State Policy, Health Care Disparities, and the Invisible Hand of the Market

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New Jersey Certificate of Need (CON) reforms sought to increase *access* and maintain *quality* in diagnostic cardiac catheterization (CATH)

- Doubled the number of CATH facilities
- Strict quality regulations
- Incentives to reduce disparities
The New Jersey CON reforms

1996  - Two-year CON pilot program for low-risk CATH patients
      - Minimum volume & maximum % negative rules
      - Community Outreach/Access Plans required
      - Audited clinical data reporting

1998  - Low-risk CATH pilot extended
      - Disparity reduction criteria for cardiac surgery CONs
      - CON no longer needed for expansion of full-service CATH
      - Full service CATH facilities may “graduate” to cardiac surgery

2001  - Low-risk CATH program made permanent
      - Low-risk CATH facilities may “graduate” to full service
Study Design

Compare trends in CATH utilization rates for “incumbent” and “new” facilities

Semi-structured interviews with policy stakeholders (June-July 2005)
- 5 current regulatory officials/advisors
- 3 former regulatory officials
- 2 senior non-governmental stakeholders

Semi-structured interviews with hospital officials (Summer 2007)
- Seven clinical staff and senior officials from three hospitals with increased percentage of black CATH patients
Number of facilities more than doubled & many have graduated to full service

Source: NJDHSS Regulatory Reports
New CATH hospitals smaller, lower-tech, not located in areas with many blacks

<table>
<thead>
<tr>
<th></th>
<th>INCUMBENT Facilities</th>
<th>NEW Facilities</th>
<th>No CATH Facilities</th>
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<tbody>
<tr>
<td>% African American/ in market area</td>
<td>15%</td>
<td>13%</td>
<td>18%</td>
</tr>
<tr>
<td>Mean # staffed beds</td>
<td>405</td>
<td>293</td>
<td>174</td>
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<tr>
<td>% with Teaching</td>
<td>37%</td>
<td>5%</td>
<td>0%</td>
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<td># high-tech services (0 to 7)</td>
<td>2.47</td>
<td>0.75</td>
<td>0.33</td>
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Sources: NJ hospital discharge abstract data and AHA Annual Survey, 1999
Ratio of black to white CATH patients rose steeply in “incumbent” facilities

Sources: NJ hospital discharge abstract data (UB-92)
Policy Formation: Observations from Regulatory Stakeholders

• Hospitals very eager to provide CATH, seen as gateway to profitable services, great pressure to ease CON rules
• Pro-market ideology among senior advisors to Governor
• Regulatory officials committed to CON...
  – Feared over-use and quality problems
  – Believed minority patients had poor access
• Commissioner of Health sought middle path...
  – Increase CATH capacity on pilot basis, strict quality checks
  – Explicit focus on disparity reduction
Policy Implementation: Observations from Regulatory Stakeholders

- Difficulty establishing concrete disparity reduction goals
  - Hospitals could select any ‘underserved’ group in Outreach & Access plan
  - No consensus on measurement

- CON regulatory enforcement focused on quality (minimum volume, % negative) rules

- Outreach & Access plan requirement seen as weak, applied only to newly licensed facilities, not enforced

- Ambitions to provide full-service CATH or cardiac surgery may provide incentive to improve minority access
CASE STUDY HOSPITAL #1

Source: NJ DHSS UB92 Hospital Discharge Billing Records
CASE STUDY HOSPITAL #1

600+ bed non-profit, system flagship hospital, 15% Medicaid or uninsured. Both total volume and the percent black patients increased after the reforms.

“I have no idea [why the proportion of black cardiac angiography patients has gone up], unless the local demographics are shifting. I hadn’t noticed a trend like that, but of course, we don’t look at our numbers like that.” -- Chief of Cardiology
CASE STUDY HOSPITAL #2

Implementation of Pilot Project
First low-risk graduate to full-service

Source: NJ DHSS UB92 Hospital Discharge Billing Records
CASE STUDY HOSPITAL #2
500+ bed, non-profit safety net hospital, 40%+ Medicaid or uninsured. New low-risk facility opened nearby in the early 2000s.

“...we had a drop [in volume] because [a nearby] hospital opened a [new low-risk] cath lab. [Since then] the volume is increasing. For blacks, health care is very poor and obesity is very high. Diabetes is very high. Hypertension is very high. They get these at a young age, and as a result of that, coronary disease is increasing.” -- Director of Cardiac Cath Lab

“Over the years, [our] hospital has gotten progressively better at [serving] minority groups, moving them through the system, [with] more advocacy.”

-- Manager of Cardiac Cath Lab
CASE STUDY HOSPITAL #3

Implementation of Pilot Project

First low-risk graduate to full-service

Source: NJ DHSS UB92 Hospital Discharge Billing Records
CASE STUDY HOSPITAL #3

400+ bed, major urban teaching center, 40% Medicaid or uninsured.

Total CATH volume decreased in the late 1990s when a high-volume cardiologist with a mainly suburban clientele left. A new chief of cardiology was recruited.

“[Our new affiliated cardiology practice] draws more from the local community than [did the former] cardiology [practice].... When the volume converted to being more [from the new affiliated practice]..., we were seeing more area patients, which may explain the increase [in black patients].... I think that’s the best interpretation of this data. But again, we’ve never looked at this, so this is new to us.”

-- Assistant VP of Cardiology
Conclusions

• Regulations directed at disparities (e.g., Outreach & Access plans) appear ineffective
  – Newly licensed facilities not located in markets with disproportionate number of blacks
  – Regulations seen as weak, not enforceable

• Disparities reduced by “incumbent” facilities
  – New competition for largely white, well-to-do patients from suburban hospitals
  – Increased services to black patients
  – Hospital leaders had difficulty articulating causes of change but they appeared to be market driven
Policy Implications

• Direct regulation to reduce disparities may be difficult
  – Outreach & Access requirement apparently failed

• Limiting hospital service capacity may exacerbate disparities
  – Strict limits may enable facilities to limit service to most financially attractive patients
  – Awarding CON franchises to “safety net” hospitals no guarantee that access for underserved will be improved
  – Market incentives are a possible tool for disparity reduction

• Tradeoffs inherent in goals of achieving high quality, limiting over-utilization, and reducing disparities