "Most physicians don't want to give away their time."

Some former Medtronic employees, however, have accused the company of paying surgeons kickbacks. A lawsuit brought by Scott A. Wiese, a former sales representative, accused Medtronic of trying to persuade surgeons to use its products with offers of first-class plane tickets to Hawaii and nights at the finest hotels. Some of those lucrative consulting contracts, the suit claimed, involved little or no work.

Medtronic said it did nothing wrong, and it denied the accusations in the lawsuit, which was filed in 2001 and settled in 2002. But the company disclosed earlier this year that the federal government was investigating charges that it paid illegal kickbacks to surgeons. Federal officials declined to comment on the investigation, and Medtronic said it would vigorously defend itself.

Still, between the allure of money and the quest for breakthroughs in treatment, some prominent spinal surgeons say that back care has gone astray.

"I see too many patients who are recommended a fusion that absolutely do not need it," said Dr. Zoher Ghogawala, a Yale University clinical assistant professor of neurosurgery who is conducting a study comparing spinal fusion with laminectomy. Health experts note that if Medicare is overpaying doctors for back operations, other kinds of care are shortchanged, because the program is budgeted a fixed amount each year for doctor's fees.

Fees vary widely around the country, but several surgeons said that Medicare reimbursed doctors roughly $4,000 for a spinal fusion, versus $1,000 for a laminectomy. Mr. Mendenhall said that hospitals typically collected $16,000 for a fusion — and $10,000 more for an increasingly common "360 degree" operation in which hardware is attached to both the front and back of the spine — versus $7,000 for a laminectomy.

"The money is driving a lot of this," Mr. Mendenhall said. The cost to patients will differ based on their insurance coverage, and patients with traditional Medicare coverage will have to shoulder some of the higher surgeon fees. But some patients may push for what they believe is the most-advanced treatment.

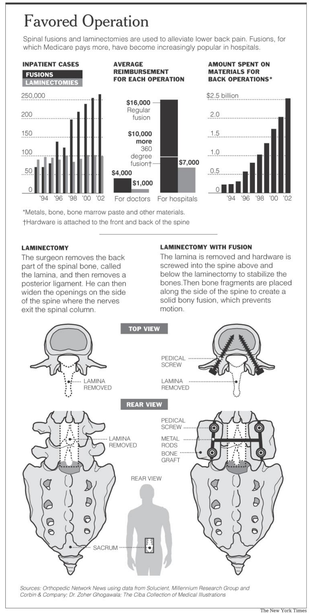
Many spine surgeons defend fusion operations, saying that some patients clearly benefit from them, even if some of the procedures are not warranted.

"There is some indication that if you do it right, it can benefit people," said Dr. Eric J. Woodard, a spine surgeon at Brigham & Women's Hospital in Boston, who noted that a well-designed Swedish study recently showed positive results for some patients. More research needs to be done, he added, to identify the category of patients who have the best odds of being helped. In the meantime, Dr. Woodard said, many doctors are being more selective about who gets a fusion operation.

In part, the rise of spinal fusions represents the natural process of medicine. Surgeons perform operations, and when — as in the case of back pain — the outcomes are mixed, surgeons strive to improve their techniques.

The Medicare payment system, in turn, rewards complexity, because it lets doctors bill for the individual procedures they perform within a single operation. It also tries to encourage the development of new medical technologies. And the makers of medical devices like fusion hardware cast themselves with frequent success in persuading Medicare to pay for their new products.

Earlier this year, for example, Medtronic persuaded the government to cover a new kind of bone graft material, called Infuse, for use in spinal fusions. Surgeons describe the new material as having the potential to represent a real advance. Still, Medtronic scored a significant coup, experts said, in Medicare's decision to make an additional payment, as much as $4,450, to hospitals to help cover the cost of Infuse, on top of the flat fee paid for the operation.



Re-examining Medicare

Since its inception in 1965, Medicare has improved the health of the elderly while playing an outsize role in shaping the delivery of health care for all Americans.

This article is the seventh in a series examining efforts to overhaul Medicare and ways that the rules of the program influence the economics and practice of medicine.

The articles will remain online at nytimes.com/business.

Jamie Rector for The New York Times

Dr. Sam Ho was told he needed surgery for his back pain. But he refused the surgery and recovered within two months.

"The power of the device industry is growing tremendously," including its ability to influence Medicare officials, said Susan Bartlett Foote, a professor of health policy at the University of Minnesota.

Medicare officials are unaware of any problems concerning reimbursements for spinal fusions, an agency spokeswoman said. Industry executives said that Medicare patients deserved quick access to breakthrough treatments that might improve the quality of their lives.

Because of the scant data on the benefits of back operations, patients with similar complaints receive widely differing treatments for their pain, according to a 1999 study by researchers at the Center for the Evaluative Clinical Sciences at Dartmouth College. The National Institutes of Health is doing a large study to determine which patients will benefit from various treatments.

"There is a real paucity of convincing science about spinal fusion in particular," said Dr. Richard A. Deyo, a professor of medicine and of health sciences at the University of Washington. He was involved in the attempt by the federal government in the mid-1990's to issue guidelines for back surgery.

The guidelines, which recommended a conservative approach and discouraged surgery, were roundly attacked by spine surgeons. Indeed, the surgeons nearly succeeded in persuading Congress to eliminate financing for the federal Agency for Health Care Policy and Research, which developed the guidelines. Sofamor Danek, the Medtronic unit that makes fusion hardware and was then an independent company, unsuccessfully sued to prevent the agency from making its recommendations public.

Some surgeons are disturbed by the level of influence that industry has on their profession, particularly in research. "This is a topic which orthopedic surgeons, neurosurgeons and the societies associated with both their groups are definitely concerned about," said Dr. Brett A. Taylor, an orthopedic surgeon at Washington University in St. Louis.

The absence of solid research means that patients sometimes have little to go on in deciding whether to have surgery.

Three years ago, Dr. Sam Ho, the chief medical officer of PacifiCare, a California insurer, suddenly developed severe back pain, the result of an extruded disc. His neurosurgeon, he said, insisted that he needed a laminectomy, but the surgeon could not offer any studies indicating that the operation would help. Nor, Dr. Ho said, could the surgeon tell him how many operations he had performed or how his own patients had fared.

Dr. Ho said he refused the surgery and made a complete recovery within two months.

Spinal fusion has a history of controversy. Device makers were the subject of numerous lawsuits in the early 1990's charging that they were paying surgeons illegal kickbacks to use their screws. Most suits were unsuccessful, often because courts were not convinced that the screws had caused injury or pain.

But similar accusations have surfaced in recent years. In his lawsuit, filed in a state court in Los Angeles, Mr. Wiese, the former Medtronic sales representative, said that he was told by his bosses to do "whatever it takes" to sell fusion hardware. Two doctors demanded consulting contracts in return for using Medtronic's products, the suit contended, but the contracts were a "sham," because little work was done for the pay. The suit was settled for undisclosed terms, and Mr. Wiese's lawyer declined to comment on the matter.

In interviews, two other former Medtronic employees said that the company engaged in similar practices as recently as last year. They said that Medtronic's sales representatives routinely offered enticements to surgeons to use the company's hardware, including lavish trips and visits to a strip club near the Memphis headquarters of the Sofamor Danek division. The former employees said they had spent as much as $1,000 a night per doctor for a night on the town.

"It's a business deal," said one of the employees, who declined to be named because he still works in the medical device industry. "It takes money to make money."

A document provided by one of the former employees listed about 80 surgeons who have consulting agreements with Medtronic that pay as much as $400,000 a year.

Mr. Hanvik, the Medtronic spokesman, said that the company had policies in place to prevent its sales agents from providing improper inducements to surgeons. The company works closely with some surgeons, he said, and pays them fairly for their time creating new devices and improving the design of existing products. The annual amounts on the list are the maximum each doctor can receive. "They only get paid for the work they do," he said.

Trying to rise above the flood of money, researchers like Dr. Ghogawala at Yale say they are now conducting studies free of industry support in search of basic answers about the efficacy of back operations. Having raised private money to finance his pilot study comparing fusions and laminectomies, Dr. Ghogawala plans to apply for government financing for a larger, five-year study.

"I think we are identifying who needs it and who does not," he said. "It's critical to know if it's a lot of unnecessary surgery for a lot of people."