

POLICY PERSPECTIVE

Specialty Hospitals Trauma Centers

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Two issues we have been following will be updated this month, and a new one introduced.

Specialty Hospitals

This is becoming a perennial, not only because it so clearly differentiates the CON states from those without CON, but because it reveals in microcosm many of the current tensions in healthcare policy. The most critical tension is that between competition and planning/regulation, but a host of other issues are also implicit within it, issues that have increasingly been the subject of policy research over the last two years.(1)

Two of these underlying issues are the low payment for most Medicaid patients and the lack of payment for uninsured patients which together create strong incentives for specialty hospitals and community hospitals alike to attract well-paying patients and avoid others. This dynamic is examined in an article by Stuart Guterman in *Health Affairs*. "Above all," Guterman concludes, "the lack of explicit financing of the broader (and unprofitable) missions of health care facilities is a major failure, with implications far beyond the question of whether or not specialty hospitals should be allowed."(2)

The Center for Studying Health System Change has been following these issues closely. In a new report,(3) it illuminates the nature of the competition these hospitals pose. The report bases its findings on circumstances in Indianapolis, Little Rock, and Phoenix, three sites where there has been significant specialty hospital development. Among its findings:

- Some purchasers 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.
- Some health plans and employers believe that physicians referred relatively easy cases to specialty hospitals and more complex patients to general hospitals, whether out of quality concerns or financial considerations.
- Although there was some evidence of increased price competition, respondents observed that the more important outcome was the perceived need for general hospitals to compete aggressively with the new physician-owned specialty hospitals by developing similar dedicated centers, as distinct hospitals-within-hospitals or freestanding facilities. Moreover, purchasers believe specialty hospitals have unfair advantages that create an unlevel playing field for hospital competition, and some suggested that certificate-of-need regulations be used to limit the growth of specialty hospitals.

- “Although respondents were not specifically asked about possible policy approaches to address their perceptions about nonproductive competition stimulated in part by specialty hospitals, some employers and health plans suggested that increased government regulation to limit specialty hospital growth might be desirable. In Indianapolis and Little Rock, respondents suggested that certificate-of-need regulation might be needed to restrict the growth of specialty hospitals. Indeed, in two other HSC sites that have not seen physician-owned specialty hospitals, Miami and northern New Jersey, health plan respondents referred approvingly to CON restrictions on specialty hospitals in their states.”

Thus the report judges that specialty hospitals are contributing to a medical arms race that is driving up costs without demonstrating clear quality advantages. The findings again confirm that even a competitive health care system does not function like most other sectors of the economy. It concludes that,

“Up until now, specialty hospitals have not had to outperform general hospitals on costs or quality because specialty hospitals have had inherent advantages from pricing distortions, physician self-referral, favorable case-mix, and lack of an uncompensated care burden. Eliminating these advantages would provide a more meaningful test of whether there is an important role for specialty hospitals as focused factories, as some have advocated. Some believe that permanent barriers to entry of specialty hospitals through targeted CON restrictions, as some states have adopted, should await such a test, so that a better assessment could be made. But others are skeptical about policy makers’ ability—or commitment—to create the conditions for a true level playing field.”

Angioplasty and Open Heart Surgery

Across the country, the number of open-heart surgeries is declining and angioplasties are leveling off. For example, the total number of bypasses in Maryland declined by 16.8 percent between 2000 and 2004 (n=7,537), and the number of angioplasty-stent procedures to open clogged heart arteries rose 27.3 percent (n=17,982). During the same period in New Jersey, bypasses declined by 16.6 percent (n=8009), and angioplasties rose 66 percent (n=25,520). Bypass surgeries in Southeastern Pennsylvania fell by 35 percent between 1997 and 2004 (n=4348), while angioplasty-stent procedures rose by 49 percent in the same period (n=12,777), showing that, as in New Jersey, three times as many angioplasties as bypass surgeries were performed in area hospitals in 2004. National guidelines call for a minimum of 100 to 125 open-heart surgeries per hospital (and ideally much more), and 200 angioplasties per hospital to maintain quality. In New Jersey, the DOH requires that hospitals do a minimum of 350 open-heart surgeries. If they fall short of that number, they must demonstrate outcomes that are in line with the state average to maintain a program. In Pennsylvania where there is no such condition for licensure, the latest report from the Pennsylvania Health Care Cost Containment Council (PHC4) shows that more than half of the 60 hospitals with open-heart programs fell below the 350 threshold encoded in New Jersey. The average number of cases per hospital decreased from 390 in 2003 to 376 in 2004, a decline of 3.6 percent. The average number of open-heart surgeries performed per surgeon has remained relatively constant since 2002 at approximately 130 cases.

The impact of Pennsylvania's loss of its CON program at the end of 1996 is evident in Philadelphia and its four suburban Pennsylvania counties (with 3.9 million people) where 22 hospitals have open-heart programs. In New Jersey, with a population of 8.5 million, just 17 hospitals performed bypasses in 2003.

PHC4's first report in 1991 showed a mortality rate of 4.90 percent for the state's open-heart surgery programs. By 2003, that rate had fallen to 2.04 percent in-hospital mortality (2.36 percent thirty-day mortality), and in 2004, to 1.98 percent in-hospital mortality (2.31 percent thirty-day mortality). These rates are still comparable to New Jersey's (2.33 percent thirty-day mortality in 2003). The agency's latest report for 2004 reveals that the area in which the state's 60 bypass hospitals most need to improve in order to further reduce their mortality rates is in nosocomial infections. Bypass patients with hospital-acquired infections (2.6 percent) had a death rate of 12.6 percent compared with 1.7 percent for those without that complication, the report shows. The infected patients had hospital stays of nearly 23 days on average compared with less than seven days for those with no infection. PHC4 data suggests that hospital-acquired infections were likely underreported for 2004.

A just-completed study at Cedars-Sinai Medical Center in Los Angeles demonstrated that treatment of the most serious form of heart disease (severe stenosis of the left main coronary artery) with angioplasty and drug-eluting stents resulted in outcomes at least equivalent to bypass surgery. It may now be seen by state regulators as appropriate to have a moratorium on new programs in order to evaluate the impact of these trends and recently approved programs on overall service quality and access.

Trauma Centers

Trauma centers are the subject of a nationwide study conducted by researchers at the Johns Hopkins Bloomberg School of Public Health and the University of Washington School of Medicine. The study,⁽⁴⁾ analyzes the outcomes of 5,190 adult trauma patients who received treatment at 18 level 1 trauma centers (the highest level of care) and 51 non-trauma centers located in 14 states between July 2001 and November 2002. The researchers also analyzed the characteristics of each hospital, such as the number of patients treated and types of specialty services available. After adjusting for factors such as severity of injury, patient age and pre-existing medical conditions, the researchers found a 25 percent overall decrease in the risk of death following care in a trauma center compared to receiving care at a non-trauma center. The adjusted in-hospital death rate was 7.6 percent for patients treated at trauma centers compared to 9.5 percent for patients treated at non-trauma facilities (relative risk, 0.80; 95 percent confidence interval, 0.66 to 0.98). The mortality rate one year following the injury was 10.4 percent for patients at trauma centers compared to 13.8 percent for patients at non-trauma centers (relative risk, 0.75; 95 percent confidence interval, 0.60 to 0.95). The effects of treatment at a trauma center varied according to the severity of injury, with evidence to suggest that differences in mortality rates were primarily confined to patients with more severe injuries.

"Hospitals have difficulty justifying the expense of maintaining trauma centers without strong evidence of their effectiveness. Now we have conclusive data to show that trauma care is effective," said the study's lead author, Ellen J. MacKenzie, PhD, professor and chair of the Department of Health Policy and Management at the

Bloomberg School of Public Health. "The findings of this study argue strongly for continued efforts at regionalizing trauma care at the state and local levels to assure that patients who suffer serious injuries get to a trauma center where they are afforded the best possible care."

(1) For an introduction to this subject, see my article, "Boutique Hospitals: Competition or Exploitation?" from the 2nd Quarter 2004 issue of *Health Planning TODAY*, online at <http://www.ahpanet.org/images/AHPAspechospArticle.pdf>.

(2) "Specialty Hospitals: A Problem or a Symptom?," *Health Affairs*, January/February 2006. The article is online at

<http://content.healthaffairs.org/cgi/content/full/25/1/95?ijkey=oMTsWRDMc5BI&keytype=ref&siteid=healthaff>.

(3) "Do Specialty Hospitals Promote Price Competition?" by Robert A. Berenson, Gloria J. Bazzoli, and Melanie Au (January 2006). To view the report: <http://www.hschange.org/CONTENT/816/>.

(4) "A National Evaluation of the Effect of Trauma Center Care on Mortality," *New England Journal of Medicine*, January 26, 2006. Funding for the study was provided by the Centers for Disease Control and Prevention's National Center for Injury Prevention and Control and the National Institutes of Health's National Institute on Aging. To view it online: <http://content.nejm.org/cgi/content/short/354/4/366>.