HB
345

Alaska State Legislature

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Member
House Finance Committee
Legislative Budget & Audit

Representative Mike Kelly

House District 7

Sponsor Statement – HB 345 (HES)

Since the passage of HB 511 four years ago Alaska's healthcare system has spawned a series of applications for new medical facilities and equipment. A rash of Administrative appeals and lawsuits regarding application of the rules of Alaska's Certificate of Need (CON) program has followed. The contentious and expensive litigation has been primarily caused by a lack of clear statutory definitions regarding medical facilities. Several of these lawsuits are still pending and their outcomes uncertain.

HB 345 offers a compromise for the hospitals that serve our communities and the physicians and others that desire to profit from owning and operating imaging equipment. The hospitals' concern is that doctors will open imaging centers that provide only the most profitable services, leaving the hospitals with everything else. It's easy to see what is motivating doctors to leave the system and set up shop separately. Our broken "big government" system forces doctors to take as little as fifty cents on the dollar for services to Medicare and Medicaid patients. Most doctors in Anchorage and Fairbanks are refusing to see new Medicare patients. Their solution – Leave the system and open up their own imaging center. Unfortunately, this leads the hospitals to provide all the red ink services that just don't pay. The HB 345 compromise attempts to protect the interests of hospitals while somewhat easing the restrictions in the CON process in larger communities for diagnostic imaging equipment.

HB 345 would exempt the purchase of imaging equipment from the Certificate of Need process as long as the equipment is used in a facility that meets three criteria:

1) The facility is located in a borough with a population of 60,000 or more
2) There is no critical access hospital supporting the community where the equipment will be used
3) The facility is at least 50% owned by one or more physicians who are licensed in the state and who actually interpret images in the facility

A facility would have to pass all three criteria for it to qualify for the CON exemption. The only communities that meet all three criteria are the Mat-Su region, Anchorage and Fairbanks. This bill protects smaller Alaskan communities, yet loosens restrictions on the market for imaging in larger communities that may be able to more easily handle an increase in competition.

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Representative Mike Kelly
House District 7

MEMORANDUM

DATE: **January 30, 2008**

TO: **Representative Kelly**

FROM: **Derek Miller**

RE: **Sectional Analysis for HB 345 (HES)**
(Version No. 25-LS1402\E)

The following sectional analysis of the bill should not be considered an authoritative interpretation of the bill. The bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Sectional analysis for HB 345 (HES) Version 25-LS1402\E

Section 1. Adds a cross-reference to an additional exemption added by section 3 of the act to the Certificate of Need process.

Section 2. Defines *critical access hospital* for purposes of section 3.

Section 3. Adds an exemption to allow a person to make an expenditure of $1,000,000 or more for diagnostic imaging equipment without authorization under the terms of the Certificate of Need process if the equipment is used in a facility that is located in **1)** a borough with a population of 60,000 or more, **2)** a city that does not have a critical access hospital and **3)** is at least 50% owned by one or more licensed physicians who are qualified to and actually perform interpretations of the images produced at the facility.

Section 4. Provides applicability standards for health care facilities in existence or proposed after the effective date of the act.

426 Main St •Juneau, AK • 99801

February 5, 2008

Representative Mike Kelly
Alaska State Capitol
Room 513
Juneau, AK 99801

Dear Representative Kelly:

Thank you for introducing House Bill 345 which would amend Certificate of Need (CON) laws to clarify when new imaging equipment must go through CON review.

Your bill would do several things which ASHNHA's members support.

First, the bill would require that new imaging equipment which exceeds the specified dollar threshold must go through CON review if it is to be used in a borough of less than 60,000 population, or in a city with a Critical Access Hospital.

This would protect the most vulnerable of our small communities from overbuilding of expensive medical equipment. Given the vastness of our state and the different types of health care delivery we have, small hospitals in small communities must be protected. House Bill 345 does just that.

Second, the bill would establish criteria in boroughs of 60,000 population or more for determining whether or not new imaging equipment should be considered part of a physician's practice and therefore exempt from CON review. This clarification is vital to fill a definitional void in Alaska CON laws that have lead to numerous administrative and judicial appeals of Department of Health decisions.

Alaska's CON laws are an important public health tool for matching expensive health care infrastructure to the needs of each community. HB 345 would improve existing CON laws by making needed clarifications rather than outright repealing CON laws as proposed in HB337 and SB245.

Sincerely,

Rod Betit

Rod L. Betit
President/CEO

central peninsula hospital

heritage place

February 8, 2008

Representative Mike Kelly
Alaska State Capitol
Room 513
Juneau, Alaska 99801

Dear Representative Kelly:

I am writing to support your introduction of House Bill 345 and express my opposition to House Bill 337, specifically the repeal of the Certificate of Need program. Last September, I drafted a letter of support of the Certificate of Need program in preparation for the September 18, 2007 Joint Committee Hearing.

Since that time, I was invited by Commissioner Jackson to participate on the Certificate of Need negotiated regulation making committee convened under the authority of AS 44.62.710-44.62.800. I participated in working toward the goal of negotiated agreement on conceptual changes to regulations, statutes, and procedures to foster a cooperative regulatory environment that would further the Department of Health and Social Services to promote and protect the health and well-being of Alaskans.

Our Committee spent five days in Anchorage negotiating in good faith to reach a consensus on the issues identified by the Department related to the Certificate of Need Program. The Committee voted on 49 questions, most importantly, we voted 16-2 (90%) that the CON program not be fully eliminated.

On Saturday, January 19, 2008, I received an e-mail from Commissioner Jackson thanking me for my input to the process and announcing that SB 245 (HB 337) was introduced calling for the repeal of the CON program. In my mind, there was a vast disconnect between the efforts of the CON negotiated regulation making committee and these two bills.

Central Peninsula Hospital is a sole community provider that risks financial instability and irreparable harm to our community residents if the State does not insure that there is a need for more health care infrastructure before it is introduced to our community. Our community residents have voted to approve a $49.9 million bond project for our Hospital expansion. Since 1974, community property taxpayers have contributed over $43 million to our Hospital. They are vested in our future success. The repeal of CON threatens our hospital-community relationship.

As such, I would like to thank you for introducing House Bill 345 which would leave the program in tact and amend the laws to clarify when new imaging equipment must go through CON review.

Please contact me at 907-714-4718 if you have any questions.

Sincerely,

Ryan K. Smith
Chief Executive Officer

CPH is a member of the Planetree Alliance.

Central Peninsula Hospital • 250 Hospital Place, Soldotna, AK 99669 • **(907) 714-4404** • www.cpgh.org
Heritage Place • 232 Rockwell Avenue, Soldotna, AK 99669 • **(907) 262-2545** • fax (907) 260-4590

From: Rush, Donald [mailto:Donald.Rush@providence.org]
Sent: Thursday, February 07, 2008 2:14 PM
To: Derek Miller
Subject: HB 345

Dear Representative Kelly,

I am the administrator of a Critical Access Hospital on Kodiak Island and fully support HB 345.

Our small hospital relies heavily on our imaging revenue in order to fulfill our mission to the community of Kodiak. We provide care to everyone regardless of their ability to pay and this charity care continues to escalate as the population with no insurance or ability to pay continues to grow.

The imaging services we provide are vital to our overall financial well being. If imaging services were duplicated unnecessarily within our community, a risk we take without CON and HB 345, then our hospital becomes financially vulnerable, which ultimately will diminish the scope of services we provide to our community or worse, the quality of care will decline to our most isolated and vulnerable populations.

Small hospitals continue to operate precariously close to the margin, and your support and passage of HB 345 would certainly help in our continuing efforts to provide adequate and quality services to the many small communities of Alaska.

Please consider this HB 345 favorably.

Thank you.....

Don Rush, CEO
Providence Kodiak Island Medical Center
907-486-9596

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From: Branco, Patrick [mailto:PBranco@peacehealth.org]
Sent: Thursday, February 07, 2008 3:02 PM
To: Derek Miller
Cc: Rod Betit
Subject: support of HB 345

Dear Derek, please pass on to Representative Kelly my support for HB 345. Despite the fact that I am in a community that would be exempt, I still fully support the premise. In my opinion, eliminating the requirements for CON entirely would significantly compromise any hospital's ability to provide full service, comprehensive care to both paying and indigent populations. i also believe that even HB 345 may only buy a little time for The fallacious argument that the Governor and others seem to endorse that eliminating CON would increase competition and reduce expense to the consumer and payers is unsound. The fact that the current reimbursement structure only rewards surgery ana imaging is a sad state of affairs and makes maintaining a positive bottom line challenging when coupled with huge amounts uncompensated care. Increasing competition in one small profitable area is akin to profiteering in time of war.

Thank you for the opportunity to express my opinion.

Patrick J. Branco
CEO
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PeaceHealth
3100 Tongass Avenue
Ketchikan, AK 99901
(907) 228-8300 ext. 7388

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Critical Access Hospital Statues and Regulations

FEDERAL: Here is the federal definitions taken from 42 U.S.C. 1395i-4 (Medicare Rural Hospital Flexibility Program).

(c) Medicare rural hospital flexibility program described

(1) In general

A State that has submitted an application in accordance with subsection (b) of this section, may establish a medicare rural hospital flexibility program that provides that—

(A) the State shall develop at least 1 rural health network (as defined in subsection (d) of this section) in the State; and

(B) at least 1 facility in the State shall be designated as a critical access hospital in accordance with paragraph (2).

(2) State designation of facilities

(A) In general

A State may designate 1 or more facilities as a critical access hospital in accordance with subparagraphs (B), (C), and (D).

(B) Criteria for designation as critical access hospital

A State may designate a facility as a critical access hospital if the facility—

(i) is a hospital that is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1395ww (d)(2)(D) of this title) or is treated as being located in a rural area pursuant to section 1395ww (d)(8)(E) of this title, and that—

(I) is located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital, or another facility described in this subsection; or

(II) is certified before January 1, 2006, by the State as being a necessary provider of health care services to residents in the area;

(ii) makes available 24-hour emergency care services that a State determines are necessary for ensuring access to emergency care services in each area served by a critical access hospital;

(iii) provides not more than 25 acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;

(iv) meets such staffing requirements as would apply under section 1395x (e) of this title to a hospital located in a rural area, except that—

(I) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open and fully staffed, except insofar as the facility is required to make available emergency care services as determined under clause (ii) and must have nursing services available on a 24-hour basis, but need not otherwise staff the facility except when an inpatient is present;

(II) the facility may provide any services otherwise required to be provided by a full-time, on site dietitian, pharmacist, laboratory technician, medical technologist, and radiological technologist on a part-time, off site basis under arrangements as defined in section 1395x (w)(1) of this title; and

(III) the inpatient care described in clause (iii) may be provided by a physician assistant, nurse practitioner, or clinical nurse specialist subject to the oversight of a physician who need not be present in the facility; and

(v) meets the requirements of section 1395x (aa)(2)(I) of this title.

STATE REGULATIONS

(This is not all of the relevant regulations, just the two that specifically mention critical access hospitals)

7 AAC 12.104. Determination of critical access hospital

(a) The department will consider a facility as a critical access hospital if the department finds that the facility

(1) provides inpatient short-term hospitalization for medical care of acute illness or injury;

(2) has no more than 25 inpatient beds;

(3) is located in a rural area of no more than 15,000 residents, based on the most recent calculations of the United States Bureau of Census; and

(4) meets the applicable requirements of 7 AAC 12.100 - 7 AAC 12.190 and 7 AAC 12.600 - 7 AAC 12.990.

(b) If a facility provides all of the services described in 7 AAC 12.105(a), the facility may elect to be licensed as either a general acute care hospital or a critical access hospital.

(c) If a facility qualifies both as a rural primary care hospital under 7 AAC 12.102 and as a critical access hospital under this section, the facility may elect to be licensed as either a rural primary care hospital or a critical access hospital.

History: Eff. 9/1/2000, Register 155; am 6/23/2006, Register 178

Authority: AS 47.32.010

AS 47.32.030

AAC 12.190. Designation of critical access hospital under medicare

(a) The department will designate a hospital that is licensed under this chapter as a critical access hospital under Medicare if the hospital meets the conditions of participation set out at 42 C.F.R. 485.601 - 42 C.F.R. 485.645, as amended through July 1, 1999 and adopted by reference, and the requirements of this section.

(b) To be eligible for designation as a critical access hospital under Medicare, a hospital must satisfy the criteria set out at 42 U.S.C. 1395i-4(c)(2)(B) and hold a license

under 7 AAC 12 as a hospital. An eligible hospital that wishes to be designated as a critical access hospital under Medicare must submit to the department

(1) an application on a form provided by the department;

(2) a description of the area served by the applicant;

(3) a community needs assessment analyzing the availability and utilization of health care services in the applicant's service area, including acute care, primary care, and emergency services, and a discussion of how operating as a critical access hospital under Medicare will better serve community needs;

(4) the applicant's plan for the delivery of health services within the applicant's service area;

(5) a financial feasibility study that analyzes the financial impact on the applicant of operating as a critical access hospital under Medicare, taking into account relevant operational factors, including changes in utilization, services, staffing, and Medicare reimbursement;

(6) a community education plan that describes the steps that have been or will be taken to educate and involve the residents of the service area in the decision to operate as a critical access hospital under Medicare;

(7) an emergency services plan that coordinates the provision of emergency medical services in the applicant's service area;

(8) a description of the volume capacity of the applicant and other related health care resources within the applicant's service area;

(9) the distance and travel time to other health care resources within the applicant's service area; and

(10) identification of barriers to accessing health care in the applicant's service area.

(c) Within 30 days after receipt of an application for designation as a critical access hospital under Medicare, the department will review the application for completeness. If the application is complete, the department will evaluate the application and designate the hospital as a critical access hospital under Medicare if the department determines that the applicant meets the requirements of this section.

(d) If the application submitted under (b) of this section is not complete or an applicant does not meet the requirements of this section, the department will

(1) return the application for additional information, as necessary; or

(2) decline to designate the applicant as a critical access hospital under Medicare.

(e) The department will, in its discretion, certify a hospital as a "necessary provider of health care services" for the purposes of 42 U.S.C. 1395i-4(c)(2)(B)(i)(II) if the hospital is less than a 35-mile drive from another hospital or, in the case of mountainous terrain or in areas with only secondary roads available, is less than a 15-mile drive from another hospital, and if the other hospital provides services only to a certain population group or subgroup and does not routinely provide services to all members of the community in which it is located.

(f) In this section, "critical access hospital under Medicare" means a critical access hospital under 42 U.S.C. 1395i-4 (Medicare Rural Hospital Flexibility Program).

History: Eff. 9/1/2000, Register 155

Authority: AS 18.05.030

AS 18.05.040

AS 18.20.010

AS 18.20.060

AS 47.05.010

AS 47.05.050

STATE OF ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES CERTIFICATE OF NEED NEGOTIATED REGULATIONS COMMITTEE REPORT

Prepared by:

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12/28/2007

Executive Summary

The Negotiated Rulemaking Committee meetings for the Certificate of Need (CON) held in October and November this year produced several strong recommendations based on high consensus of the group. They included;

- That the CON process as it is currently, is broken
- It should not be eliminated
- Clear definition and specificity on the Physician office exemption (POE)
- What should be in for CON and what should be out
- CON covered entities should be required to serve all comers regardless of their ability to pay
- CON should be in alignment with Medicare guidelines

Several other areas of consensus of the committee included;

- The need for an ad-hoc advisory group to support the state in reviewing equipment thresholds, new procedures and remodels/renovations related to CON
- The state would benefit from having an ad-hoc advisory group for technical expertise in disputed CON situations
- Recommendation that the state collect data that shows whether the CON process actually accomplishes its stated purpose of cost containment and access.
- The State be empowered to a higher level of enforcement and monitoring that providers are staying within their CON
- That for definition purposes Anchorage, Mat-Su, and Fairbanks would be considered large communities and all other areas in Alaska would be considered small communities.

Efficacy of the CON was a major discussion topic. Where the CON is designed to contain costs and improve access, the committee noted a lack of data on whether the CON process actually accomplishes its intended purpose. The committee acknowledged that any movement towards collecting data will be time consuming and that all providers of services should be included in data collection in order to get a more comprehensive picture. Concurrently, the committee also noted the need to protect smaller community hospitals in select areas from being driven out of business and that the CON process accomplishes that end. Failure to do so will leave the CON vulnerable to attack and elimination.

The Physician office exemption (POE) definition was the most discussed and contentious topic at every session. The committee debated throughout the

sessions the definition of what a physician office is and is not for purposes of exemption from the CON. While the committee did reach consensus on specific language for the POE, it was based on the fear of the misuses of the POE process as perceived by many members versus a more positive outcome driven definition.

The negotiated rulemaking committee has the distinct merits of bringing together stakeholders to derive consensus on issues that are of importance to their communities and the state. In this first attempt to reduce the litigious atmosphere surrounding the CON, there were two distinct stakeholders not represented on the committee;

1. Patient / consumer representation was absent from the committee. The absence of patient viewpoint would be valuable in future committees to ensure that the committee stays focused more on what is best for the citizens of Alaska rather than healthcare business interests.
2. State of Alaska Healthcare point of view and plan. Several times the lack of state and or community healthcare plans/ goals, vision was notably absent as needed information for the committee to use in making decisions. If a plan was developed the CON decisions could be made in reference to the community and state plans as a guide.

Finally, as a matter of improving the committee process it is recommended that once a committee member is selected that substitutions not be allowed as it interferes with the group dynamic and the ability of the group to reach consensus.

Alaska, Healthcare plan, meant the only voices heard were from the financially vested physicians and hospitals. Though several hospitals represented were community hospitals, there were few comments about what was best for patient, access or cost containment. Most comments were concerning what was best for those present. Diversity of representation must be present in order to ensure a balanced approach to this volatile topic.

Substitutions for committee members were allowed due to the short notice of the scheduling of the committee meetings and as a method to maintain representation. This had a negative effect on the building of consensus. Consensus building is best served when a group gets to know each other's interests and concerns over time. This allows for trust and common interest to be developed. The allowance of substitutions goes a long way in isolating positions and interests.

The absence of data for the efficacy of the CON was duly noted by committee members and the need for it was also highly recommended. The lack of overall reference points including data diminished the ability of the group to have a more substantive process and eliminate the personal interest factors from the room. The development of cohesive plans by communities and the State of Alaska regarding healthcare services will go a long way in guiding the CON process in ensuring the needs of a community are met. The ongoing collection and analysis of utilization and capacity data would go a long way in reducing disputes and making CON decisions more defensible.

III. Areas of High Consensus

HIGH CONSENSUS REACHED FOR THE FOLLOWING*:

- Eliminate CON fully?
- Radiation therapy to be subject to CON?
- Imaging services subject to CON?

- Should a new committee member be added? 70% YES.
  (The member was not added originally due to a communication issue).

- Should ambulatory surgery be included in CON? 65% YES.

- That statutorily defined Health Care Facilities, by definition, do not include physician offices. 100% agreed

- P.O.E. should be dis cussed separately from Radiology proposal.
  84.21%, YES

- Should CON programs require all entities to serve all patients?
  78.95%, YES

- Should CON processes and definitions be in alignment with Medicare
  80%, YES

- Should Ad-hoc advisory groups be formed to assist DHSS in technical or contested decisions, what type? 73.68% YES

- Recommend the state to seek out resources for clarification of issues in CON – tech advisory [illegible] YES

- All facilities/equipment above the threshold must request P.O.E. letter of exemption - State issues letter of determination, 71.43% YES

- The decisions reached are the best we ca n do, 71.43% YES

Please refer to "Consensor results" attachments for raw results

IV. Areas of General Consensus

General Consensus was defined as either general agreement by show of hands, verbal support of the group to a concrete concept without opposition, or a vote that achieved between 66% and 71% (see attached meeting notes and "Consensor results" for raw voting results).

Different definitions for smaller communities needed for the CON process.

There are no hard deadlines in the CON process. Committee recommends the state establish process timeline deadline lengths, in days.

Committee asked who can file an appeal? *Reference: Current regulations; must prove you are truly adversely affected party in order to file an appeal. If you don't prove you're adversely affected there may be a consequence. Committee decided that the burden is on the appellant.

Who has the authority to enforce? The Commissioner should have the authority.

Committee requests that the state clarify: Appellants should have to prove they're providing "similar" services (make less vague). Recommendation to state: clarify what is "similar"

- Laws should be passed requiring physician's offices – or those practicing medicine have to serve all comers (all patients regardless of whether they have insurance or are able to pay).
- The CON Committee agreed by show of hands that "quality" was off the table for discussion as related to the CON. The Committee agreed that quality assurance is important, but better addressed in other forums.
- All committee members agreed that they wanted to protect smaller communities and let larger communities have competition.

AUGUST 2006

REPORT TO THE CONGRESS

Physician-Owned Specialty Hospitals Revisited

MEDPAC Medicare Payment Advisory Commission

Executive summary

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required that MedPAC investigate several aspects of physician-owned specialty hospitals. We fulfilled this mandate with our March 2005 specialty hospital report. In that report we found that:

- Physician-owned specialty hospitals (specialty hospitals) did not have lower costs per severity-adjusted discharge than competitor community hospitals in their markets, although their patients had shorter lengths of stay.
- Specialty hospitals generally admitted less severe cases (which are expected to be more profitable) and concentrated on particular diagnosis-related groups (some of which were expected to be relatively more profitable than the average).
- Specialty hospitals tended to have lower shares of Medicaid patients than competitor community hospitals.
- Specialty hospitals drew patients from community hospitals, resulting in a small reduction in Medicare revenue growth. However, the financial impact on competitor community hospitals was limited because these hospitals took steps to compensate for lost revenue growth. Competitor community hospitals have had profit margins that are comparable to those of community hospitals located in markets without physician-owned specialty hospitals.
- From 1996 to 2002, cardiac surgeries per capita grew 4 percent faster in markets that gained a physician-owned heart hospital than in other markets. However, the 4 percentage point difference in growth rates was not statistically significant. The heart hospital markets also had a higher than expected rate of coronary artery bypass graft (CABG) surgery. The association between physician-owned cardiac hospitals and changes in the rate of CABG surgery per capita through 2002 was statistically significant.

However, the report also stressed that our findings could change as specialty hospitals evolve and capture a larger share of the market for hospital services. The 2005 report was based on the limited set of specialty hospitals that were operating for all of 2002. Our 2005 report and this report do not evaluate the quality of care in physician-owned specialty hospitals. Congress mandated that the Centers for Medicare & Medicaid Services (CMS) address that issue (CMS 2005).

After we presented the results from our March 2005 report, members of the congressional committees with jurisdiction over Medicare asked us to do some follow-up work when more data were available. The purpose of this paper is to update our analysis of physician-owned hospitals using two additional years of data (2003 and 2004) from an expanded set of specialty hospitals. We use the expanded data set to reexamine specialty hospitals' cost of inpatient care, Medicaid

share, impact on competitor community hospitals, and whether market entry of physician-owned heart hospitals is associated with an increase in cardiac surgeries.

In general, our findings are similar to our earlier work; however, the statistical significance of some findings has increased due to having a larger number of specialty hospitals to examine. Specifically we find:

- The number of physician-owned specialty hospitals roughly doubled from 2002 to 2004. Specialty hospitals continue to locate in areas that lack certificate-of-need laws and have above average population growth.
- The median heart hospital has 56 beds and a strong focus on Medicare inpatient services.
- The median orthopedic/surgical hospital has 14 beds, focuses on outpatient services, and receives a majority of its revenue from private payers.
- Both types of physician-owned hospitals tend to have lower shares of Medicaid patients than local competitors and nonlocal peer hospitals that specialize in cardiac or orthopedic care.
  - Medicaid patients represented 3 percent of discharges at the median physician-owned heart hospital and 2 percent at the median physician-owned orthopedic and surgical hospital. The median competitor community hospitals in those markets had a 13 percent Medicaid share. Competitor community hospitals may attract a larger share of Medicaid patients primarily because they offer a different set of services including obstetrics.
  - In an effort to control for service mix, we also compared physician-owned specialty hospitals to peer hospitals (hospitals with similar levels of specialization that are not physician owned). The median peer heart hospitals had a 7 percent Medicaid share, and the median peer orthopedic/surgical hospital had a 3 percent Medicaid share. The Government Accountability Office (GAO) found similar differences in their analysis of Medicaid shares.
- Specialty hospitals' inpatient services are not less costly than community hospitals' services, as might be expected from a "focused factory" hypothesis. But they do have some competitive advantages, such as shorter lengths of stay.
  - Heart hospitals have inpatient costs per discharge that are comparable to those of competitor community hospitals.
  - Orthopedic/surgical hospitals tend to have inpatient costs per discharge that are about 20 percent higher than those of competitor community hospitals. The difference in costs is statistically significant.

- Both groups of specialty hospitals have 20 percent to 25 percent shorter lengths of stay than competitor community hospitals, and the difference is statistically significant.
- However, the potential savings from shorter stays are not sufficient to offset the effects of other factors on orthopedic/surgical hospitals' costs.
    - Some of the higher costs per discharge at physician-owned orthopedic/surgical hospitals are due to low inpatient volume and higher unused capacity (medians of 14 beds and 28 percent occupancy).
    - Higher levels of depreciation and lease expenses per discharge may explain a small share of the higher costs at orthopedic/surgical hospitals.

- Physician-owned heart hospitals were associated with a statistically significant increase in the rate of cardiac surgeries in the market area.
    - For a typical market, we estimate that entrance of a physician-owned cardiac hospital was associated with a 6 percent increase in the number of cardiac surgeries per 1,000 Medicare beneficiaries (confidence interval 1 percent to 11 percent).
    - The typical heart hospital had 26 percent of the cardiac surgery market in 2004 and obtained most of its market share (roughly 20 of the 26 percentage points) by diverting patients from competitor community hospitals.
    - As was the case with our analysis of 2002 data, heart hospital markets had more CABG surgeries per 1,000 Medicare beneficiaries than would have been expected given the market's historical experience and national trends. Our model estimates that the entrance of a physician-owned hospital into a market is associated with a 9 percent increase in the number of CABG surgeries (confidence interval 1 percent to 18 percent) over the rate per 1,000 beneficiaries that would have been expected in the absence of the heart hospital.
    - We also categorized cardiac surgery patients into relatively high- and low-profit cases. Physician-owned hospitals did not have a significantly larger effect on the volume of relatively high-profit surgeries (low-severity patients) than they had on historically less profitable surgeries (high-severity patients) in the market.
    - Taken together these findings—an increase in overall surgeries, but no material shift in the ratio of high-severity to low-severity surgeries—are consistent with more than one hypothesis. One hypothesis is that physicians have a financial incentive to invest in cardiac hospitals, and these new specialty hospitals result in more surgical capacity and hence more surgeries per capita. Alternatively, individual physicians' clinical decision making is directly affected by financial incentives, but the change is a broad shift toward more surgeries rather than a precise shift toward the most profitable surgeries.

- While the specialty hospitals took profitable surgical patients from the competitor community hospitals (slowing Medicare revenue growth at some hospitals), most competitor community hospitals appeared to compensate for this lost revenue. From our site visits in 2004, we learned that in some cases competitor community hospitals cut expenses by cutting staff; in some cases they instituted "aggressive pricing strategies" to raise revenue from private payers; and in many cases they expanded profitable business lines such as imaging, rehabilitation, pain management, cardiology, and neurosurgery. These responses to the specialty hospital challenge coupled with population growth in many of the markets where specialty hospitals operate combined to allow competitor community hospitals to maintain profit margins that are in line with national averages.

As physician-owned entities capture more profitable service lines, the effect on community hospitals may increase. However, we found that community hospitals' profit margins appeared stable through 2004, even in markets where physician-owned hospitals captured more than 10 percent of all admissions.