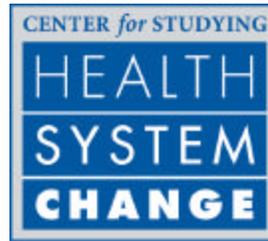


Project: 6270



*Providing Insights that Contribute
To Better Health Policy*

A Report on Medical Specialty Centers in Wyoming

Final Report
November 22, 2006

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Table of Contents

EXECUTIVE SUMMARY	5
Chapter 1: Stakeholder Perceptions and Recommendations	9
A. Introduction	9
B. The Impetus for Medical Specialty Centers	10
C. Impact on Competition	11
D. Impacts on the Cost of Health Care	15
E. Impacts on Health Care Quality	16
F. Impacts on Access to Care	16
G. Stakeholder Policy Recommendations	18
Chapter 2: The Financial Performance of Hospitals in Wyoming	19
A. Introduction	19
B. Data Sources and Hospital Selection	19
C. Characteristics of Wyoming Hospitals	20
D. Summary	26
Chapter 3: Characteristics of Market Areas with Medical Specialty Centers	29
A. Introduction	29
B. Data Sources and Selection of Comparison States	29
C. Location of Medical Specialty Centers	30
D. Key Characteristics of Market Areas with MSCs	31
E. Likelihood of a Medical Specialty Center Emerging in a Market Area	33
F. Financial Impact of Medical Specialty Centers on General Hospitals	34
G. Summary and Implications For Wyoming	35
H. Limitations of the Analysis	36
Chapter 4: Potential Policy Approaches for Wyoming	37
A. Introduction	37
B. Watchful Waiting	37
C. Improving Community and Faculty Monitoring	37
D. Hospital Licensure	39
E. Ownership Disclosure	40
F. Self-referral	40
G. A Level Playing Field	41

H. Certificate-Of-Need Laws	42
I. Moratorium.....	42
J. Summary and Discussion.....	43
Appendix A.....	45
Appendix B.....	47
Appendix C.....	49
Appendix D.....	51
References	53

EXECUTIVE SUMMARY

The proliferation of medical specialty centers (MSCs) nationwide and in neighboring states has raised concern about the potential impact of medical specialty centers on full-service general hospitals. In this report, we present findings based on three components as requested by the Wyoming Health Care Commission:

- A descriptive analysis that provides a current snapshot of the status and financial performance of for-profit and not-for-profit general hospitals in Wyoming.
- An analysis of the estimated likelihood of an MSC locating in a particular market based on the characteristics of that market, and a comparison of mean characteristics in Wyoming and in seven other states
- A summary of policy implications for Wyoming.

As of 2004, Wyoming had 29 hospitals, of which 25 were Medicare sole community general, acute-care hospitals. Of the 25 general hospitals included in the analysis, 22 are not-for-profit general hospitals with three for-profit general hospitals statewide. Currently, Wyoming does not have any MSCs operating in the state. In the neighboring states of Colorado, Idaho, Montana, Nebraska, South Dakota, and Utah, 20 MSCs were in operation as of 2004.

To help understand the impact of medical specialty centers on general hospitals and access, quality and costs of health care in Wyoming, we conducted a series of interviews with stakeholders in four geographic areas: Casper, Cheyenne, and the areas of Rock Springs and Gillette.

Representatives from MSCs in states bordering Wyoming reported that their facilities developed out of physician frustration with their general hospital. Other catalysts included physician concerns about the quality and efficiency of general hospitals, with opportunity for financial gain rarely mentioned.

The single greatest concern related to the added competition from MSCs is the potential negative financial impact on general hospitals. Several respondents expressed concern that because physician owners would be able to select the patients referred to their MSC, general hospitals could lose volume in the profitable services that subsidize indigent and emergency care. In addition, general hospitals voiced concern that revenues from these patients could enable MSCs to offer staff higher salaries and a better quality of life, thereby intensifying the physician recruitment challenges already faced by general hospitals.

In contrast, other stakeholders predicted that increased competition from MSCs would ultimately provide an incentive for general hospitals to improve their own efficiency. Stakeholders indicated that MSCs could improve quality of care for patients by specializing in

certain procedures, improving nurse-to-patient ratios, shortening procedure times, focusing more on the patient and providing a more comfortable atmosphere. Many respondents maintain that the introduction of competition might moderate hospitals' advantage over insurers to set payment rates and possibly help contain Wyoming's relatively high health care costs.

Stakeholders offered a range of policy responses to address the potential impact of MSCs, including no response at all. While some uphold the principles of free markets and competition, other respondents want to create a level playing field to protect general hospitals from the potential negative effects of MSCs, including regulating self-referral, requiring MSCs to accept a certain percentage of uninsured and Medicaid patients, subsidizing general hospital indigent care, or possibly requiring MSCs to operate an emergency department.

The average capacity of for-profit general hospitals in Wyoming is slightly larger than that of not-for-profit hospitals. In 2004, for-profit hospitals averaged 59-staffed beds per facility compared with 50-staffed beds in general hospitals. Although total inpatient admissions in Wyoming did not change much for both types of facility between 2000 and 2004, for-profit hospitals experienced a 48 percent increase in outpatient visits, while not-for-profit hospitals experienced an 8 percent decrease during the same period. Consistent with a growing number of outpatient visits, for-profit hospitals experienced a steady rise in the average number of admissions per bed.

The operating room capacity of general hospitals was similar across not-for-profit hospitals and for-profit facilities. For-profit hospitals performed more outpatient surgeries on average than not-for-profit hospitals in 2004. With respect to payer mix, not-for-profit facilities had a lower percentage of revenues (47 percent) received from private and other payers than for-profit hospitals (68 percent).

During this period, the operating margins of general hospitals showed a wide and persistent discrepancy between for-profit and not-for-profit facilities. During the 2000-2004 period, for-profit hospitals reported being in a strong financial position with average operating margins between 11 percent and 37 percent. In contrast, average operating margins for not-for-profit facilities were consistently negative in all years where data were available. Furthermore, this downward trend indicates that the financial status of not-for-profit hospitals worsened over this period.

Based on our analysis of trends from 2000 to 2004, medical specialty centers are more likely to locate in market areas with higher population levels. In Texas, of the 13 market areas with an MSC, all had population levels of at least 100,000. In the six comparison states that share a common border with Wyoming, all the market areas with MSCs had a population of at least 50,000 and 11 of the 16 health service areas (HSAs) with an MSC had 100,000 residents or more. Since no Wyoming HSA had more than 100,000 people in 2004, it seems unlikely that an MSC would emerge in every region of Wyoming. However, an MSC might emerge in the two

market areas with a population of at least 50,000. This finding is consistent with the recent announcement of a new MSC breaking ground in one of these two market areas.

The strongest predictors of the likelihood that an MSC would emerge in a market area are population level and the number of for-profit hospitals. MSCs tend to emerge in areas with greater populations because the patient base and demand for hospital services is likely to be greater. These market areas are more likely to support the emergence of new entrants, such as MSCs, despite potential competition with existing general hospitals. If the overall size of the market population is also growing, the entry of a new MSC may not necessarily have an adverse impact on general hospitals by competing for the same patients. In addition, high population areas are more likely to have a robust community of physicians, including surgical specialists who provide services in the MSCs.

To address the possibility of negative community outcomes, states around the country are trying to address the emergence of MSCs in a variety of ways, ranging from “watchful waiting” to a temporary moratorium on new specialty facilities. In the context of Wyoming’s current hospital and health care environment, some intermediate approaches suggest themselves.

- Requiring ownership disclosure by referring physicians would be consistent with CMS’s forthcoming policy regarding disclosure.
- Wyoming also may want to consider using its trauma care management process to assess the community benefits of requiring full-service emergency departments in potential new MSCs.
- The outcome of this assessment, in turn, might indicate whether MSCs ought to be subject to the same licensing requirements as general hospitals or be part of a separate licensing category.
- Finally, Wyoming could consider strengthening its hospital data collection and analysis capabilities to assess the community impacts of such MSCs, as well as to support other state planning and policy-making objectives.

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Chapter 1: Stakeholder Perceptions and Recommendations

A. Introduction

In this chapter, we report our findings from interviews with 27 stakeholders in Wyoming on their perceptions of the potential impacts of medical specialty centers (MSCs) on the health care market. Stakeholders were selected in four areas of the state: Casper, Cheyenne, the Rock Springs area (Sweet Water and Lincoln counties) and the Gillette area (Campbell and Crook counties). They included representatives from general hospitals, emergency medical services, health insurers, specialty physician groups, local health departments, health centers and health care advocacy organizations. We also included MSCs in states bordering Wyoming. The interviews were guided by semi-structured protocols that included open-ended questions about stakeholders' perceptions in a number of areas, including:

- Factors that contributed to the development of medical specialty centers (in neighboring states);
- The potential impact of medical specialty centers on the overall competition among hospitals to provide specialty services;
- The potential financial impact of medical specialty centers on general hospitals;
- Potential impacts of medical specialty centers on the cost of care;
- Potential impacts of medical specialty centers on quality of care; and
- Potential impacts of medical specialty centers on access to care.

Wyoming Senate Bill 0057 defines medical specialty centers (MSCs) as facilities that focus on cardiac, orthopedic and/or surgical services and allow patients to remain on the premises for 24 hours or longer. Many stakeholders reported that ambulatory surgery centers (ASCs) are merely MSCs that keep patients for less than 24 hours. To capture the stakeholder perceptions about potential impacts of MSCs, we limited our discussions to facilities that keep patients 24 hours or longer. Currently, there are sixteen ambulatory surgery centers in Wyoming. When the stakeholder interviews were conducted, there were MSCs in the states bordering Wyoming but no MSCs within the state. However, National Surgical Hospitals Inc. has broken ground on a MSC in Casper.

The MSCs in the communities outside of Wyoming represent a wide range of ownership arrangements including joint ventures between physicians and a local general hospital system; joint ventures among physicians, corporations, or other investors; sole physician ownership; and no physician ownership. Among MSCs with partial physician ownership, the group of

physician owners typically has majority control of the enterprise. Yet, an individual physician generally owns only a small portion of the facility.

B. The Impetus for Medical Specialty Centers

To obtain stakeholder perspectives from MSCs, facilities in both Idaho and South Dakota were interviewed. Unlike many MSCs throughout the country, most of these MSCs have been in existence for at least 10 years. Many of them started as ambulatory surgery centers, and then obtained a hospital license to expand and open inpatient beds. These MSCs are similar to general hospitals because they offer a wide range of surgical services—in some cases more than the local general hospital. As one MSC representative said, “We do everything from bariatrics to tonsils.” Although the factors prompting the opening of each hospital are slightly different, the following motivating factors were similar across hospitals.

Physician Dissatisfaction. The most common impetus for the formation of the physician-owned hospitals was physician frustration with the existing community hospital. Representatives of physician-owned hospitals often reported, “feeling both stymied and frustrated in terms of their interaction and input.” This feeling often stemmed from the fact that physicians were not included in the management and/or decision-making process at the community hospital. For example, one stakeholder of a physician-owned MSC noted that physicians were “concerned about non-responsiveness to issues of service and quality.” Some complained more specifically about the hospital not providing the technology, equipment, or appropriate staffing levels needed by physicians.

Quality. Several representatives of physician-owned MSCs commented that physicians were displeased with a range of quality-related issues, including infections, problematic patient outcomes and high nurse-to-patient staffing ratios in community hospitals. Nevertheless, all representatives, regardless of the hospital’s ownership or specialty status, mentioned quality as a prominent aspect of their mission.

Overall Efficiency. “If you specialize in it, you can do it better, swifter, and more economically.” This belief was a major motivator for developing MSCs. MSC representatives reported that, in general, they have the latest technology, their operating room turnover is quicker, and surgery times are shorter than in the community hospital.

Financial Gain. Only one stakeholder associated with a MSC attributed the motivation for opening these facilities to physicians’ desire for financial gain, and this factor was mentioned only as a secondary motivation.

The Medicare Modernization Act of 2003 (MMA) Moratorium on New Physician-Owned Cardiac, Orthopedic, and Surgical MSCs. The Centers for Medicare and Medicaid Services

(CMS) suspended Medicare and Medicaid payment to new specialty hospitals until 18 months after the passage of the Medicare Modernization Act in December 2003. CMS then declined to process new applications and the Deficit Reduction Act of 2005 further extended the moratorium by another six months. The moratorium expired on August 8, 2006.

Respondents reported that the moratorium has not had a direct impact on the development of MSCs in Wyoming or the surrounding states. There is a general belief that MSCs “would be a long time in developing” given the rural nature and overall small state population. Most stakeholders contend that only Casper or Cheyenne might support a facility, and even then, it would likely need to become a “destination facility” that would draw from the state at large.

C. Impact on Competition

Most stakeholders in Wyoming anticipate that the development of physician-owned MSCs in their communities could have a significant impact on competition in the market for specialty services. Development of MSCs would introduce competition to general hospitals that currently serve as their community’s sole provider of inpatient services. However, while most stakeholders agree that medical specialty centers will increase competition, they disagree over the degree and type of impacts such competition would present. In particular, stakeholders hold a range of views on the impact that increased competition would have on the financial status of general hospitals, as well as on health care costs, quality, and access.

Through the stakeholder interviews, we explored how this change in the competitive environment might influence hospitals’ relationships with physicians and their relationships with insurers, as well as the anticipated financial impact of medical specialty centers on general hospitals and the expected variation across markets.

1. Relationship with Physicians

Current Environment. Currently, physician recruitment reportedly is a major obstacle facing hospitals in Wyoming. This is partly because Wyoming is a very rural state with a small population, making it difficult to attract families looking to settle in larger metropolitan centers. Additionally, malpractice premiums in Wyoming are relatively high compared with neighboring states. Consequently, both general hospitals in Wyoming and out-of-state MSCs reported that maintaining relationships with physicians is a top priority, and they spend considerable time and resources nurturing existing relationships and establishing new ones.

To recruit physicians, Wyoming hospitals have had to raise physician compensation to maintain competitive with neighboring hospitals both in and out of state. Additionally, many hospitals reported having to pay surgeons a daily rate to serve on call in their emergency and trauma departments. Hospitals have hired professional recruiters and have developed programs to integrate members of the community and medical schools into recruiting efforts. Hospitals have also begun to hire salaried physicians and hospitalists—physicians who specialize in

treating inpatients—partly to provide malpractice coverage to physicians. Many representatives from general hospitals claimed that they are able to offer physicians a better quality of life than in other states, as there is only one general hospital per county and most physicians only have to take call at that single hospital.

Yet, a number of factors encourage physicians to perform procedures outside the hospital setting by investing in their own ambulatory surgery centers, diagnostic equipment, and office capacity. Many of the smaller hospitals are capable of offering primary and secondary services, but only two general hospitals in Wyoming serve as tertiary referral centers. For tertiary care such as open heart or neurosurgery, consumers reportedly are accustomed to going to hospitals in the larger markets of Casper and Cheyenne or out of state. Even for other services and procedures, reportedly several county hospitals in Wyoming do not allow itinerant physicians—specialists who treat patients in numerous parts of the state—to have admitting privileges. Some respondents indicated that these restrictions grew out of quality concerns and pressure from staff physicians who do not want to compete with itinerants. Additionally, stakeholders from out-of-state MSCs noted that, in general hospitals, physicians have limited ability over patient care decisions, as they are required to compromise with hospital administrators in areas such as the purchasing of new equipment.

Indeed, in Wyoming, physicians in recent years have invested in ambulatory surgery centers and equipment, reportedly diverting market share from the local hospitals. Given the high demand for physicians in the market, physicians currently have considerable leverage over hospitals to pursue alternative sources of income. As one general hospital representative said, “If a physician has it in his or her mind to open a surgery center, there is little I can do...at the end of the day if capitalism is their philosophy, you will lose the business.”

In an attempt to retain at least a portion of patient volume going to physician-owned facilities, many hospitals have opted to enter into joint ventures with physicians for relatively lucrative services, even if the joint venture would ultimately hurt the hospital’s bottom line. To hospitals, this is preferable to the alternative of losing the business altogether. As one general hospital representative stated, “The main thing that we consider when deciding to partner with physicians is what will happen if we don’t partner...doctors are going to do it (invest in equipment, surgery centers, etc.) themselves and they are going to find another partner... to prevent this from happening, we would rather have a part of something than all of nothing.”

Potential Impact of MSCs on Physician/Hospital Relationships: Many stakeholders expressed concern that the current tensions between general hospitals and physicians would likely intensify with the development of medical specialty centers. General hospitals fear that the potential of medical specialty centers to draw the most lucrative patients enable them to lure physicians, nurses, and technicians from general hospitals with higher salaries and a better quality of life, typically with regular 8 a.m. to 5 p.m. shifts. General hospitals noted that physicians do not like to cover patients and take call at additional hospitals and contend that, if there is another hospital in town, it will be harder to recruit physicians. At the same time, some

general hospitals also are concerned that they may lose physicians to specialty centers because these hospitals would likely have fewer trauma and emergency cases and entice physicians with promises of reduced call for emergencies. In a climate where physician recruitment ranks among the greatest challenges facing hospitals, these potential developments are seen as particularly threatening by some stakeholders from general hospitals.

B. Relationships with Insurers

The nature and dynamics of health plan contracting are similar across markets, payers, and hospitals in Wyoming. Since Wyoming is an “any-willing-provider” state, insurers must accept any provider willing to accept their contractual terms, including negotiated rates for services. Unlike many areas of the country, the very rural nature of Wyoming means that all of the hospitals are sole community providers. This creates a monopolistic pricing situation between providers and insurers where hospitals receive reimbursement for charges or some discount off charges. Therefore, payment rates reportedly are generally higher than in other states where insurers hold more leverage and can negotiate lower payment rates. This combination of monopoly market power and high payment rates results in Wyoming having “health care that is terribly expensive,” according to a respondent.

The entry of MSCs into this dynamic potentially presents an opportunity for increased bargaining between insurers and providers. Representatives of health insurers indicated that although price is an important factor in the decision to include MSCs as an approved provider, price is not the only factor. There needs to be an understanding of the “total impact on the acute care facilities” before a decision can be made about contracting with a MSC. As one respondent commented, “The specialty hospital may give you a better price, but if that takes away Medicare funding from the local hospital and the local hospital jacks up their price, what have we done?”

Stakeholders indicate that employers—in their role as purchasers of health insurance—typically have not been vocal about the impact MSCs would potentially have on health plan negotiations and health coverage for their employees. Nevertheless, one of the top concerns of employers is that health services are relatively expensive in Wyoming. Reportedly some large employers encourage their employees to go out of state for treatment because it is less expensive.

C. Financial Impact on General Hospitals

The financial impact on Wyoming’s general hospitals appears to be the single greatest concern related to the added competition medical specialty centers would bring. Many stakeholders expect that physician owners in specialty hospitals would be able to “cherry pick,” or refer the most lucrative patients to their own hospitals. These are usually insured, low-acuity patients receiving expensive services, such as elective surgery. As one stakeholder said, “Physicians know who can and can’t pay. They’ll say to the patient that, ‘We need you to go to the hospital for this surgery or test.’” The predicted result is that general hospitals would lose

volume in their most profitable services, and charity care would become a larger percentage of services provided.

General hospitals rely on profitable service lines to subsidize indigent and emergency care. If the medical specialty centers cherry pick the well-insured patients, county hospitals would face declining revenues and reduced insured patient volume over which to spread fixed costs. Moreover, general hospitals worry that the addition of medical specialty centers will cause them to lose sole provider status and the extra Medicare funding provided for sole provider hospitals. To compete with MSCs, general hospitals claimed that they would have to cut back both on less lucrative services (such as emergency care and substance abuse treatment) and care for uninsured patients.

However, some general hospitals reported that they would not mind the increased competition from medical specialty centers, as long as the Wyoming Legislature provided regulations on these centers to “level the playing field” to control cherry picking. Even if MSCs were required to have emergency departments, some stakeholders believe that, in practice, the ED volume would comprise a small percentage of total volume at specialty hospitals, as physician-owners would admit only the insured patients with the lowest acuity, and refer the high-acuity cases to the community hospitals. Many stakeholders from general hospitals contend that the implementation of certain policies and regulations could ameliorate these problems (see Policy Recommendations).

In contrast, other stakeholders, particularly those from medical specialty centers in neighboring states, believe that competition from medical specialty centers would improve efficiency and ultimately decrease costs for general hospitals and the overall community. While many representatives from MSCs in neighboring states conceded that their presence did divert business and initially hurt the margins of the general hospitals in their communities, they contended that ultimately this pressure encouraged local hospitals to examine ways to improve their own efficiency and regain patients. Ultimately, MSC stakeholders argued that the hospitals recovered their margins, and that the added competition encouraged better patient care.

4. Market Variation

The potential impact of medical specialty centers in Wyoming seemingly would vary across markets. Three factors are relevant in determining the extent of impact in each market:

Border versus Central Markets: Many general hospitals in markets along Wyoming’s borders currently compete with out-of-state medical specialty centers and general hospitals. These hospitals already face the challenges associated with competing with other hospitals for physicians and patients, and these problems likely would be exacerbated by the addition of another medical specialty center into the market. On the other hand, general hospitals in these markets may be more adept at adapting to competition than hospitals located in the center of the state, as these hospitals have served as sole providers with virtually no competition for years.

Rural vs. Urban Markets: While respondents across the state expressed concerns about the potential impact of medical specialty centers, stakeholders in urban centers, particularly Casper and Cheyenne, were more likely than stakeholders in rural markets to view the development of medical specialty centers as an imminent reality. However, some stakeholders noted that, because Wyoming citizens are used to traveling long distances for all types of services, the creation of a specialty hospital in one part of the state potentially could have ramifications in other markets as well. Also, depending on the size of potential medical specialty centers and types of services they offer, any volume medical specialty centers absorbed would likely be less of a percentage of business for larger, urban hospitals than for smaller rural hospitals.

Population Growth: Many respondents noted that certain communities, particularly around Rock Springs and Gillette, have experienced an influx of younger, transient workers drawn to the recent growth in energy-related industries. The implications of this demographic change remain unclear. The increase in population may provide additional demand for hospital services, thereby increasing the viability of an additional hospital in certain markets. However, these workers tend to be younger and lower income and frequently lack health insurance, which could exacerbate the strains on county hospitals resulting from new medical specialty centers.

In contrast, while Casper and Cheyenne have experienced some population growth, this growth is much smaller and mostly consists of older retirees. Again, while this increase in population may raise demand for hospital services, it remains unclear how an older population would affect competition for specialty surgeries if an MSC opened in those cities.

D. Impacts on the Cost of Health Care

Many stakeholders perceive Wyoming to be a high-cost health care market currently, because of a number of factors. Given the state's rural nature, each community has a sole community hospital and no competition from other hospitals. Some stakeholders referred to community hospitals as monopolistic. As discussed earlier, community hospitals in Wyoming currently are not subjected to deep discounts through insurer contracts. Moreover, given the costs of recruiting and retaining physicians and nurses, many general hospitals' respondents noted that spending on recruitment is a top pressure they face. Indeed, a number of stakeholders reported concerns that employers are or are considering sending employees out of state to receive health care because it is less expensive than in Wyoming.

Stakeholders anticipate that the development of MSCs could have a range of effects on health care costs in Wyoming. Many respondents lamented the lack of hospital competition in the state, and some contended that entry of new providers would help limit sole community providers from reportedly driving up unit prices; some think that MSCs would offer lower unit prices. Indeed, respondents representing specialty practices or facilities typically argued that MSCs are innovative providers that create efficiencies in care delivery that ultimately reduces health care costs.

Yet most stakeholders noted concern that increased competition from MSCs would increase costs for reasons such as driving up utilization, wages, duplicating services and adding expensive technology. According to one general hospital representative, “Competition in health care does not reduce costs. It raises costs. You’ll have higher wages, everyone will have a CT, MRI, and the cost of health care increases. There is no doubt it will.”

E. Impacts on Health Care Quality

Representatives from general hospitals in Wyoming said that providing high quality care is a key—and increasingly important—part of their mission. Some reported spending considerable effort on improving quality, such as working to improve their performance in quality reporting programs. Yet a number of other stakeholders report that consumers who have the ability to go elsewhere often do because they perceive that care outcomes would be better in a larger city, such as Denver or Salt Lake City. For example, consumers reportedly perceive other hospitals to have more up-to-date technology or more highly skilled staff.

Overall, stakeholders predict that the entrance of MSCs could improve quality of care both for patients treated in those facilities and potentially more broadly among all hospitals. Representatives of physician groups and other specialty providers expect that MSCs would provide higher quality by, for instance, employing more specialized teams of practitioners, having better nurse-to-patient ratios, having relatively shorter procedure times, focusing more on the patient and providing an atmosphere that is more conducive to recuperating. In addition, those respondents and some others predicted that increased competition would have the positive effect of all hospitals working to provide such quality gains—that the presence of such facilities would lead to “Everyone having to step up their game.”

At the same time, some respondents across sectors expressed concern that increased competition from such facilities could strain existing general hospitals to the point of causing quality concerns. To the extent that general hospitals could lose privately insured patients to the new facilities, they may not bring in revenues sufficient to maintain their core services and the new hospitals could lure more talented, experienced staff from general hospitals with better salaries and working environments. In addition, some stakeholders noted that the introduction of MSCs could foster more itinerant surgeons, which could hurt quality of care because the surgeons potentially would not remain with the patient during follow up (yet others argue this is a concern currently; see Relationships with Physicians section). Still a few others do not foresee that MSCs would have any impact on quality of care.

F. Impacts on Access to Care

Stakeholders generally perceive that the 26 general hospitals and other facilities in Wyoming offer adequate capacity and access, and some physicians indicated that a MSC in their community would not provide any significant or particularly needed improvements in access, other than potentially reducing wait times for elective procedures. However, stakeholders have

some specific concerns about access—including distance to providers, physician supply, and care for low-income populations—with various predictions of how the development of MSCs in Wyoming could influence these issues.

First, although some Wyoming residents reportedly opt to travel to hospitals out of state because of perceived quality or cost differences (as noted earlier), stakeholders reported that many people travel long distances—within the state or outside—out of necessity given the rural nature of the state. Stakeholders noted concern that distances to a hospital are barriers to access for many people, particularly in emergent situations. Some respondents see additional hospitals as a means to reduce driving distances for people in isolated areas and to potentially offer consumers a choice of provider. Some predict that this improved access would also help stem the out migration of services. In any case, many stakeholders questioned whether the population would be large enough outside of the larger cities of Casper and Cheyenne to make such hospitals viable.

Stakeholders hold mixed views on whether the development of MSCs would improve physician recruitment and retention. On one hand, the promise of another source of revenue through such investment opportunities could draw needed specialists to the state. Yet, another respondent predicts that the presence of additional inpatient facilities could dissuade physicians from practicing in the state if they were pressured to practice in multiple facilities. Indeed, a number of stakeholders noted that a more manageable work schedule and better quality of life are benefits of practicing in Wyoming currently. There is also some concern that, if physician ownership leaves general hospitals with a higher percentage of more acute patients, malpractice costs at general hospitals could rise and exacerbate recruiting challenges.

Furthermore, stakeholders reported that the current set of specialists in Wyoming do not adequately serve the needs of a reportedly growing population of low-income people. Some community respondents expressed cautious optimism or hope that MSCs could improve access by providing a more stable source of specialty care and distributing the uninsured and other low-income people across more providers to reduce the burden on any one provider. More common is the concern that MSCs would focus on well-insured patients and not treat significant numbers of low-income ones, which could reduce the financial viability of general hospitals and hinder their ability to subsidize care for patients who do not have the ability to pay. Also, as mentioned earlier, there is concern that the MSCs would be able to lure specialist physicians away from general hospitals, removing physicians that currently have some obligation to treat low-income people, such as through serving on call in the emergency department.

For the population at large, many stakeholders are more concerned about access to primary care over specialty care. Reportedly the supply of primary care physicians (PCPs) is inadequate, related to inability to earn an adequate income, and some general hospitals are working to build their networks of PCPs by employing them. Stakeholders are concerned about the continued erosion of primary care, which presumably MSCs would not influence unless they offered a broader range of services.

Some stakeholders predict the need for additional hospital capacity given rising numbers of uninsured people and population growth in some parts of the state. Indeed, many general hospitals in Wyoming are expanding a range of services.

G. Stakeholder Policy Recommendations

In light of the range of impacts that stakeholders expect with the potential development of medical specialty centers in Wyoming, stakeholders suggested a range of policy responses to these predicted impacts or no response at all.

Overall, stakeholders uphold that Wyoming has a “frontier mentality” and support free markets and competition, yet at the same time many want to create a level playing field to protect the community hospitals from the anticipated negative effects of potential MSCs. A number of stakeholders suggested policy responses such as requiring that MSCs accept a certain number or percentage of uninsured and Medicaid patients and/or controlling self-referrals through expansion of the Stark laws. Some respondents suggested that the state should subsidize general hospital indigent care if MSCs were to develop. Stakeholders hold mixed views on whether a MSC should be required to operate an emergency department, given the resources required to serve relatively small populations.

Some stakeholders recommended considering each potential MSC on a case-by-case basis, perhaps through reintroduction of certificate-of-need (CON) legislation to ensure that there is sufficient demand for any additional hospitals in a given market. A few stakeholders contend that the changes CMS is making to Medicare diagnosis-related group (DRG) payment rates will curb incentives to develop MSCs, and they hope that increased Medicare payment rates for some primary care services will help with physician recruitment. And some stakeholders—particularly those representing physician groups—do not think state restrictions on MSC development are necessary or desirable, with some arguing that such hospitals would not be considered economically feasible in much of Wyoming and any that were developed would unlikely affect the general hospitals significantly.

Finally, a number of stakeholders urged the state to focus on tort reform to help bring down the price of medical malpractice insurance for physicians. And, a number of respondents suggested that, given Wyoming’s reported strong economic and budget situation, more resources could be devoted to controlling malpractice premiums (such as through reinsurance) and supporting the health care infrastructure to serve rising numbers of uninsured people.

Chapter 2: The Financial Performance of Hospitals in Wyoming

A. Introduction

The proliferation of medical specialty centers nationwide has drawn the attention of both federal and state governments to examine the characteristics of these facilities and their potential impact on general hospitals in areas where they are located. Before determining the likelihood of medical specialty center construction in Wyoming or its possible effect on general hospitals, it is important to gain a sense of the operational and financial status of general hospitals in the state.

This chapter provides a descriptive snapshot of the financial performance and status of Wyoming general hospitals between 2000 and 2004. Wyoming does not currently have any medical specialty centers (MSCs), but it does have for-profit general hospitals. Since nearly all MSCs are for-profit institutions, MSC exhibit more similarities with for-profit general hospitals than with not-for-profit general hospitals. Therefore, we compare for-profit hospitals to not-for-profit hospitals in Wyoming in terms of their financial status, capacity, patient volume, payer mix, and other selected characteristics.

B. Data Sources and Hospital Selection

The analyses in this chapter use data from the Wyoming Hospital Association (WHA), the annual American Hospital Association (AHA) Survey, the Health Resources and Services Administration Area Resource Files (ARF), the U.S. Census Bureau, and the Wyoming Health Care Commission. The WHA provided hospital financial data on measures of operating margin, total margin, and uncompensated care as a percent of revenue. As of 2004, 29 hospitals were reporting data to the WHA. To generate a sample of only general acute-care hospitals, we excluded three public hospitals (Veterans Administration centers and state facilities) from our analyses (GAO 2003). We also excluded one behavioral hospital. The 25 remaining Wyoming hospitals were classified as general, acute care facilities (Table II.1).

Table II.1 Total Number of Licensed Wyoming Hospitals by Year (2000-2004)

	2000	2001	2002	2003	2004
Total Hospitals	28	28	29	29	29
Public Hospitals	3	3	3	3	3
Behavioral Hospitals	1	1	1	1	1
General, Acute Hospitals	24	24	25	25	25
For-Profit Hospitals	3	3	3	3	3
Not-For-Profit Hospitals	21	21	22	22	22

Source: AHA Survey, 2000-2004; Wyoming Hospital Association data, 2000 and 2002-2004.

Note: Public Hospitals include VA Medical Centers and state hospitals.

C. Characteristics of Wyoming Hospitals

Number of Hospitals: The number of Wyoming hospitals reporting financial information in the WHA dataset increased by one facility between 2000 and 2004 (Table II.1). However since the submission of financial data to the WHA is voluntary, it is possible for an individual hospital to report missing or incomplete data for a single year. Since no new hospitals opened in Wyoming during this time, the increase in the number of hospitals may be attributable to the voluntary nature of hospital participation in the WHA survey.

For-Profit Status: Most Wyoming hospitals are not-for-profit. Of the 25 general hospitals included in this analysis, 22 are not-for-profit and three are for-profit facilities (Table II.1). The not-for-profit hospitals are operated by the county or health authority. In some cases, corporations such as Banner Health or Brim Healthcare own or manage hospitals as not-for-profit institutions. Corporations own and operate the three for-profit hospitals in the state. Most general hospitals across the nation are not-for-profit, while nearly all MSCs are for-profit.¹ Like other for-profit enterprises, for-profit hospitals have a fiduciary obligation to maximize investor returns. As corporations, they must pay federal, state, and local taxes. Results from a nationwide survey of hospitals from 1990 to 1997 indicate that the average total margin among for-profit hospitals was more than double that among nonprofit hospitals (Thorpe et al. 2000). In contrast, not-for-profit profit hospitals and other nonprofit organizations are exempt from taxes. In exchange for their tax-exempt status, not-for-profit profit hospitals must provide community benefits, usually in the form of charity care for indigent patients.

Hospital Capacity and Patient Volume: Total inpatient admissions in Wyoming hospitals did not change much between 2000 and 2004 (Table II.2). However, there is a large contrast between growth in for-profit and not-for-profit hospital volume. Although for-profit hospitals averaged fewer inpatient admissions, outpatient visits, and emergency department (ED) visits, they experienced increased growth in those categories between 2000 and 2004, while the average volume for all three service types in not-for-profit hospitals declined over the same period. In particular, for-profit hospitals experienced a 48.2 percent increase in outpatient visits, while not-for-profit hospitals experienced a decrease of 7.5 percent over the same period.

¹ A national survey of 100 specialty hospitals conducted by the Government Accountability Office (GAO) in 2003 found that more than 90 percent of specialty hospitals that opened since 1990 were for-profit. In addition, 70 percent of the more than 100 specialty hospitals in operation or under development were owned at least in part by physicians (GAO 2003).

Table II.2 Mean Number of Hospital Admissions, Outpatient Visits, and Emergency Department (ED) Visits, 2000-2004

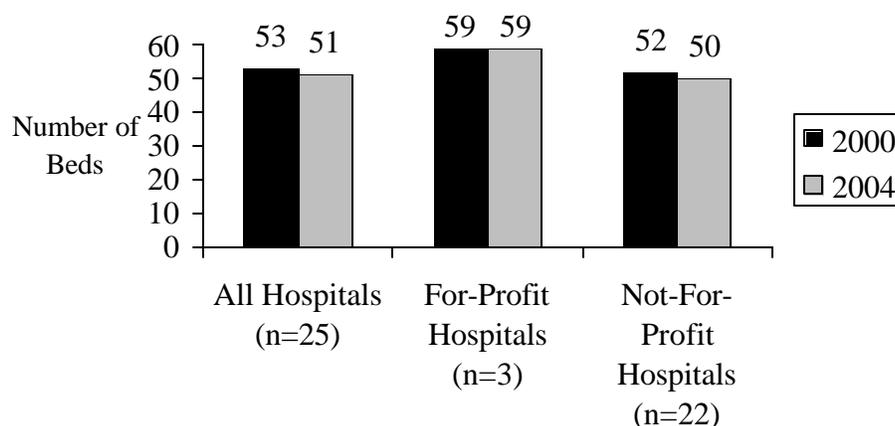
	2000	2001	2002	2003	2004	Percentage Change 2000-2004
Mean Hospital Admissions						
All Hospitals	1,956	N/A	1,939	2,073	1,971	0.8%
For-Profit Hospitals	1,642	N/A	1,614	1,733	1,766	7.5%
Not-For-Profit Hospitals	2,003	N/A	1,985	2,119	1,998	-0.2%
Mean Outpatient Visits						
All Hospitals	29,342	N/A	26,581	26,434	28,647	-2.4%
For-Profit Hospitals	20,195	N/A	25,458	22,124	29,924	48.2%
Not-For-Profit Hospitals	30,786	N/A	26,741	27,021	28,473	-7.5%
Mean ED Visits						
All Hospitals	8,213	N/A	8,555	8,606	8,659	5.0%
For-Profit Hospitals	7,950	N/A	8,464	8,588	8,485	6.7%
Not-For-Profit Hospitals	8,252	N/A	8,568	8,608	8,683	5.2%

Source: Wyoming Hospital Association data, 2000 and 2002-2004.

Note: 2001 data not available

The mean number of hospital beds per Wyoming hospital decreased between 2000 and 2004 from 53 to 51 (Figure II.1). Not-for-profit hospitals drove much of this decline in capacity by decreasing from 52 to 50 beds on average. Average for-profit hospital bed capacity was greater than not-for-profit bed capacity (59 beds) and remained constant over the period.

Figure II.1 Mean Number of Hospital Beds in Wyoming General Hospitals, 2000 and 2004



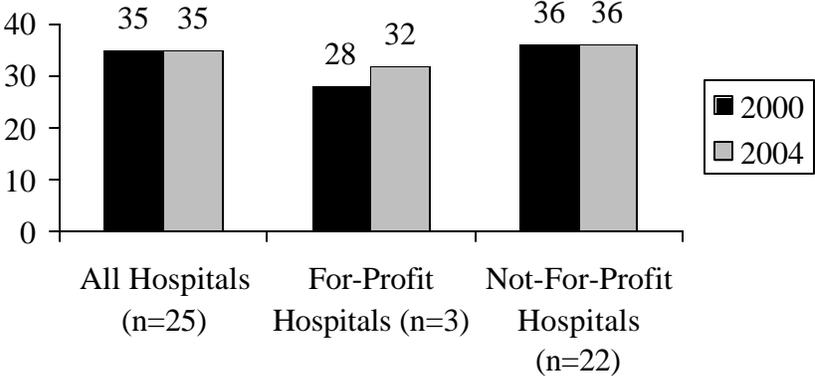
Source: Wyoming Hospital Association data, 2000 and 2002-2004.

Note: 2001 data not available.

The average number of admissions per bed remained the same among the not-for-profit hospitals and increased among for-profit hospitals from 2000 to 2004 (Figure II.2). Not-for-

profit hospitals used beds more intensively, admitting more patients per bed than for-profit hospitals during each year of the analysis. In 2004, not-for-profit hospitals admitted 36 patients per bed on average, while for-profit hospitals admitted an average of 32 patients per bed.

Figure II.2 Mean Admissions Per Bed in Wyoming General Hospitals, 2000 and 2004



Source: Wyoming Hospital Association data, 2000 and 2002-2004.
 Note: 2001 data not available

Operating Room Capacity and Volume: Wyoming hospitals had a low operating room capacity in 2004, with a mean number of 2.7 operating rooms per hospital. For-profit hospitals had a slightly higher average number of operating rooms at 3.0 compared with an average of 2.7 operating rooms among not-for-profit hospitals.

The average number of total surgeries performed at Wyoming hospitals increased by 5 percent between 2000 and 2004 (Table II.3). For-profit hospitals drove much of this increase with a 30 percent rise in total surgeries compared with an average increase of only 1.6 percent among not-for-profit hospitals. The most striking difference in surgical volume between the two hospital ownership types was for outpatient surgeries over the period. The average number of outpatient surgeries in for-profit hospitals increased 35.3 percent, from 1,197 in 2000 to 1,619 in 2004. The average number of outpatient surgeries at not-for-profit hospitals decreased 5 percent, from 1,126 in 2000 to 1,070 in 2004. There was a difference in inpatient surgery growth as well, with an average 15 percent growth for for-profit hospitals compared with an average 1.2 percent growth for not-for-profit hospitals.

Table II.3 Mean Number of Total, Outpatient, and Inpatient Surgeries in Wyoming General Hospitals, 2000-2004

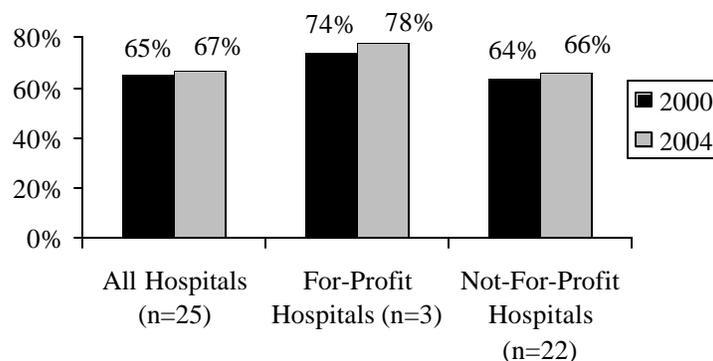
	2000	2001	2002	2003	2004	Percentage Change 2000-2004
Mean Total Surgeries						
All Hospitals	1,782	N/A	1,848	1,833	1,871	5.0%
For-Profit Hospitals	1,609	N/A	1,694	1,907	2,093	30.0%
Not-For-Profit Hospitals	1,809	N/A	1,873	1,821	1,838	1.6%
Mean Outpatient Surgeries						
All Hospitals	1,135	N/A	1,145	1,159	1,136	0.1%
For-Profit Hospitals	1,197	N/A	1,272	1,431	1,619	35.3%
Not-For-Profit Hospitals	1,126	N/A	1,127	1,122	1,070	-5.0%
Mean Inpatient Surgeries						
All Hospitals	569	N/A	549	527	585	2.8%
For-Profit Hospitals	412	N/A	422	476	474	15.0%
Not-For-Profit Hospitals	593	N/A	567	534	600	1.2%

Source: Wyoming Hospital Association data, 2000 and 2002-2004.

Note: 2001 data not available

For all Wyoming general hospitals, outpatient surgeries as a percent of total surgeries increased slightly between 2000 and 2004 (Figure II.3). For-profit hospitals performed more outpatient surgeries on average than not-for-profit hospitals, and they performed them at a higher percentage of their total surgeries. Of total surgeries performed at for-profit hospitals, 78 percent were outpatient surgeries in 2004. At not-for-profit hospitals, the proportion of outpatient surgeries as a percent of total surgeries was 66 percent.

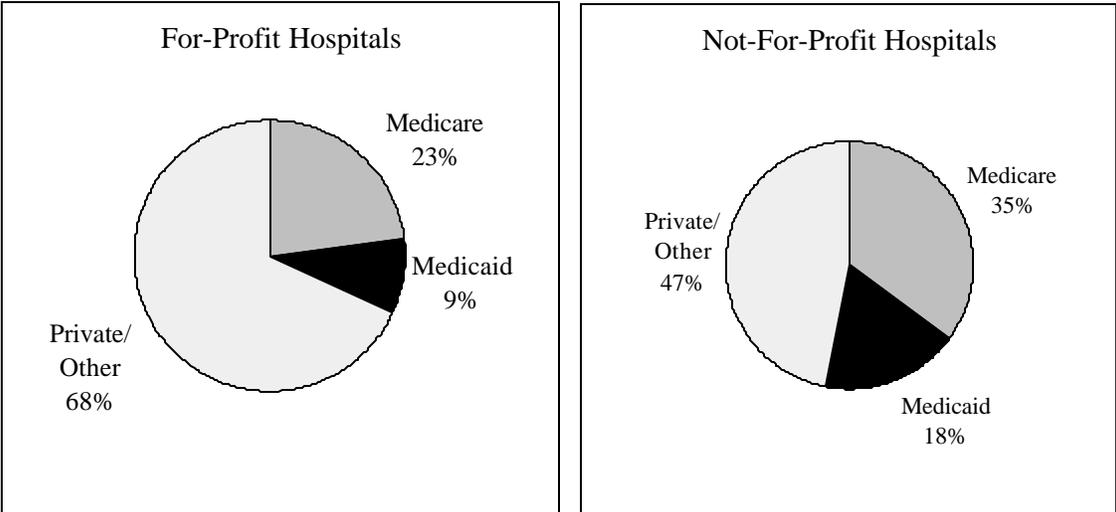
Figure II.3 Mean Outpatient Surgeries as a Percent of Mean Total Surgeries in Wyoming General Hospitals, 2000 and 2004



Source: Wyoming Hospital Association data, 2000 and 2004.

Payer Mix: About half (51 percent) of all patient revenue for Wyoming hospitals came from public payers in 2004—either Medicare or Medicaid (Figure II.4). There was a large difference, however, between for-profit and not-for-profit hospitals in terms of payer mix. In 2004, not-for-profit hospitals reported a much higher percentage of revenue from publicly insured patients than for-profit hospitals. Not-for-profit hospitals reported receiving double the revenue from Medicaid, which tends to have a lower reimbursement level than private payers. Although we could not distinguish privately insured patient revenue from other non-public sources, only 47 percent of the not-for-profit hospitals’ revenue came from private or other payers, while 68 percent of revenue for-profit hospitals came from those sources.

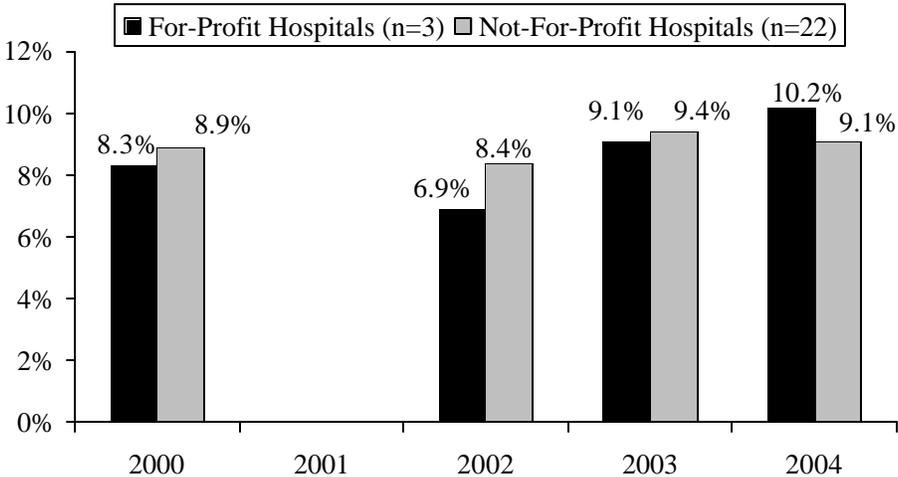
Figure II.4 Average Payer Mix in Wyoming General Hospitals as a Percent of Total Patient Revenue, 2004



Source: Wyoming Hospital Association data, 2004.

Overall, Wyoming hospitals’ uncompensated care, including charity care and bad debt, equaled approximately 9 percent of patient revenue in 2004 (Figure II.5). There was very little difference between for-profit and not-for-profit hospitals in terms of the revenue percent of uncompensated care provided. In 2000, for-profit hospitals provided a slightly lower average percentage of uncompensated care (8.3 percent) than not-for-profit hospitals (8.9 percent), but by 2004, for-profit hospitals provided slightly more uncompensated care as a percent of revenue than not-for-profit hospitals (10.2 percent vs. 9.1 percent, respectively).

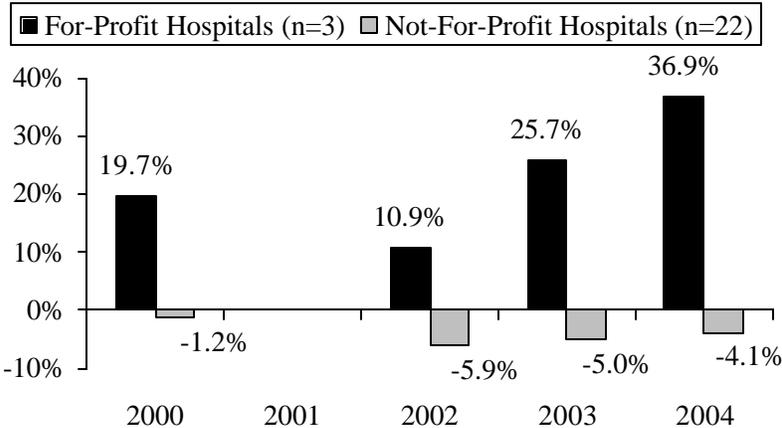
Figure II.5 Mean Uncompensated Care as a Percent of Patient Revenue in Wyoming General Hospitals, by For-Profit and Not-For-Profit Status, 2000-2004



Source: Wyoming Hospital Association data, 2000 and 2002-2004.
 Note: 2001 data not available

Operating and Total Margins: There is a large and persistent discrepancy between the operating margins of for-profit and not-for-profit hospitals (Figure II.6). During the 2000-2004 period, for-profit hospitals reported an average positive operating margin ranging from 11 percent to 37 percent. With the exception of 2002, this average increased each year. In contrast, average operating margins for not-for-profit hospitals were negative, ranging from -1 percent to -6 percent. This means that on average, Wyoming not-for-profit hospitals were operating in the red from 2000 to 2004. In addition, the average operating margin for these hospitals in 2004 was lower than in 2000, indicating that the financial status of not-for-profit hospitals worsened over this period.

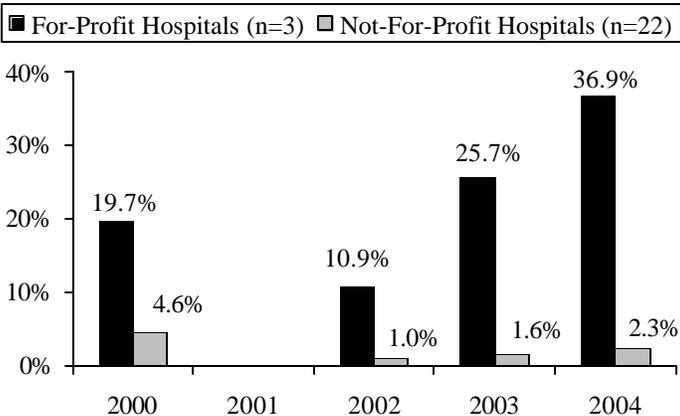
Figure II.6 Mean Operating Margin as a Percent of Patient Revenue for Wyoming General Hospitals, by For-Profit and Not-For-Profit Status, 2000-2004



Source: Wyoming Hospital Association data, 2000 and 2002-2004.
 Note: 2001 data not available

An examination of hospitals’ total margins reveals a similar pattern (Figure II.7). Total margins include non-operating revenues and expenditures, such as capital gains and investments, as well as operating revenues and costs. For-profit hospitals reported their range of average total margins between 2000 and 2004 were the same as their average operating margins. Overall, total margins for not-for-profit hospitals were positive but still significantly lower than for-profit hospitals, ranging from 1 percent to 5 percent. Additionally, average total margins in 2004 (2.3 percent) for not-for-profit hospitals were lower than their average total margins in 2000 (4.6 percent), providing added evidence of the declining financial position of Wyoming not-for-profit hospitals.

Figure II.7 Mean Total Margin as a Percent of Patient Revenue for Wyoming General Hospitals, by For-Profit and Not-For-Profit Status, 2000-2004



Source: Wyoming Hospital Association data, 2000 and 2002-2004.
 Note: 2001 data not available

D. Summary

From 2000 to 2004, there was no change in Wyoming’s hospital market in terms of entry and exit of hospitals. In terms of utilization and financial status, however, the data reveal strongly divergent results for for-profit vs. not-for-profit hospitals during the period. Although only based on three for-profit hospitals, the most dramatic difference is that during the four years, for-profit hospitals experienced an average 48.2 percent increase in outpatient visits and an average 35.3 percent increase in outpatient surgeries. Meanwhile, not-for-profit hospitals experienced a decline in both outpatient visits and outpatient surgeries over the same period.

Although there was not a large difference between for-profit and not-for-profit hospitals with respect to bed capacity, the two types of hospitals appear to be using beds differently: for a given year, the number of inpatient admissions per bed was higher in not-for-profit hospitals than in for-profit hospitals. However, the average admissions per bed in for-profit hospitals showed an increase from 28 to 32 patients per bed over this period. These data point to a general trend of for-profit hospitals increasing mostly outpatient services, particularly the number of outpatient surgeries performed. For-profit hospitals also had a much higher share of private payer patients in 2004. In contrast, not-for-profit hospitals experienced a decline in the average number of

outpatient surgeries (-5 percent) and visits (-8 percent) over this period. Not-for-profit general hospitals also had a greater proportion of Medicare and Medicaid patients than for-profit hospitals.

These differences are reflected in the financial health of these hospitals. For-profit hospitals operated in sound financial health and improved their financial position between 2000 and 2004, while not-for-profit hospitals experienced negative operating margins that generally declined from 2000 to 2004.

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Chapter 3: Characteristics of Market Areas with Medical Specialty Centers

A. Introduction

As of 2004, Wyoming had 29 hospitals, of which 25 were general acute-care facilities designated as Medicare sole community hospitals.² However, Wyoming does not have any medical specialty centers (MSCs) operating in the state.³ Therefore, this analysis of the potential effect of MSCs on general hospitals in Wyoming addresses the following questions:

- What factors raise the likelihood that an MSC will emerge in a market area?
- If an MSC were to start operating in Wyoming, what would be the potential impact on general hospitals in the same market area?

This chapter examines the location decisions of MSCs in states outside Wyoming to understand what market-level characteristics are associated with their entry. We first compare key market characteristics of areas with MSCs and areas without MSCs. We then present a statistical analysis of the likelihood of an MSC locating in a market area given these characteristics. Finally, we summarize our key findings on the impact of medical specialty centers on the financial performance of general hospitals in Texas, and draw implications for the state of Wyoming.

B. Data Sources and Selection of Comparison States

The analyses in this chapter use data from the Wyoming Hospital Association (WHA), the Health Resources and Services Administration Area Resource File (ARF), and demographic data from the U.S. Census Bureau. Since Wyoming does not have any MSCs operating yet, our comparative analysis is based on MSCs that operate in the following states: Texas, South Dakota, Idaho, Montana, Nebraska, Utah, and Colorado. These states were selected based on the prevalence of MSCs in the state or on the state's socio-demographic similarity to Wyoming. For example, the total population level, population growth rate, and percent of population that is white in each of the six adjoining comparison states are closer in magnitude to Wyoming than to Texas. We include Texas in the set of comparison states to draw implications for Wyoming based on our empirical findings in that state (Chollet et al, 2006). To identify market areas with an MSC, we used the Centers for Medicare and Medicaid Services (CMS) list provided in its August 2006 report (CMS 2006). In this report, the definition of an MSC is equivalent to the definition of a niche or specialty hospital and does not include other types of facilities, such as ambulatory surgery centers.

² A Medicare sole community hospital is a facility that is the only source of inpatient care in a community, either because of geographic isolation or because severe weather conditions or local topography limits travel to another hospital. Sole community hospitals are eligible for higher payments based on historical, hospital-specific costs rather than average costs across multiple facilities (CMS, 2006).

³ A recent article noted that Chicago-based National Surgical Hospitals Inc. would open a new for-profit specialty hospital by mid-2008 in Natrona County, Wyoming, where a not-for-profit hospital, Wyoming Medical Center, currently operates. The new hospital will initially have between 24 and 28 beds and is expected to eventually grow to 37 beds (Casper Star-Tribune, October 20, 2006; November 2, 2006).

We defined markets based on hospital service areas (HSAs) within each state. An HSA is a standard geographic measure based on the travel distances of Medicare patients seeking hospital care (Makuc et al. 1991). HSAs represent a cluster of contiguous counties within a single state or across two neighboring states.⁴ We also examined alternative measures of hospital market areas in Texas (such as the county in which the hospital is located or trauma service areas) to test the sensitivity of our results to how we defined hospital markets. Neither the county unit nor the trauma service area performed as meaningful market areas in the analysis for Texas.

C. Location of Medical Specialty Centers

MSCs are more likely to locate in states where hospitals are allowed to add beds or build new facilities without obtaining regulatory approval and in market areas where the population is growing relatively quickly (GAO 2003). The increase in demand for care that accompanies population growth and an aging population tends to support hospital capacity growth for both MSCs and general acute-care facilities (Chollet et al, 2006). In addition, MSCs tend to locate in areas where well-established communities of physicians, including surgical specialists, are already present.⁵ Urban market areas with high population density tend to support growing communities of physicians, which in turn, provide favorable conditions for the emergence of an MSC. New physicians are likely to establish a new practice in an area that already has an existing group of physicians.⁶

The location of medical specialty centers in Texas is consistent with earlier studies that show these facilities are more likely to operate in market areas with high population density (Table III.1). In 2004, Texas had 61 HSAs with 13 HSAs having at least one MSC present. These 13 HSAs with MSCs are primarily in densely populated markets with 12 having more than 250,000 residents. Only one HSA with an MSC had between 100,000 and 249,000 residents. In contrast, 26 of the 48 HSAs without an MSC were areas of less than 100,000 people.

Among the six comparison states that share a border with Wyoming, 16 HSAs have at least one MSC in operation (Table III.1). Like Texas, most MSCs in these states are located in more densely populated areas with at least 100,000 residents, although five of the 20 MSCs operate in moderately populated HSAs with 50,000 to 100,000 residents.

⁴ Three medical specialty centers were located in HSAs that spanned contiguous counties across two neighboring states and were coded accordingly.

⁵ There are several reasons why physicians might support development of an MSC: (1) the margin for the procedures delivered by the MSC is expected to be relatively high, (2) physicians have more autonomy in how they practice in such hospitals, and (3) physicians can often increase their income through hospital ownership (Casalino et al. 2003).

⁶ Past surveys of newly trained physicians found that contact with other physicians, availability of medical facilities, and professional growth opportunities are key factors in where a physician decides to locate (Leonardson et al, 1985; Rosenthal et al, 1992).

Table III.1: Count of Health Service Areas (HSAs) With and Without MSCs, by 2004 Population Level

HSA Population Level	Texas HSAs with MSCs	Texas HSAs without MSCs	Other States* HSAs with MSCs	Wyoming All HSAs
500,000 or more	6	2	3	N/A
250,000 to 499,999	6	4	1	N/A
100,000 to 249,999	1	16	7	N/A
50,000 to 99,999	0	7	5	2
Less than 50,000	0	19	0	11
Total HSAs	13	48	16	13

Source: U.S. Census data estimates, (Makuc et al., 1991)

N/A indicates that the state did not have any HSAs in that population category.

* Other neighboring states with MSCs are Colorado, Idaho, Montana, Nebraska, South Dakota, and Utah.

Wyoming currently has 13 HSAs across the state, with no market areas greater than 100,000 residents. Two HSAs have a population level of 50,000 to 99,999 residents. However, the remaining 11 HSAs in Wyoming are located in more sparsely populated areas with fewer than 50,000 people. Based on the experience of the other comparison states, if a new MSC were to emerge in Wyoming, it would most likely choose to locate in one of the two HSAs with more than 50,000 residents.

Table III.2: Count of Medical Specialty Centers and General Hospitals, by HSA Population Level in 2004

HSA Population Level	Texas MSCs	Texas General Hospitals	Other States* MSCs	Wyoming All Hospitals
500,000 or more	15	142	3	N/A
250,000 to 499,999	5	67	2	N/A
100,000 to 249,999	1	104	10	N/A
50,000 to 99,999	0	15	5	3
Less than 50,000	0	35	0	22
Total HSAs	21	363	20	25

Source: U.S. Census data estimates, (Makuc et al., 1991)

N/A indicates that the state did not have any HSAs in that population category.

* Other neighboring states with MSCs are Colorado, Idaho, Montana, Nebraska, South Dakota, and Utah.

D. Key Characteristics of Market Areas with MSCs

An analysis of market areas in Wyoming and the comparison states reveals other important differences in market characteristics outside of population density that appear to be associated with MSC presence. The population growth rate is also higher in HSAs where MSCs are present (Table III.3). MSC HSAs in Texas experienced a 1.5 percent rate of population growth annually, while areas without MSCs had a growth rate of 0.8 percent. Similarly, comparison state HSAs with MSCs had a 1.2 percent rate of growth.

The demographic characteristics of Wyoming are notably different from Texas with respect to race and education, but are similar to the six comparison states bordering Wyoming. In Texas, the proportion of the total population that is self-identified as non-white is 43.4 percent and 40.8 percent in HSAs with and without MSCs, respectively. However, in Wyoming this proportion is lower with 10 percent of the population identifying as non-white. In the six comparison states bordering Wyoming, this figure is 12 percent. The percent of the population completing high school is higher in Wyoming (87 percent) and the comparison states (86 percent) than in Texas (44 percent) across both types of HSAs.

Table III.3: Mean Characteristics of Market Areas with MSCs in 2004

	Texas HSAs with MSCs (n=13)	Texas HSAs without MSCs (n=48)	Other States* with MSCs (n=16)	Wyoming HSAs without MSCs (n=13)
Demographic Characteristics				
Total Population	1,270,626	124,414	247,528	38,914
Percent Change in Population	1.5	0.8	1.2	0.7
Percent White	56.7	59.3	88.0	90.1
Percent Non-White	43.4	40.8	12.0	9.9
Percent Female	50.2	49.6	50.1	49.6
Percent 65 Years or Older	10.7	14.5	12.2	12.8
Percent with High School Completion	43.8	43.7	86.4	87.2
Local Market Characteristics				
Total Physicians per 1,000 people	1.97	1.14	2.15	1.53
Primary Care Physicians per 1,000 people	0.30	0.28	0.43	0.44
Surgical Specialists per 1,000 people	0.44	0.25	0.50	0.37
Per Capita Income per HSA	\$17,680	\$15,312	\$18,354	\$33,178
Number of Hospitals per HSA	16.5	3.5	7.6	1.9
For-Profit Hospitals per HSA	7.2	0.7	0.4	0.2
Ambulatory Surgery Centers per HSA	16.5	1.3	5.8	1.2

Source: U.S. Bureau of the Census, HRSA Area Resource Files

Note: The number of hospitals includes all hospitals (e.g. general, public, psychiatric, rehabilitation, etc.).

* Other neighboring states with MSCs are Colorado, Idaho, Montana, Nebraska, South Dakota, and Utah.

The supply of physicians tends to be higher in market areas where MSCs are present (Table III.3). Texas HSAs with MSCs have approximately 1.97 physicians per 1,000 residents. In the comparison state HSAs with MSCs, this figure is even higher with 2.15 physicians per 1,000 residents. However, Wyoming and Texas HSAs where MSCs are absent have lower numbers. Similarly, the proportion of surgical specialists is higher in HSAs with MSCs in Texas and in the comparison states compared with Wyoming. However, we do not see a clear relationship between HSAs with and without MSCs with respect to primary care physicians per 1,000 residents.

MSCs also tend to locate in areas with a larger number of hospitals and ambulatory surgery centers. In Texas, on average, HSAs with MSCs had 16.5 hospitals compared with 3.5 hospitals in HSAs without MSCs. While comparison state HSAs averaged 7.6 hospitals in their market areas, Wyoming had an average of 1.9 hospitals in its HSAs. The same comparisons hold for the location of ambulatory surgery centers, suggesting that growing market demand may support larger numbers of both facility types.

E. Likelihood of a Medical Specialty Center Emerging in a Market Area

We conducted an analysis of the likelihood of a MSC emerging in a given HSA as a function of that area's demographic and other local market characteristics.⁷ The unit of observation for the estimation sample was a Texas HSA for each of the years between 2000 and 2004. This resulted in an estimation sample of 61 HSAs over five years for 305 observations. In addition, a series of time dummy variables was included to account for other environmental factors such as potential changes in regulations that would affect all hospitals within a state. Control variables in the analysis included age, race, gender, and education measures (Appendix A).

Our primary finding is that total population size is a strong predictor of the likelihood of establishment of an MSC. Specifically, for a market area with average demographic characteristics, the predicted probability of an MSC being established rises by 0.1 percentage points with an increase in population from 25,000 people to 50,000 people (Appendix B). However, the predicted probability rises by 0.3 percentage points with an increase from 25,000 people to 100,000 people, and 0.4 percentage points with an increase from 25,000 people to 250,000 residents.

An increase in the number of for-profit hospitals is also a strong predictor of the likelihood of an MSC emerging. For a market area with average demographic characteristics, an increase from three to four for-profit hospitals in that market area raises the predicted probability of an MSC being present by five percentage points (Appendix B). Moving from three to five for-profit hospitals increases the difference in predicted probability by eight percentage points.

Other things being equal, controlling for age, race and education levels, market areas with higher per capita income, were also more likely to attract an MSC hospital (Appendix A). HSAs with higher proportions of non-white populations and people who completed high school were less likely to have an MSC. This counterintuitive finding may be attributed to unobservable market factors that are correlated with race and education in urban market areas, where an MSC is likely to be present.

⁷ We used a logistic regression to estimate the likelihood of an MSC hospital emerging in a given market area. Coefficient estimates with a two-tailed p-value of less than 5 percent – indicating at least a 95 percent chance that the relationship was non-zero – were accepted as statistically significant, and are reported as odds ratios in Appendix A.

F. Financial Impact of Medical Specialty Centers on General Hospitals

Whether MSCs draw revenue away from general hospitals and weaken their financial position is an important question for general hospitals, as well as the communities they serve. However, much of the research in this area is largely anecdotal with mixed empirical results that show either no evidence of an adverse impact or a small negative effect based on a limited number of case studies.

Empirical studies conducted using national data, as well as data from a single state, have shown that MSCs did not have an adverse effect on the financial performance of general hospitals. A recent Medicare Payment Advisory Commission (MedPAC) report (2006) found no evidence that MSCs undercut the ability of general hospitals to provide essential services. Similarly, Schoemaker and Schulman (2005) found neither a consistent relationship between a hospital's overall profitability and its degree of specialization nor any relationship between the profitability of specialty care and the hospital's location, case-mix index, or degree of specialization.⁸

A more recent analysis of MSCs in Texas (Chollet et al., 2006) also found no direct evidence that the presence of MSCs affected the financial performance of general hospitals in the same market area. It is possible that no effect would be discernible if, as suggested in other studies, general hospitals adjusted their business practices during the course of a reporting year to offset anticipated declines in profit margins.⁹ The authors were also unable to find any impact on the general hospitals' levels of uncompensated care associated with the presence of a MSC.

Instead, the most important predictor of the financial performance of a general hospital was its status as a for-profit or not-for-profit facility. For-profit general hospitals had systematically higher operating margins than not-for-profit general hospitals and slightly lower amounts of uncompensated care. Based on the descriptive analysis that appears earlier in this report, this recent empirical finding from Texas is consistent with the 2000-2004 financial performance of for-profit vs. not-for-profit general hospitals in Wyoming.

However, two studies concluded that MSCs did have an adverse effect on general hospitals in their communities. In 2005, the American Hospital Association sponsored a series of case studies in four communities: Rapid City, South Dakota; Lincoln, Nebraska; Wichita, Kansas; and Oklahoma City, Oklahoma (Moore and Coddington 2005). In all four communities, the earnings of general hospitals declined after MSCs were opened. Furthermore, the general hospitals in these communities reported that they had reduced or eliminated programs that required cross-subsidization, including, in two hospitals, emergency and trauma care.

Also, researchers at the National Bureau of Economic Research estimated an ordinary least squares regression model using Medicare Provider and Analysis Review (MedPAR) data

⁸ They found a positive relationship between bed size and profitability, and attributed it primarily to economies of scale available in larger facilities.

⁹ For example, surveys of hospital executives and physicians have found that the development of ambulatory surgery centers and specialty/niche hospitals had not (to date) affected general hospital margins, because general hospitals had managed to raise prices for profitable service lines in order to recoup revenue losses from "out-migrated" services (MedPAC 2006).

from 1993, 1996, and 1999 to calculate the level of expenditures for patients admitted to an MSC vs. a general hospital (Barro et al. 2005). They found that hospital expenditures among patients in a hospital referral region (HRR) with a cardiac MSC grew significantly less from 1996 to 1999 than did expenditures among patients in an HRR with no MSC hospital.¹⁰

G. Summary and Implications For Wyoming

Based on our analysis of trends from 2000 to 2004, medical specialty centers are more likely to locate in market areas with higher population levels. In Texas, of the 13 market areas with an MSC, all had population levels of at least 100,000. In the six comparison states that share a common border with Wyoming, all the market areas with MSCs had a population of at least 50,000 and 11 of the 16 HSAs with an MSC had 100,000 residents or more. Since no Wyoming HSA had more than 100,000 people in 2004, it seems unlikely that an MSC would emerge in every region of Wyoming. However, an MSC might emerge in the two market areas with a population of at least 50,000. This finding is consistent with the recent announcement of a new MSC breaking ground in one of these two market areas.

The population and market characteristics of Wyoming are, on average, more similar to the surrounding states of Colorado, Idaho, Montana, Nebraska, South Dakota, and Utah than to Texas. For example, the mean population of HSAs in Texas with MSCs is well over 1 million people, while the mean population of HSAs in the six comparison states is around 250,000 residents. Wyoming, on average, has almost 40,000 people per HSA.

Based on our findings, the strongest predictors of the likelihood that an MSC would emerge in a market area are population level and the number of for-profit hospitals. MSCs tend to emerge in areas with greater populations because these market areas may be more favorable to the entry of MSCs since the patient base and demand for hospital services is likely to be greater. These market areas are more likely to support the emergence of new entrants such as MSCs, despite potential competition with existing general hospitals. Since the overall size of the market population is also growing, the entry of a new MSC may not necessarily have an adverse impact on general hospitals by competing for the same patients. Also, high population areas are more likely to have a robust community of physicians, including surgical specialists who provide services in the MSCs.

The number of for-profit hospitals in a market area is also a strong predictor of whether or not an MSC opens. In Wyoming, the for-profit hospitals operate in smaller HSA market areas where it is unlikely an MSC would open because of the small population base. This is consistent with our findings in the Texas report. Although the number of ambulatory surgery centers was not a significant predictor of whether MSCs locate or not in an area, these centers may be correlated with MSCs to the extent that both types of facilities emerge in high population markets with rapid population growth.

¹⁰ Hospital referral regions consist of a number of HSAs that are aggregated into one category (Makuc et al 1991).

H. Limitations of the Analysis

The design of this study reflects the constraints of data availability. Because no MSCs are currently operating in Wyoming, it was necessary to analyze the likelihood of an MSC emerging by using data from a set of comparison states. The estimation model relied primarily on observations of relevant market areas in Texas since the availability of financial performance data in other comparison states was limited. The financial data provided by the Wyoming Hospital Association did not include the year 2001, which constrained our ability to observe a continuous trend over this period.

A more complete analysis of medical specialty hospitals would examine the financial impact of MSCs on all general hospitals in the six comparison states of Colorado, Idaho, Montana, Nebraska, South Dakota, and Utah. However, a comprehensive analysis of this scale would require access to financial data that is not available in the AHA survey dataset.

In addition, the MSC likelihood model is based on a set of market characteristics that may have omitted variables of interest such as socio-economic factors and physician-ownership of hospitals. We do control for regulatory constraints on the establishment of medical specialty centers through our time dummy variables. However, control variables for race and education may be picking up unobservable socio-economic factors, such as the level of private insurance, within market areas that influence the likelihood of an MSC emerging.

Chapter 4: Potential Policy Approaches for Wyoming

A. Introduction

While it is unlikely that many medical specialty centers (MSCs) would locate and survive in Wyoming, their presence could offer both potential benefits and problems. MSC proponents would contend that their presence would benefit consumers by providing alternative treatment facilities and improved quality of care. However, MSCs also might “skim” the profitable business of existing hospitals, undermining their ability to provide essential but less profitable services in their communities.

To address the possibility of negative community outcomes, state regulators around the country have addressed the emergence of MSCs in a variety of ways, ranging from “watchful waiting” to a temporary moratorium new specialty facilities. Between these two extremes are increased monitoring of effects on general hospitals and the community, improving the transparency of hospital ownership, and re-introducing or strengthening certificate-of-need (CON) laws.

Each of these policy approaches is discussed below in the context of Wyoming’s hospital and health care environment.

B. Watchful Waiting

One policy option is to do nothing, recognizing that few MSCs are likely to emerge in Wyoming and that the evidence of adverse impacts is inconclusive. However, if adverse effects are detected and remedies considered, established centers could argue to be “grandfathered” and excluded from any new oversight. In light of the fact that at least one MSC currently plans to enter the Casper market and Wyoming’s current low level of monitoring capacity, the State may wish to consider alternative options.

C. Improving Community and Faculty Monitoring

States often use hospital financial and utilization data to support policymaking, state health planning, and other activities. Such data could be used to monitor the impact of new MSCs at the community and facility level. Specifically, Wyoming could compare levels of uncompensated care, emergency department use, and the demand for specialty services, such as cardiac or orthopedic care, before and after the emergence of an MSC in a community. Sometimes the mere act of measuring something can induce desirable market behaviors.¹¹ We are unaware of any states that currently use hospital discharge data in this precise way, but some

¹¹ The Pennsylvania Health care Cost Containment Council believes that annual hospital performance reporting contributed to a dramatic drop in inpatient mortality over a 10-year period (NAHDO, 2004). The well-documented phenomenon whereby human behavior changes in response to being measured or studied (as opposed to in response to an intervention) is sometimes referred to as the Hawthorne effect.

engage in closely related efforts, such as assessing the community impacts of hospital conversions to for-profit status, hospital closures or mergers.

Wyoming currently collects and uses little information about hospital utilization or finances. In Wyoming, hospitals submit inpatient discharge data voluntarily. As is common in voluntary data collection systems, the Wyoming Hospital Association (not the state) collects the data, and the data quality is problematic. Quality controls are minimal, the data that are submitted are often incomplete, and the scope of the information collected is relatively narrow.¹² While the Wyoming Hospital Association reports quarterly on these data to the Wyoming Department of Public Health, the data are not typically used to support health planning or other purposes. We are unaware of any data collection efforts that address outpatient procedures, emergency department visits, or ambulatory surgery procedures at the hospital or community level.

In addition to the voluntary submission of inpatient discharge data, Wyoming hospitals provide information to the Wyoming Hospital Association as part of the annual survey fielded by the American Hospital Association (AHA). These data provide a valuable overview of hospital facilities and utilization at the facility level but not for units of the facility (for example, inpatient costs and revenues separate from outpatient costs and revenues). MSCs may or may not contribute data to this survey, depending on their affiliation with the state and national hospital associations.

While almost all states collect inpatient discharge data,¹³ they vary widely in the other hospital data they collect:

- Thirty-two states collect ambulatory surgery data from hospitals (and in some states, freestanding ambulatory surgical centers (ASCs) as well);
- Twenty-six states collect data on hospital emergency departments (EDs) (10 states currently collect data on ED ambulance diversions); and
- Kansas, Maine, Maryland and Pennsylvania collect outpatient claims data (NAHDO 2005).

We are unaware of any states that use these data specifically to monitor the impacts of new MSCs, and in many of the states with significant MSC penetration, data collection and analysis are minimal.

¹² A trauma care report prepared for the WHCC in 2004 that attempted to use these data noted that “three hospitals that do not participate in the data submission program or were not submitting data at that time. In addition, three other hospitals submitted partial datasets...” (NCI, 2004). The study authors requested supplementary data from the hospitals regarding inpatient charges and payments, outpatient services and readmissions. Compliance was as follows: “(t)wenty hospitals responded to our request for inpatient hospital data, 16 hospitals responded to our request for outpatient data and 10 submitted readmissions data.” Furthermore, a portion of the data received was unusable due to diagnosis coding errors and other problems.

¹³ Derived from the national Uniform Bill (UB) 92, inpatient discharge data typically include demographic, clinical and financial information for all patients admitted to acute care hospitals. Ambulatory surgery and emergency departments use the UB 92 form as well, although these data are collected by relatively few states. A new form, UB 04, will be used beginning in March 2007.

Considering the inconclusive research evidence on MSCs' community and facility impacts and also the potential value of hospital and emergency department utilization data to the state for many purposes,¹⁴ Wyoming might consider assembling data to support analysis of trends in the state—including the potential impacts of MSCs, should they develop. Such a data collection and analysis system would represent a new investment for the state.

To be meaningful, data submission must be mandatory and include utilization and financial information on outpatient procedures, emergency department visits, and ambulatory surgery procedures, as well as inpatient admissions. All facilities—specialty hospitals, ambulatory surgical centers, and general hospitals—ought to report comparable data for the services they provide,¹⁵ and data quality controls instituted. Facility specific reports could be prepared periodically for the hospitals and the public; making the data publicly available would encourage further analysis to support community health assessment, facilities and emergency planning, and other purposes.

If instituted, monitoring efforts such as these could be coordinated with other related efforts already in place.¹⁶ For example, as a condition of licensure, hospitals must submit information about the traumatic injuries they treat to the state's trauma registry; these data are used to help allocate and manage trauma resources in the state. In addition, Wyoming has undertaken a temporary effort to obtain data voluntarily from hospitals on adverse outcomes. While such data are extremely useful to policymakers, minimizing hospitals' burden of complying with requirements for data submission is essential.

D. Hospital Licensure

For the purpose of licensure, Wyoming uses a broad definition of a hospital that classifies MSCs as general hospitals (Appendix C).¹⁷

Some states have adopted a separate class of hospital licensure for MSCs. For example, Texas has proposed creating a sub-class for hospitals that do not operate an emergency department to allow the state to monitor the development and operation of these facilities. Such an approach may work well for states with the potential for excess emergency department

¹⁴ States use these datasets for a wide variety of purposes beyond community assessments and state health planning, including public safety, disease surveillance, public reporting for informed purchasing and consumer education, quality assessment and performance improvement, and policy development (Schoenman et al 2005).

¹⁵ Since medical specialty centers are considered "hospitals" in Wyoming, they would be subject to such hospital data collection requirements. However, ambulatory surgery centers currently do not submit data, even voluntarily.

¹⁶ Wyoming is also developing a data system called the Wyoming Health Information Network. This system integrates claims data from various public programs (worker's compensation, unemployment Why unemployment—there are no medical benefits, Medicaid) and will be used to better coordinate services for residents using these programs. As such, it will not support the community level analysis being discussed here.

¹⁷ To be licensed as a hospital in Wyoming, the facility must participate in the state's trauma care system and maintain a full-service emergency department. The level of participation in the trauma system is voluntary. Many hospitals participate as Level IV centers, which provide only initial care and arrange for patient transfer. Hospital participation in Wyoming's trauma care system is legislatively mandated; it is the only one in the United States where all hospitals must participate.

capacity. South Dakota has a single separate hospital license category for all hospitals that do not meet the legislative definition of a general hospital in the state and provide a limited scope of services.¹⁸ This approach may lack the precision needed to accomplish state facility planning goals. Wyoming’s comprehensive approach to trauma care management could inform the state regarding options for full-service EDs in new MSCs.

E. Ownership Disclosure

As reported in Chapter 1, stakeholders in Wyoming recommended that physicians be required to disclose ownership position to patients when they refer the patient to an MSC. CMS also has recommended disclosure (CMS 2006).

At present, 16 states require physicians to disclose an investment interest in a hospital to patients. However, two states (Florida and South Carolina) have a “whole hospital” exception, which allows physicians to refer patients to a hospital where the physician has an ownership interest without disclosure, if the physician personally provides the care or the hospital is located in a rural area. Such an exception in effect makes the Florida and South Carolina disclosure laws ineffective with respect to MSCs. Of the remaining 14 states, all but one (Pennsylvania) relies on professional discipline to enforce the disclosure requirement. An example of Pennsylvania’s legislative language is included as Appendix D.

In addition, some states require that hospitals report ownership information when applying for licensure. Similarly, CMS will require specialty hospitals to disclose their investment relationships with physicians on the new Medicare enrollment forms (CMS 2006). While Wyoming currently has neither type of disclosure, instituting such a requirement would be consistent with CMS policy regarding transparency and disclosure. Wyoming may want to consider both types of disclosure at the same time and with respect to all health care facilities, not just MSCs.

F. Self-referral

Some stakeholders recommended prohibiting or limiting physician self-referral to MSCs when the physician has an ownership interest. Wyoming has no laws governing self-referral, so federal laws that apply to Medicare and Medicaid patients—referred to as the “Stark laws”—are the only constraints on physician self-referral in the state.¹⁹ In contrast, 13 states have regulations governing self-referral, although five have whole-hospital exceptions. Of the

¹⁸ As a result, not only MSCs but pediatric hospitals fall into this “default” category because they do not accept patients of all ages.

¹⁹ These laws restrict self-referrals to designated health services in which the physician or an immediate family member has a financial or ownership interest. However, these laws contain a “whole hospital exception” that allows physicians to refer patients to a hospital where the physician has an ownership interest, if the physician personally provides the care or the hospital is located in a rural area. Hence, they do not preclude patient referral to an MSC in which the physician has an ownership or financial interest.

remaining eight states, all but Nevada exempt services that the physician provides personally from their prohibitions on self-referral.²⁰

Prohibiting self-referral in Wyoming may be problematic. In Wyoming, no community has more than one hospital, and stakeholders report a shortage of non-hospital services, such as community based clinical laboratories and radiology facilities. Prohibiting self-referral may overly constrain treatment options.

G. A Level Playing Field

Several stakeholders advocated the creation of “a level playing field,” with MSCs facing the same community obligations as all general hospitals, regardless of profit status. Such a policy could be implemented in a number of ways.

Patient Mix. At least one state requires that MSCs accept a certain share of uninsured and Medicaid patients. For example, in Oklahoma all new MSCs and ASCs must ensure that Medicare or Medicaid patients account for at least 30 percent of their annual net revenues. Otherwise, they must pay into a state fund for the uninsured the difference between 30 percent of their annual net revenues and their actual Medicare/Medicaid revenues.

Uncompensated Care Fund. New Jersey imposes a 3.5 percent annual tax on gross revenues for all ASCs that are not owned by hospitals.²¹ The money is deposited into a “Health Care Subsidy Fund” to finance hospital uncompensated care. We are unaware of any states that have adopted such a provision for MSCs, although in a forthcoming report to the Texas legislature, stakeholders in Texas have proposed such a policy (Chollet et al. 2006).

Emergency Care Obligations. Currently in Texas, all hospitals—including MSCs—are required to have a full-service ED open to all patients. Colorado also requires 24-hour emergency medical treatment be available. However, for CMS it remains an open question whether an MSC that does not operate an emergency department for general admissions (but still provides full-time emergency services) should be regarded as a hospital “with specialized capability or facilities.” Under the Emergency Medical Treatment and Labor Act (EMTALA), such hospitals are obligated to accept appropriate transfers of patients from community hospitals.

Several states impose a lesser obligation on MSCs as well as other hospital facilities. For example, Montana, North and South Dakota, Nebraska, Utah and Idaho uniformly stipulate that hospitals without an ED (with the exception of critical access hospitals²²) must provide 24-hour access to stabilize patients and transfer them to the nearest appropriate facility.

²⁰ We include Michigan in this list of eight. This state has a “whole hospital” exemption but then exempts specialty hospitals from the exemption. In other words, prohibitions on self-referral apply to specialty hospitals.

²¹ The maximum payment is \$200,000 per year per ASC (Choudhry et al., 2005).

²² The federal government designates many small hospitals in Wyoming as critical access hospitals, increasing the amount of reimbursement they receive from Medicare. Federal law prohibits critical access hospitals from turning patients away if they have the resources to care for them.

H. Certificate-Of-Need Laws

In an effort to avoid inefficient capital growth, every state enacted certificate-of-need (CON) laws at some time during the last 40 years. In general, these laws required State approval for the construction of new health care facilities or expansion of existing facilities, based on a formal assessment of community health needs.²³ In practice, CON can take many forms. For example, most existing CON laws apply to hospitals and nursing facilities, but in some states they also are applied to capital in other settings such as physician offices, clinics, and/or imaging and surgical centers. They can apply to the entire facility, or they can address specific pieces of expensive equipment such as computerised axial tomography (CAT), magnetic resonance imaging (MRI) or positron emission tomography (PET) scanners.²⁴ There is some evidence that CON laws have constrained hospital capital expenditures, mostly by encouraging more planning, having a sentinel effect on growth, and reducing duplication of services (Spector 2005).

CON laws can be used as a regulatory tool to avoid unnecessary duplication of facilities and/or equipment. Furthermore, the very existence of a CON law appears to have an extremely dampening effect on the introduction of MSCs. As noted earlier, 96 percent of MSCs that opened between 1990 and June 2003 were in states without CON laws; all MSCs under development as of June 2003 were in states without CON laws.

Like many Western states, especially, Wyoming repealed its CON law in the 1980s. Reintroducing CON would require an information and planning infrastructure that does not currently exist in the state. CON presumes a process for planning community-based health services and health facilities.²⁵ Such processes depends on data and support other goals that the state may have such as slowing overall health care spending growth, improving the state health delivery system, and assessing and meeting community needs. This effort may be more than is warranted solely to address the potential for excess capacity posed by the relatively few MSCs that are likely to locate in Wyoming.

I. Moratorium

Both Montana and Washington State have had moratoriums on the construction on new MSCs—expiring July 1, 2006, and July 1, 2007, respectively. Several other states (including Indiana, Mississippi, and Missouri) have introduced similar legislation unsuccessfully. In Wyoming, stakeholder interviews indicated little support for a moratorium on MSC construction,

²³ Between 1976 and 1982, CON review was mandatory in all states except Louisiana, in compliance with the National Health Planning and Research Development Act (PL 93-641).

²⁴ According to one tabulation, providers and capital expenditures subject to CON may include acute care hospitals, air ambulance service, ambulatory surgical centers, burn care, business computers, cardiac catheterization units, CT scanners, gamma knives, home health care, intermediate care facilities for the mentally retarded, lithotripsy, long-term care, medical office buildings, mobile health technology, MRI scanners, neonatal intensive care units, obstetric units, open heart services, organ transplantation units, PET scanners, psychiatric service units, radiation therapy units, rehabilitation facilities, renal dialysis units, sub-acute facilities, substance abuse facilities, swing beds, and/or ultrasound.

²⁵ Wyoming is in the process of developing a Rural Health Plan that could serve as the basis for such a planning process.

and the low likelihood that many MSCs would locate in Wyoming suggests little practical need for a moratorium.

J. Summary and Discussion

While it is unlikely that many MSCs would locate and survive in Wyoming, the dearth of information to monitor changes in health care delivery and financing from any source (including the development of MSCs) is notable. In other states, data systems have been developed to support community health assessment, emergency planning, and the development of public policy. To the extent that Wyoming may have a broad interest in developing data systems to support such goals, monitoring and assessing the potential impacts of MSCs (as well as other facilities, such as ambulatory surgical centers) would be a natural component.

Requiring ownership disclosure by referring physicians would be consistent with CMS' forthcoming policy regarding disclosure. Wyoming may want to consider requiring ownership disclosure to both patients and the Wyoming Office of Healthcare Licensing & Surveys of all physician-owned health care facilities, not just MSCs. On the other hand, an outright prohibition on self-referral in Wyoming may be problematic. Such a prohibition may overly constrain treatment options and may be ineffective.

The goal of broadly distributing the burden of uncompensated or poorly compensated care is a laudable one. For states with monitoring systems that permit the measurement of uncompensated care burden, adopting an approach like that of Oklahoma or New Jersey could be part of an overt, comprehensive strategy for distributing the burden of uncompensated care fairly across all providers. In practice, few states operate with such a strategy (Massachusetts being another important exception).

Wyoming could use its trauma care management process to assess the community benefits of requiring full-service EDs in potential new MSCs. In turn, it may possibly address the issue of having more than one hospital licensure class by providing information and encouraging a comprehensive approach to the provision and payment of uncompensated care.

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Appendix A

Estimated Likelihood of a Medical Specialty Center Locating in a Market Area

	Odds Ratio Estimate	95% Confidence Limits
Demographic Characteristics		
Log of Total Population	53.698 **	[6.77, 425.80]
Change in Population	0.817	[0.54, 1.23]
Percent Non-White	0.845 **	[0.77, 0.93]
Percent Female	0.973	[0.56, 1.68]
Percent 65 Years or Older	1.283	[0.94, 1.76]
Percent with High School Completion	0.659 **	[0.51, 0.85]
Market Characteristics		
Primary Care Physicians per 1,000 people	0.063	[<.001, 451.10]
Surgical Specialists per 1,000 people	8.140	[0.03, >999.99]
Log of Per Capita Income per H.S.A.	9.093 **	[1.74, 47.43]
Number of Hospitals per H.S.A.	0.754	[0.52, 1.08]
For-Profit Hospitals per H.S.A.	2.776 **	[1.51, 5.10]
Ambulatory Surgery Centers per H.S.A.	0.836	[0.67, 1.04]
Year		
Year 2001	1.041	[0.16, 6.95]
Year 2002	1.147	[0.18, 7.41]
Year 2003	1.246	[0.18, 8.62]
Year 2004	1.700	[0.26, 11.04]

Source: U.S. Bureau of the Census, HRSA Area Resource Files, 2000-2004.

Notes: Analysis of estimated likelihood of an MSC locating in a market area is based on 61 HSAs in Texas across 5 years for 305 observations. The number of hospitals per HSA includes all types of hospitals (e.g. general, public, psychiatric, rehabilitation, etc.)

** Indicates a coefficient estimate with a 95% level of statistical significance.

Reference categories are percent white, percent male, percent less than 65 years of age, percent not completing high school, and the year 2000, respectively.

Appendix B

Predicted Probabilities of a Medical Specialty Center Locating in a Market Area with Average Demographic Characteristics

Population Level		Predicted Probability	For-Profit Hospitals		Predicted Probability
1,000,000		0.9822	10		0.9108
500,000		0.9812	9		0.9019
250,000		0.9802	8		0.8909
100,000		0.9787	7		0.8773
50,000		0.9773	6		0.8597
40,000		0.9769	5		0.8362
30,000		0.9762	4		0.8033
25,000		0.9758	3		0.7539
20,000		0.9753	2		0.6713
10,000		0.9735	1		0.5052

Source: U.S. Bureau of the Census, HRSA Area Resource Files, 2000-2004.
MPR analysis of coefficient estimates from logistic regression.

Appendix C

Hospital Licensing Requirements in Wyoming

The rules and regulations for our Office of Healthcare Licensing & Surveys can be found at the following web link:

Ch. 3 - Construction Rules for Health Care Facilities 07-15-2004

Health, Dept. of Health Facilities Current Rules and Regulations
<http://soswy.state.wy.us/RULES/5571.pdf>

Ch. 17 - Licensure of Critical Access Hospitals 11-04-2004

Health, Dept. of Health Facilities Current Rules and Regulations
<http://soswy.state.wy.us/RULES/5665.pdf>

Ch. 20 - Health Care Facilities Jurisdiction and Delegation 07-15-2004

Health, Dept. of Health Facilities Current Rules

Ch. 1 - Health Care Facilities Licensure Fees 03-30-1998

Health, Dept. of Health Quality
<http://soswy.state.wy.us/RULES/2978.pdf>

Appendix D

SB 803

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 2. Disclosure of interest in referral facilities.

- (a) General rule.-Any practitioner of the healing arts shall, prior to referral of a patient to any facility or entity engaged in providing health-related services, tests, pharmaceuticals, appliances or devices, disclose to the patient any financial interest of the practitioner or ownership by the practitioner in the facility or entity. In making any referral, the practitioner of the healing arts may render any recommendations he considers appropriate, but shall advise the patient of his freedom of choice in the selection of a facility or entity.
- (b) Penalty.- A person who violates this section shall be liable to the Commonwealth for a civil penalty not to exceed \$1,000.
- (c) Enforcement.-The licensing boards in the bureau shall enforce this section.

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