INFORMATION FOR THE MISSOURI SENATE INTERIM COMMITTEE ON CERTIFICATE OF NEED

Missouri Hospital Association
August 1, 2006

The interim committee has been appointed to review the certificate of need program, assess the implications of repealing or limiting it and examine the effects of physician self-referral. The Missouri Hospital Association offers the following comments as the committee begins its deliberations.

CERTIFICATE OF NEED REPEAL AND SPECIALTY HOSPITAL DEVELOPMENT

- The Missouri Hospital Association opposes the repeal of laws requiring CON review of the construction of a new hospital. Experience in other states clearly shows that repealing CON laws promotes the proliferation of physician-owned specialty hospitals.

What are specialty hospitals?

- Specialty hospitals limit their services to the relatively few medical services that are profitable and target well-insured patients. Most commonly, they provide surgeries on patients with cardiac or orthopedic ailments. They usually are owned by specialist physicians.

- There currently are no physician-owned specialty hospitals in Missouri, but a few are operating on the Kansas side in the Kansas City metropolitan area.

- Physician-owned specialty hospitals have grown out of an exemption in the federal Ethics in Patient Referrals Act of 1989, which is known as the "Stark" law after its congressional sponsor. The Stark law prohibits a physician from referring Medicare or Medicaid patients to various types of "designated health services" in which he or she has an ownership or investment interest. Congress expanded the list of designated health services in 1993. In doing so, it created an exemption for a physician's investment in a "whole hospital" based on the premise that a single physician's ownership interest would be so diffuse across all of the departments of a traditional full-service hospital that it would not be significant. However, Congress did ban physician investment in a single department or division of a hospital, such as orthopedics or cardiology. Congress did not envision the creation of single-specialty hospitals that would essentially function as a freestanding department of a full-service hospital. The result of the current Stark law is that a physician is allowed to invest in and refer patients to a 20-bed freestanding orthopedic hospital, but that same investment and referral is banned if it involves a 20-bed orthopedic unit that is part of a full-service hospital.

Why are specialty hospitals of concern?

- **The Safety Net Implications of Specialty Hospital Cherry-Picking.** Unlike community hospitals, specialty hospitals focus on the most lucrative procedures and patients. In doing so, they undermine the relatively few profitable services at community hospitals that subsidize the current safety net.

  - Without some profitable services, many community hospitals will be challenged to sustain the unprofitable but essential services that communities expect.

  - Some of these unprofitable services include 24-hour emergency departments, trauma care and access to care for the uninsured, who comprise about one in every 10 Missourians.

- **Patient Steering.** Specialty hospitals that are owned by the physicians who practice there create additional concerns. They compete against community hospitals with a significant advantage. Physicians decide where their patients are sent for treatment and the type and amount of services they receive. The physician owners of specialty hospitals have a financial incentive to refer the most lucrative patients and procedures to their own facilities and send potentially unprofitable patients — the uninsured, Medicaid patients and individuals with higher-risk medical conditions — to community hospitals.

- **Effects of Self-Referral on Cost and Utilization.** Physicians' "self-referral" to facilities in which they have an ownership interest also raises concerns about utilization and cost. Federal and private researchers have found physicians with a financial interest in facilities and ancillary services tend to have higher referral and utilization rates for those services than other physicians. For example, the attached graphs show the findings of one such study of specialty hospitals treating workers' compensation back injury cases in Oklahoma. Further information on the effects of physician self-referral will be provided to the committee at a future hearing.

<u>What are federal and state governments doing about specialty hospitals</u>?

- In December 2003, Congress imposed an 18-month moratorium on physician ownership of and referral to new specialty hospitals.

  - The moratorium expired in June 2005. However, the Centers for Medicare & Medicaid Services, which is the federal agency that administers Medicare and Medicaid, effectively extended the moratorium through February 2006.

  - In February 2006, Congress enacted a second legislative moratorium for six months, with a possible two-month extension, while further studies are completed and recommendations developed.

- In November 2005, the U.S. Senate approved its version of the Omnibus Budget Reconciliation Act that included language that would permanently ban physician self-referral to new specialty hospitals.

- The federal agency that oversees Medicare and Medicare is developing a series of Medicare hospital payment changes designed to reduce the opportunity for hospitals to benefit financially by targeting particular procedures and healthier patients. However, those changes will affect only Medicare patients. Also, it now appears unlikely that those changes will go into effect until mid-2007. Because of the complexity of the proposed changes, 53 U.S. Senators and 189 U.S. Representatives recently have signed a letter calling for the federal agency to postpone putting those changes into effect until their implications on the delivery system have been more thoroughly assessed.

State Actions

- Missouri state law had a moratorium on the licensing of specialty hospitals that was enacted in 2004 and expired August 28, 2005.

- In June 2004, Florida Governor Jeb Bush signed legislation to permanently ban the licensing of new specialty hospitals that primarily or exclusively provide cardiac, orthopedic, surgical or oncology treatments.

- On May 10, 2006, the Council of State Governments approved the following resolution at its Spring National Committee and Task Force Meetings: "Be it therefore resolved, that The Council of State Governments encourages the Department of Health and Human Services to conduct a thorough and complete analysis of the physician-owned specialty hospital issue and to provide appropriate rules, regulations, and legislative guidance to eliminate any unfair competitive advantage that physician referrals may have and ensure that all health care providers provide appropriate support to State Medicaid programs and participate in appropriate emergency services networks."

Certificate of Need and Market Innovation

Some argue that the CON process stifles innovation in the marketplace. However, this does not seem to be borne out in Missouri. At the Missouri Health Facilities Review Committee's last meeting, a CON was reviewed and unanimously approved for a type of cutting-edge technology called focused ultrasound ablation, which uses magnetic resonance imaging and a focused beam of ultrasound waves to heat and destroy uterine fibroids. The CON approval was granted in advance of either public or private insurers providing coverage for the service.

As another example, St. John's Mercy Health Care system, which operates St. John's Mercy Medical Center in Creve Coeur and St. John's Hospital in Washington, Missouri, opened a heart hospital as part of its Creve Coeur campus. The facility is treating patients in the same model of specialization often claimed by specialty hospital advocates as the "driving force behind specialty hospitals" (Dr. John House, American Surgical Hospital Association). However, as part of the St. John's Mercy Health Care system, the heart hospital continues to support the safety net activities of the hospital system and provides treatment to all cardiac patients, not just the preferred patients or procedures.

Research Findings about Specialty Hospitals

- As part of its first moratorium, Congress directed the Medicare Payment Advisory Commission (MedPAC) to assess the effect of physician-owned specialty hospitals on community hospitals. MedPAC's conclusions included the following.

  - Physician-owned specialty hospitals do not have lower Medicare costs per case than other hospitals.

  - The current Medicare payment system should be changed to prevent specialty hospitals from "cherry-picking" the most lucrative procedures and patients, which negatively affects community hospitals' ability to support safety net services.

  - Specialty hospitals concentrate on more profitable diagnosis-related groups and patients who are less severely ill, who also tend to be more profitable.

In April 2006, MedPAC updated its findings based on two additional years of data.

- "We conclude that heart specialty hospitals' inpatient costs are similar to those in other hospitals but orthopedic and surgical specialty hospitals clearly have higher inpatient costs than their competitors." (MedPAC transcript, April 19, 2006, pg. 110).

- "In contrast, the mean and median standardized costs for orthopedic and surgical hospitals are 31 percent and 20 percent higher than the national amounts. The costs in these hospitals are significantly higher than their competitors." (MedPAC transcript, April 19, 2006, pg. 110).

In January 2006, the Center for Studying Health System Change, which tracks health care markets in 12 metropolitan areas across the nation, conducted a series of interviews with purchasers, health plan executives, benefit consultants and providers in Indianapolis, Little Rock and Phoenix. These communities have a substantial specialty hospital presence in their markets. The following findings are from the Center's Issue Brief 103, "Do Specialty Hospitals Promote Price Competition?" January 2006.

- "Although employers and health plans are predisposed to favoring new hospital entrants to produce greater competition, in the three sites studied, they generally believe that specialty hospitals are contributing to a medical arms race that is driving up costs.

- "Although previous research indicates that purchasers believe specialty hospitals have lower unit costs, some believe that referring physicians, especially those with a financial interest in the specialty hospital, increase volume by inducing patient demand for elective procedures. The higher volume more than offsets the savings achieved from lower prices from competition, leading to increased aggregate costs. … Health plans indicated they had few tools to restrain the induced utilization that physician ownership of specialty hospitals can engender.

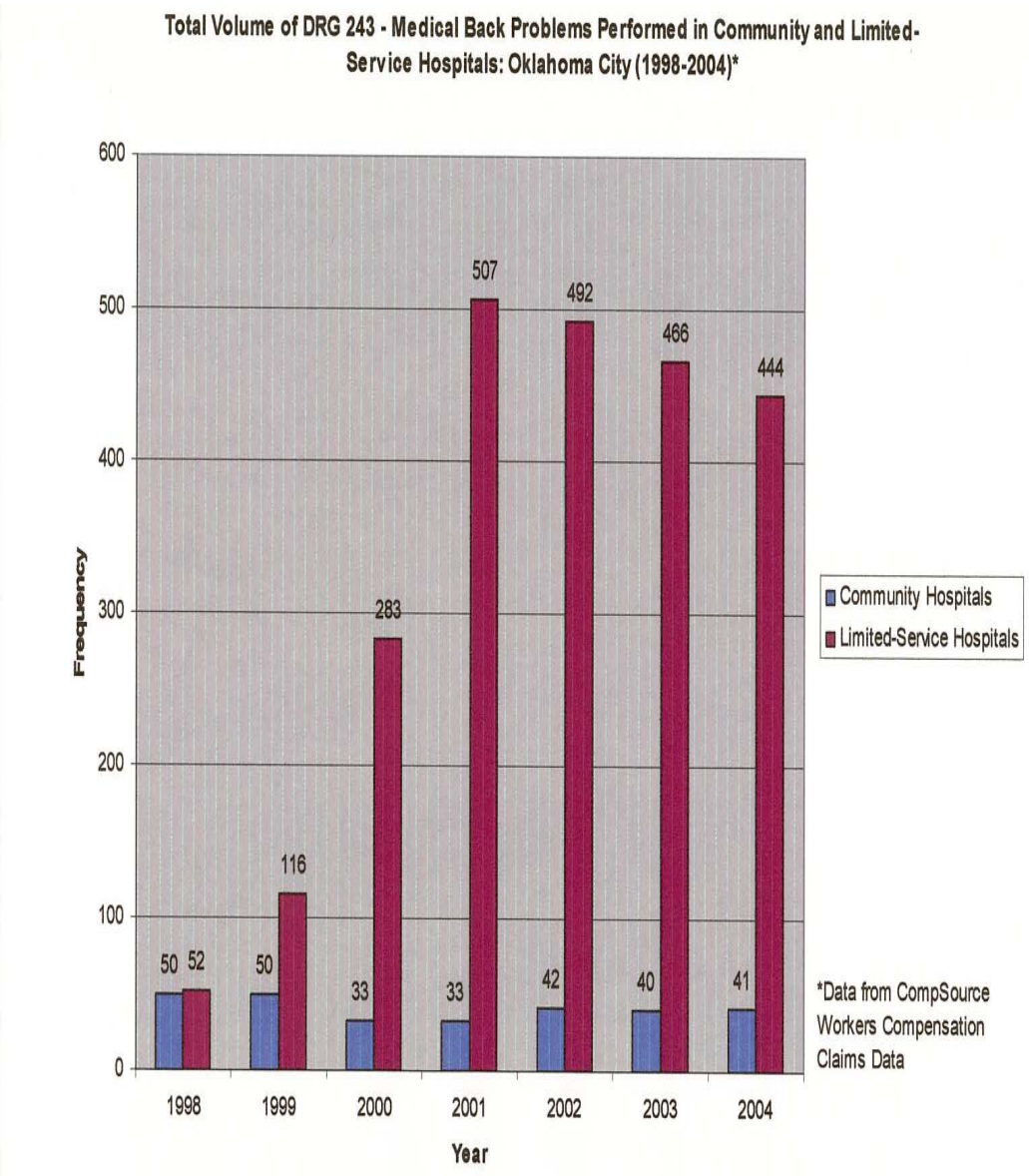
- "It is striking that purchasers and their health plan agents, some of which themselves are for-profit, entrepreneurial ventures, who might be expected to favor increased hospital competition, generally do not view the development of specialty hospitals positively. They believe that specialty hospitals add to health care costs and have not demonstrated clear quality advantages. Further, purchasers are concerned about the opportunity for physician owners to induce demand through self-referral, to cherry pick among the patient population and to threaten community hospitals' reliance on profitable services to make up for shortfalls in other areas."

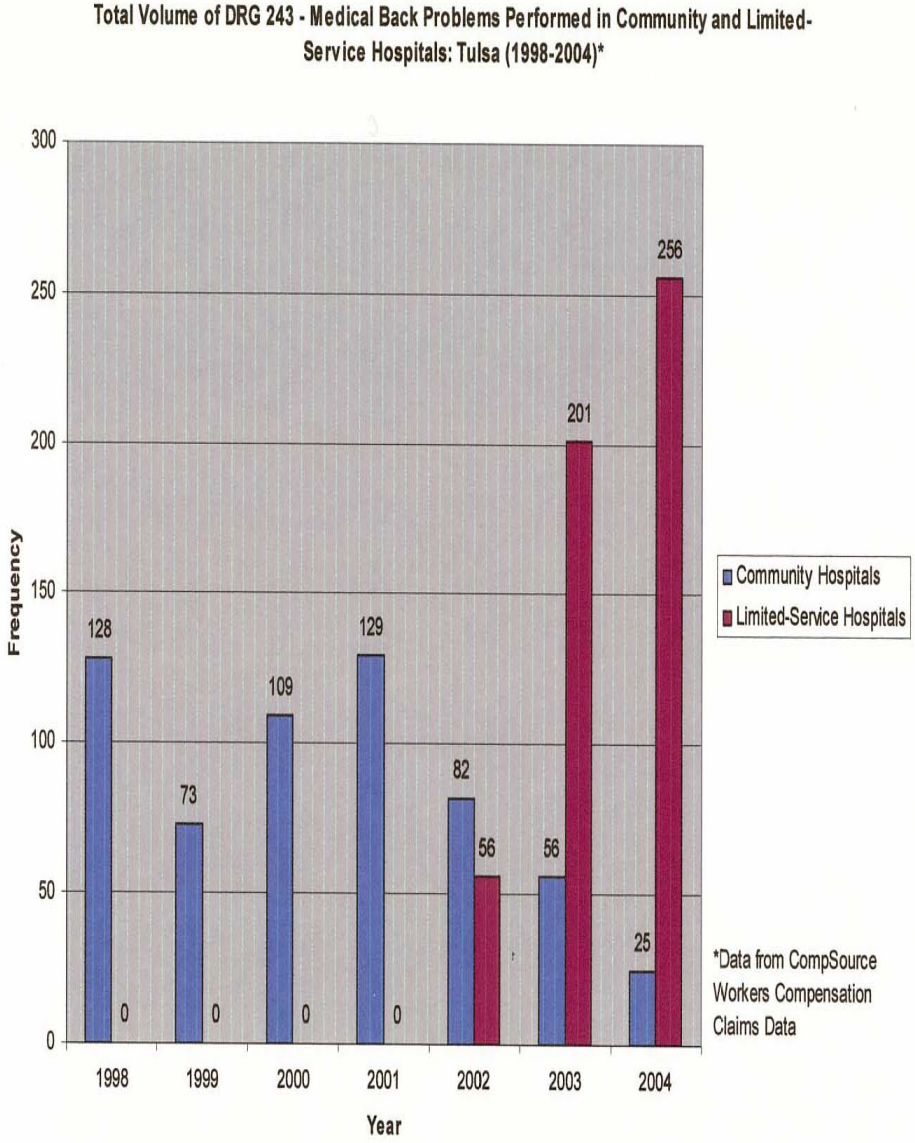
- A second recent GAO study showed that the proportion of severely ill patients who were treated was lower at 21 of the 25 specialty hospitals than at general hospitals, for patients with the same diagnosis. ("The Emergence of Physician-Owned Specialty Hospitals, New England Journal of Medicine, January 6, 2005, pg 80)

MONITORING THE HEALTH CARE MARKET

As the interim committee reviews CON issues, the Missouri Hospital Association encourages it to consider the role that CON plays in helping the state maintain an inventory of facilities and services. This inventory is one of a few tools available to the state to track the supply of health care services and to understand how the market is evolving. In the absence of CON, the state would need to rely on its licensing functions to monitor what types of facilities and services are available to Missouri patients. However, relatively few types of facilities are licensed, namely hospitals, ambulatory surgical centers, nursing homes, residential care facilities and assisted living centers. Facilities such as imaging, endoscopy and dialysis centers are unlicensed.

Maintaining some means of tabulating where services are available in the health care market is a worthwhile objective. Ideally, the state should know where facilities and services are located and what standards of quality assurance, if any, apply to them. As legislators move to expand the reporting of health care data on price and quality to assist consumers in their purchasing decisions, those data standards should apply to all those delivering similar services.


Total Volume of DRG 243 - Medical Back Problems Performed in Community and Limited-Service Hospitals: Oklahoma City (1998-2004)*
Frequency
600
500
400
300
200
100
0
50 52
50 116
33 283
33 507
42 492
40 466
41 444
1998
1999
2000
2001
2002
2003
2004
Year
Community Hospitals
Limited-Service Hospitals
*Data from CompSource Workers Compensation Claims Data


Total Volume of DRG 243 - Medical Back Problems Performed in Community and Limited-Service Hospitals: Tulsa (1998-2004)*
Frequency
300
250
200
150
100
50
0
128 0
73 0
109 0
129 0
82 56
56 201
25 256
1998
1999
2000
2001
2002
2003
2004
Year
Community Hospitals
Limited-Service Hospitals
*Data from CompSource Workers Compensation Claims Data