F I S C A L I M P A C T R E P O R T

SPONSOR: Papen DATE TYPED: 3/20/03 HB

SHORT TITLE: Licensing Requirements For Certain Hospitals SB 767/aSPAC /aSJC

ANALYST: Dunbar

APPROPRIATION

Appropriation Contained		Estimated Additional Impact		Recurring or Non-Rec	Fund Affected
FY03	**FY04**	**FY03**	**FY04**		
			See Narrative		

(Parenthesis ( ) Indicate Expenditure Decreases)

Duplicates: HB 802

SOURCES OF INFORMATION

Responses Received From
Department of Health (DOH)
Health Policy Commission (HPC)

SUMMARY

Synopsis of SJC Amendment

The Senate Judiciary Committee amends the bill by:

- Changing the name in the title of Section 1 from "Boutique" to "Certain" hospitals.
- Removing language in legislative findings that indicates that patients are threatened by "boutique" hospitals and that these hospitals would affect the financial viability of hospitals that operate emergency departments.
- Changing the name in Section 1 from "boutique" to "limited service" hospitals.
- Defining "low income patients"
- Removing language pertaining to "cost benefit analysis".
- Providing for licensure of a hospital on the condition that the hospital maintains and operates and emergency department and participate in the Medicaid, Medicare and county indigent program. Moreover, the hospital must provide emergency care to nonpaying patients and low-income reimbursed patients. The conditions for the latter will be deter-

mined by DOH with a statewide hospital organization, the government of the county in which the facilities are located and the affected hospitals; provided that the hospital may appeal the department determination and that the annual cost of care required to be provided shall not exceed an amount equal to 5% of the hospital annual revenue.

- Providing for a health care provider to disclose a financial interest before referring a patient to the hospital.
- Removing language pertaining to suspension of a license when a hospital fails to comply with previously imposed conditions.

Significant Issues of SJC Amendment

DOH indicated the following concerns with the amended bill:

- An inconsistency with Section 1D 3 which provides for a department determination and subsequently places a cap of 5% on hospital's annual revenue.
- Require additional staff to conduct hearings (reference is also made to "administrative implications" below".)
- Question the new language in Section 1D pertaining to "acute –care" hospital.

Synopsis of SPAC Amendment

The Senate Public Affairs Amendment amends Section 1 D of the bill which provides conditions for issuance of a license to a general hospital or boutique hospital to include language that requires a physician owner to disclose a financial interest in the hospital before referring a patient to the hospital. Additionally, language is added to the same section of the bill that the hospital must comply with the same quality standards applied to other hospitals.

Also, the words "general hospital" are inserted prior to "boutique hospital" in Sections pertaining to licensure of hospitals.

Synopsis of Original Bill

Senate Bill 767 requires "boutique" hospitals to have the Department of Health (DOH) conduct a cost-benefit analysis and consider the need for the hospital by the State and local community. "Boutique" hospitals are defined as new hospitals (initially licensed after 1/1/03) that limit admissions according to medical or surgical specialty, type of disease or medical condition, or hospitals that limit inpatient hospital services to surgical services or invasive diagnostic and treatment procedures.

Significant Issues

SB 767 proposes legislative findings that the ability of NM hospitals to continue to provide emergency services is threatened by "boutique hospitals" that offer only profitable services.

Boutique hospital is defined in SB 767 as:

- a hospital that limits admissions according to specialty, type of disease or medical condition.
- a hospital that limits its inpatient services to surgical services or invasive diagnostic and treatment procedures.

Boutique is further defined to not include:

- a hospital licensed as a special hospital.
- a charitable hospital that does not bill for services.
- a hospital that has been granted a license prior to Jan 1, 2003.

SB 767 requires the Department of Health to perform a cost-benefit analysis upon receiving the licensure application. The Department's analysis must consider:

- the need for the hospital by the community and state.
- the effects of the hospital on medical care in the local community including the potential harm to existing facilities.
- employment opportunities the applicant may provide.
- the identification of any special requirements that would maximize benefits or minimizes costs.

SB 767 requires the Department to not issue a license unless the hospital agrees to:

- maintain an emergency department that provides basic or comprehensive emergency services comparable to those provided by licensed acute are hospitals.
- participate in Medicare, Medicaid, and county indigent programs.
- provide emergency services to low income and nonpaying patients in the same proportion as other local hospitals.
- comply with any special conditions identified in the cost benefit analysis.

SB 767 notes that after licensure, if the boutique hospital fails to comply with previously imposed conditions, the license is suspended until the conditions are met.

The purpose of SB 767 is to have the DOH conduct a "certificate of need" type process to determine the need and impact of boutique hospitals on area medical services. Approved boutique hospitals would require DOH Health Facility Licensure and Certification Bureau (HFL&C) licensure. Current state licensure regulations require the minimal provision of emergency services.

According to DOH the HFL&C Bureau (which licenses and certifies health facilities), they do have the of qualified staff to do the costs benefits analysis. Additional workload would require additional FTE to administer the program as well as to survey and evaluate new facilities, including annual licensure surveys.

SB 767 declares an emergency for the act to take effect immediately.

FISCAL IMPLICATIONS

There is no appropriation in the bill to fund the cost benefit analysis.

ADMINISTRATIVE IMPLICATIONS

The department perceives a need for additional staffing, management personnel, and funds for capital and operating needs.

If SB 767 were enacted, new regulations would need to be promulgated. The DOH currently does not conduct cost-benefit analyses nor does it issue certificates of need. Although SB 767 would require that applicant licensure fees pay the cost-benefit analysis, there are currently no personnel, resources or established policies to administer or make such determinations.

DUPLICATION, RELATIONSHIP

Duplicate of HB 802

Relates to: HB 662, Health-Based Business Referrals, which prohibits any physician or physician assistant from referring patients to health care facilities, laboratories or businesses in which the physician or physician assistant has a financial interest.

TECHNICAL ISSUES

Participation in the Medicare and Medicaid Programs is voluntary and currently not mandated. The old certificate of need process was discontinued in 1987.

OTHER SUBSTANTIVE ISSUES

The shifting health care landscape in New Mexico reflects a nationwide trend toward smaller, physician-owned or sponsored hospitals and treatment centers. Around the country, smaller specialized medical care facilities are opening up to treat a variety of illnesses and conditions. The leading specialty arenas include cardiology, women's health, cancer, orthopedics and surgery centers. Already in place is an acute care hospital in Albuquerque, which caters to cardiac patients. Other facilities have opened such as cancer centers that are not hospitals, but are specialized treatment facilities that are geared toward a specific disease or medical condition.

HPC notes that:

- Consumers and public policymakers have proposed that physician owned surgical hospitals create incentives for physicians to make referrals based on financial arrangements, rather than quality of care considerations. Further, some studies suggest that these arrangements encourage unnecessary duplication and over utilization of services, thereby adding to the escalation of health care costs.

- The American Medical Association has in place a detailed code of ethics that binds all physicians. Section E-8.032 explicitly deals with conflicts of interest that arise over health facilities owned by physicians. In general, the code prohibits referrals to such facilities, but also recognizes that in some situations, facilities may not be built if physicians are not involved in investing in them. In such a situation, the code details a number of requirements, including full disclosure, no non-competition clauses, and financial returns linked to equity in the facility and not to volume of patients. The AMA Code of

Ethics is more detailed and more situation-specific than that found in HB662, and would seem to address both the issue of inappropriate referrals and responding to communities in need quite well.

- Specialty boutique hospitals may drain high-paying, profitable patients away from community hospitals and force those "department stores" of health care to cut back on service or go out of business.
- Patients who turn to specialty care facilities may benefit from a health perspective. A facility that revolves around a narrow clinical focus should improve and have better clinical outcomes than one that does not. Literature in the medical field is replete with examples of “Centers of Excellence” in which hospitals and doctors with a higher volume of doing a particular kind of work have better clinical outcomes than those that do not have commensurate volume.
- Boutique hospital supporters say they offer better care for their specialties than general community hospitals do. With a narrowly focused mission, boutique hospitals can buy the latest technology sooner and can more intensely focus on that area of medicine than can general hospitals.
- Skeptics say there is no proof that specialty hospitals provide better care than general hospitals. They also say that diseases often come in pairs and triplets and are often related. That means that a boutique hospital might not be able to treat a patient who has other medical problems, whereas a general hospital could, and that complications will be better managed in facilities with a wide range of services.

AMENDMENTS

HPC suggests amending the bill to provide for :

- Physician’s discloser of any financial interest they have in a healthcare organization to which they refer patients. The AMA Code of Ethics is a good model for the conditions of acceptable referral and the criteria for disclosure
- Enforcement of the same quality standards of other hospitals. Specialty service settings should be held to the same federal quality standards as a hospital when delivering exact clinical services.

BD/sb:yr