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Why Beaumont Does Not Need and Should not Have a Third Hospital
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Your Life Your Health
The Examiner
April 17, 2008

The re-emergence of a possible, new, private, for-profit hospital on the West End of Beaumont raises the alarm about the real potential for unsettling a delicate balance in the delivery of healthcare in Southeast Texas. The proposed "Mediplex" is the successor to the original plan by the owners of the Renaissance Hospital in Groves to build a hospital in Beaumont. That plan fell through when local physicians organized a meeting to discuss why that was not a good idea. The Associated General Contractors have taken up the plan for a new hospital with a group of unidentified investors who are attracted by the potential for profit from the economic growth which is expected over the next five years in the Golden Triangle.

No one objects to the development of new projects in Southeast Texas. However, when a group of investors, particularly investors who are not residents of the local area, propose to build a hospital, public-interest concerns arise. The news reports of the April 10, 2008, ground-breaking included a brief comment by a Beaumont City Councilman who dismissed concerns about the negative impact of a new hospital with the statement, "I just trust God. I don't like to think about the negative but only the positive." Unfortunately, for this councilman and other elected officials, part of their fiduciary responsibility to their constituents is to consider the potential negative impact this new initiative could have on healthcare in our community.

Four Alarm Public Relationship firm's spokesperson, Paula Bothe, stated, "This project is not set in concrete and the first phase does not have anything to do with the hospital…The final plan is not complete. I fear that people are getting excited about something that is premature. The next phase of the project would be for nursing homes and assisted living centers, but I have not seen any drawings for a hospital." This statement is disingenuous as it appears to be an effort to get main-stream physicians to help the private investors build their infrastructure and then spring a hospital on them. At present, I know of no physician leaders nor of any significant group of mainstream physicians who are willing to support a new hospital. Unless this investment group is willing to enter into a binding agreement never to build a hospital, those same physicians will find it impossible to support the "mediplex".

Roemer's Law of Supply and Demand

Healthcare is possibly the most regulated business in the United States. There was a time in Texas when these developers would have had to obtain a "certificate of need" before they could build a new hospital. Unfortunately, that requirement no longer exists.
Because of the highly regulated nature of healthcare, traditional principles and laws of economics, particularly supply and demand, do not apply. In 1961, M. I. Roemer postulated

what is called Roemer's Law of Demand which essentially states that supply may induce its own demand where a third party practically guarantees reimbursement of usage, i.e., Medicare and Medicaid. Thus, the probability is that rather than solving healthcare problems in Southeast Texas, the proposed new hospital may only increase the cost of care.

Milwaukee, Wisconsin struggled with the same problem. The following analysis there applies to Beaumont as well:

> "The Milwaukee area is about to find out whether that phenomenon, known as Roemer's Law, still holds true. Last month, Aurora Health Care announced plans to build a hospital in Grafton in southern Ozaukee County. The announcement came about one year after it won approval to build a hospital in western Waukesha County. **Both hospitals will be within five miles of existing hospitals. Both will be in affluent suburbs that don't lack for health care services**. No one knows for certain what Aurora's move will mean for health care costs in the Milwaukee area. But critics and competitors contend that the new hospitals and the inevitable duplication of services that attends them will increase costs. **They can point to research that shows that markets with more hospitals, specialists and other health care services generally have higher health care costs, with no significant improvement in the population's health**." (Emphasis added)

Jefferson County Commissioners, Beaumont City Council members and area Congressmen should consider this possibility and indeed this probability before they lend their support to a new hospital.

Healthcare Regulation Began with Fee Fixing

The regulation of healthcare began with the regulation of fees. However, the regulation of the fees of physicians, hospitals and other healthcare deliverers did not include regulation of what the suppliers of services and goods to hospitals and physicians could charge. In addition, while regulating fees, the government continued to add services which had to be provided to patients without anyone providing any additional reimbursement. These were called "unfunded mandates," i.e., the government mandated that this or that service must be provided but no payment was made for the service.

Medicare and Medicaid

The regulation of health-care delivery in the United States did not begin with the Medicare and Medicaid law signed by President Johnson July 30, 1965, but that was the first major step in the public assumption of responsibility for paying for healthcare and thus it was a significant step toward the eventual federal regulation of healthcare costs and the fees of healthcare providers. The sequence of events was as follows:

- The Deficit Reduction Act of 1984 created the Participating Physician Program, which required physicians to decide on an annual basis whether to enter into a participating agreement with the government. This statute froze the fees of non-

participating physicians...

- The Omnibus Budget Reconciliation Act of 1986 lifted the freeze on non-participating physician fees, but did not permit non-participating physicians to charge more than the "Maximum allowable actual charges" (MAAC) established by the government.
- In 1989, the Omnibus Budget Reconciliation Act included provisions designed to further "protect Medicare beneficiaries against…balance billing" by non-participating physicians. "Balance billing" refers to the patient being responsible for the portion of the physician's charge which was not covered by Medicare. The 1989 Act replaced the MAAC formula with a concept called the "limiting charge," which limits non-participating physicians' charges to set percentages of the Medicare-defined allowed charge for services. The "temporary" setting of prices by the government had become permanent!

Shortly, private insurers adopted the Medicare methodology of controlling their cost by requiring physicians to sign contracts which lowered and controlled their fees. As a result, some physicians decided to stop treating patients with Medicare or Medicaid.
Those physicians and others began offering quasi-medical services for weight loss, skin care, and special, personalized care for those who could pay large fees, along with treatments and medications to forestall the ravages of aging. Physician who thusly redefined their roles put greater and greater burden on physicians providing traditional forms of care for the neediest of people. New hospitals often design their locations and services to accomplish the same limitations of service to the neediest of people.

EMTALA – the ultimate unfunded mandate

Also in 1986, the Emergency Medical Treatment and Active Labor Act (EMTALA) was passed by the Congress. EMTALA was part of the Consolidated Omnibus Budget Reconciliation Act (COBRA). This act required hospitals and ambulances to provide care to anyone needing emergency treatment regardless of citizenship, legal status, or ability to pay. The bill had no reimbursement provisions for these mandated services. As a result of the act, patients needing emergency treatment can be discharged only under their own informed consent or when their condition requires transfer to a hospital better equipped to administer the treatment.

EMTALA applied to "participating hospitals", i.e., those that accept payment from the Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS) under the Medicare program. However, in practical terms, EMTALA applied to virtually all hospitals in the U.S. The combined payments of Medicare and Medicaid, $602 billion in 2004, or roughly 44% of all medical expenditures in the U.S., made not participating in EMTALA impractical for nearly all hospitals. EMTALA's provisions apply to all patients, and not just to Medicare patients.

The cost of emergency care required by EMTALA is not directly covered by the federal government. Because of this, the law has been criticized by some as an unfunded mandate. Similarly, it has attracted controversy for its impacts on hospitals, and in particular, for its

possible contributions to an emergency medical system that is "overburdened, underfunded and highly fragmented". More than half of all emergency room care in the U.S. now goes uncompensated. Hospitals write off such care as charity or bad debt for tax purposes. Increasing financial pressures on hospitals in the period since EMTALA's passage have caused consolidations and closures, as a result the number of emergency rooms is decreasing despite increasing demand for emergency care. There is also debate about the extent to which EMTALA has led to cost-shifting and higher rates for insured or paying hospital patients, thereby contributing to the high overall rate of medical inflation in the U.S.

Foundation of Concern about a new Hospital in Beaumont

This is the foundation of concern about a new hospital in Beaumont, particularly one which is for-profit. There are ways “around” EMTALA. Several of them have been employed by at least one hospital in the Golden Triangle to decrease their cost of serving the uninsured, under-insured or indigent population.

- One way is to have a small emergency room which makes it inconvenient to be seen there.
- Another is to build a hospital in area which is distant from the majority of uninsured or indigent patients making it more convenient for them to choose another hospital.
- A third way, which at least one area hospital administrator has boasted of, is to make the indigent and uninsured so uncomfortable that they choose another hospital in the future.
- A fourth way is to choose not to perform services which attract trauma and other high-cost services which are often utilized by uninsured and indigent patients.

In these and other ways, a for-profit hospital which is managed by those accountable to investors can limit their liability while attracting paying patients away from hospitals who fulfill their EMTALA responsibilities. This has and will result in damage to existing hospitals and have resulted in the closing of hospitals who served the public as a principal commitment.

Diagnostic Related Groups -- DRGs

When you get your automobile repaired, the estimator goes to a book where he will find the value of that service which is listed as the amount of time it will take to repair a panel, or to tune an engine. Multiplied times an hourly charge, that becomes the labor-cost part of the bill. If the book says that it takes 6.2 hours to provide a service but the workman can do the job in 3 hours, he makes a higher profit. If the job takes 8 hours, he loses money. The dealer limits his liability and puts the major burden on the worker by paying the worker only for the calculated time, regardless of how long it takes him to do the job.

This is similar to the Diagnostic Related Groups (DRGs) under which hospitals now operate. The major difference, however, is that in the case of the automobile industry those providing the services set the fee, while in the case of the hospital, the fee is set by the payer. Can you imagine the difference in reimbursement that the automobile dealership would experience if the customer were setting the fee?

Hospital cases are classified into one of approximately 500 groups referred to as DRGs, which are expected to have similar hospital resource use. Thus, conceptually, making it possible to pay hospitals on a standard scale. DRGS were developed for Medicare as part of the prospective payment system which hoped to help control healthcare costs. DRGs have been used since 1983 to determine how much Medicare pays the hospital.

The Problem For Hospitals

Here is the problem for hospitals. If the DRG calls for a $7,000 payment but the cost of the patient's care is $50,000, the hospital gets paid $7,000. Unlike the car dealership which protects itself by limiting what it pays the mechanic, the hospital is often dependent upon the physician for the determination of the cost of the patient's care without the hospital having any ability to control that cost. The physician continues to be paid a fee-for-service, per day of hospitalization even if the patient is in the hospital for 25 days; while the hospital's DRG funding may expire in 6 or 7 days. This controlling of hospital reimbursement by the government makes it difficult if not impossible to recover from "paying" patients the cost of the care of the uninsured, under-insured and indigent mandated by, but not paid for by, the government.

A New Hospital will not share the EMTALA Burden

Add to this reimbursement plan the requirement for the hospital to provide medical care for the uninsured and or indigent patient under EMTALA and you have tremendous financial pressure on the hospital. Add to that mix, a new hospital which cleverly, but legally, limits its EMTALA obligation and the financial pressure becomes overwhelming on the hospitals meeting the needs of all of the residents of a region.

Long Term Acute Care -- LTAC

In the future, the financial pressure on hospital and other healthcare providers is going to increase. The reduced reimbursement to durable medical equipment companies has driven half of the companies out of the market and that pressure will increase. The pressure on nursing homes is having the same effect. Long Term Acute Care hospitals (LTAC) have been a place where investors have made a great deal of money. This January significant rate decreases were put into place for LTAC. A new LTAC was planned for Beaumont and has not come to fruition because of the financial pressures which have apparently made it impossible to get funding to build the new LTAC. This is demonstrative of what is going to happen to many healthcare organizations and providers. And, it is suggestive of what could happen to our area hospitals with a third

hospital being built which does not share the burden of caring for the uninsured, under-insured and indigent.

Rate Limiting steps – Nursing Staff and Support Staff

In a chemical reaction, there will be a step in the process which takes longer than the other steps. This is called the "rate-limiting step." In hospital-based healthcare delivery, we have pointed out that the size of your emergency room can be used as a rate-limiting step to decrease the hospital's cost under EMTALA. That is the result of manipulation. However, there are unavoidable and/or unintentional rate-limiting steps in healthcare delivery.

One of them which we are currently experiencing in Beaumont is nursing personnel. There are hospital beds in this community which go unused, not because someone is limiting their EMTALA obligation, but because the necessary, qualified personnel are not available to open those beds for patient use. Can you imagine what would happen if a for-profit hospital, with deep pockets from rich investors, opens in Beaumont? They will further limit the availability of nursing personnel to our current hospitals. This will cause our current hospitals to decrease their number of hospital beds, placing them at risk of not being able to continue to operate.

Eventually, the new hospital will experience the consequences of DRGs, EMTALA and other limitations on the profitability of healthcare and will begin laying off staff and closing beds, but in the short run they will wreck havoc by outbidding our current hospitals for nursing personnel. By the time the new for-profit hospital starts laying people off due to poor investor return, the damage to our current hospitals will already have taken place.

This has already been experienced in the local healthcare delivery community where nursing personnel were attracted to a new healthcare enterprise because of a "salary increase," they "could not turn down," but which salary increase was unsustainable. Several of those nurses returned to their former employer in less than a year when they were laid off from their new, high-paying jobs due to the inability of their new employers to pay their salary.

Competition -- Market doesn't work

In a business as highly regulated as healthcare, market factors do not work. In a normal commercial enterprise, it is possible to allow competition to work out who survives, who succeeds and who fails. In healthcare, it is often those who take the public health and their public responsibility the most seriously that fail when unbalanced competition takes place. The developers of the new hospital, which is now being promoted as a development of nursing homes and assisted living, but which will inevitably result in a new hospital once the investors have a patient base and a provider base to support the new hospital, suggest that their plan is friendly competition. In non-regulated, non- healthcare industries unbridled competition is fine, but in healthcare, a need must be

demonstrated in order to justify the professional community supporting a new enterprise which has significant potential for injuring the hospitals already here, not to speak of the driving up of healthcare costs.

Healthcare Summit

Southeast Texas needs a Healthcare Colloquium or Summit to examine the need for a new hospital. All stakeholders should be present: politicians, professionals, public advocates, insurers, hospital administrators, investors and others. If well planned, this summit could resolve the questions about what a new hospital would or would not do for this community.

At the present, anyone who has Southeast Texas interests at heart, whether politician, patient, professional, administrator, entrepreneur or investor, would and should refuse to work with the "mediplex," or with their nursing homes, their assisted living or especially with their new hospital. Many physicians have already declared their intent not to work with the new hospital.

Southeast Texas Medical Associates, LLP has taken a public stand that we will not seek or accept membership on the medical staff of the new hospital. Should the hospital open, we will notify all of our patients that we will not admit them to the new hospital or see them during their hospitalization if they choose to be seen in the emergency room of the new hospital.

Southeast Texas Medical Associates, LLP providers will continue to see all of our patients who seek care at Memorial Hermann Baptist and at Christus St. Elizabeth. We invite all physicians who care about Southeast Texas to make the same declaration so that the investors in the new hospital can take this into consideration in their planning.