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# Health Planning TODAY

the newsletter of the

American Health Planning Association

## Health Care "Reform" . . . & Planning?

*Dean Montgomery*

With the "curious incident of the dog in the night time," Sherlock Holmes teaches us that something that does not happen, but should, often is more significant than evidence in plain sight.[1] Planning is the dog that has yet to bark in the unfolding health care debate. It remains to be seen whether planners and planning, as distinct from health "plans," will be heard.

Whatever the direction and degree of change "reform" may bring, more effective planning is critical to improving the system. Making explicit provision for a planning structure and process that draws economic and institutional support from within the system should be a key features of any reform scheme adopted. Valuable roles that an independent community oriented planning body could play include:

***Identify Community Needs***: Regardless of size, resources, intentions, or tax status, few health care entities are in a position to identify and assess objectively the health care needs of the community they serve. Reliance on market forces as the organizing principle of health care delivery virtually assures that the focus of health plans and service programs will be targeted and narrow. Those offering services, and the larger community, need an independent entity dedicated to identifying community

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## Health Planning Today

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### Health Care Reform . . . & Planning?

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needs and measuring objectively over time how well those needs are met.

***Facilitate Community-Oriented Institutional Planning***: Private sector health care entities necessarily put organizational, institutional and economic concerns first as they develop their capital and operational plans. An independent, community oriented planning body could be invaluable in articulating the community context for these plans and, thereby, and help private entities take into account community needs and aspirations.

***Provide Community Health Care Forum***: Health care is a critical element of the social and economic fabric of most communities. There is a pressing need for objective, neutral settings in which health care concerns and issues can be raised and fully vetted.

***Promote System Transparency***: Few social systems are less transparent than health care. This derives partly from the technical economic and clinical complexity of medical care, but there is no legitimate reason for not making readily available to all health system data and information that affects personal and community health. An independent community-oriented planning entity could shed much needed light on the system and how it functions.

***Provide Community Voice in Policy Formulation***: With or without a rational national policy, health care, like politics, is a local matter. There is a continuing need for a stable structured mechanism to permit, and facilitate, participation in health care policy questions that affect personal and community wellbeing.

***Monitor System Performance***: Health care systems are not capable of self monitoring and correction. State level licensure and inspection, and national regulation and guidance through such mechanisms as CMS, are necessary but not sufficient. Local planning entities could be of distinct value in assessing system performance and in identifying early inadequacies and failures**.**

***Link Public and Private Services***: Our health care delivery system is largely private, but many critical services essential to maintaining community health are public. There is relatively little systematic interaction of these disparate entities. Meaningful interaction must necessarily occur at the local level.

There will be planning, with or without reform. Health systems, health "plans," and entrepreneurs will plan, at least to protect their interests. The only question is will there be a meaningful local community voice and role?

[1] Arthur Conan Doyle, *"Silver Blaze," The Memoirs of Shrelock Holmes*, 1892.

# Virtuous Virtual Service Planning … Virtually

*AHPA Planning Consortia*

Planners and regulators often face the challenge of facilitating the orderly and economically efficient diffusion of new medical technologies and practices. The introduction of CT colonography (CTC) in colorectal cancer screening illustrates how difficult this can be. The May 12, 2009 Centers for Medicare and Medicaid Services (CMS) decision not to pay for CT scans for screening for colorectal cancer (CRC) complicates planning for the service. It also gives planners some much-needed time to assess the complex questions raised by the emergence of CTC.

CMS's reluctance notwithstanding, CT colonography appears to be on the brink of becoming the preferred CRC prevention and diagnostic tool. The American Cancer Society (ACS), several specialty medical associations, politicians (e.g., the Congressional Black Caucus), and a number of interest groups have endorsed CTC for CRC screening. They continue to press for broader insurance coverage at all levels. Seventeen states have added coverage of CT colonography for CRC screening to their mandated coverage laws, requiring private insurers offering plans in the state to provide coverage. Pressure on CMS to extend Medicare coverage, already intense, is almost certain to increase, not dissipate.

### *Virtual Colonoscopy*

Early indications are that "virtual colonoscopy," the promotional term for CT colonography favored by advocates, has much to offer. Recent studies show that the sensitivity of CTC in detecting medium to large intestinal growths is comparable to that of traditional optical colonoscopy. Both procedures have sensitivity levels of about 90% for large polyps, those >9 millimeters. Sensitivity decreases to between 80%-85% for medium size lesions, polyps 5-9 mm in size. Experience is limited, but evidence to date suggests that both optical colonoscopy and virtual (CT) colonoscopy result in missing between 10% and 12% of the lesions that may become colon cancer.

The principal reason cited by CMS for not authorizing payment for CT colonoscopy is the lack of objective data demonstrating the efficacy of CT colonography among the Medicare population, those 65 years of age and older. Positive reports to date are for the population 50 to 64 years of age, the younger end of the age range most authorities recommend being screened for CRC. Studies are underway to determine the efficacy of CTC among the Medicare population.


Compared with other screening tests, the major advantages of CTC as the principal screening test for CRC are that it

- is less invasive and less risky than optical colonoscopy and sigmoidoscopy,[1]
- costs much less, typically less than half the cost of optical colonoscopy,
- yields more clinical data (intestinal and abdominal) and potential findings than other CRC screening tests,
- could reduce the number of unnecessary optical colonoscopies substantially, if widely used, and
- has potentially greater patient acceptance than optical colonoscopy, making higher screening rates among asymptomatic adults more likely.

Given these advantages, CTC could become the standard of care in CRC screening. If so, it is likely to be the next major clinical application of advanced CT technology.

### *Colorectal Cancer Demography*

Colorectal cancer (CRC) is one of the more frequently diagnosed cancers in the U.S. More than 150,000 people are diagnosed with the disease annually, and more than 50,000 die from it. Excluding skin cancer of all types, CRC incidence ranks third in most communities, exceeded only by lung and breast cancer diagnoses and deaths. As with most cancers, CRC incidence and mortality varies widely demographically and geographically. Both are higher among men than women, higher among Blacks than Whites,

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## *Virtuous Planning … Virtually*

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and increase sharply with age. Reported incidence and mortality are more than four times higher among those over 65 years of age than those between 50 and 64 years.

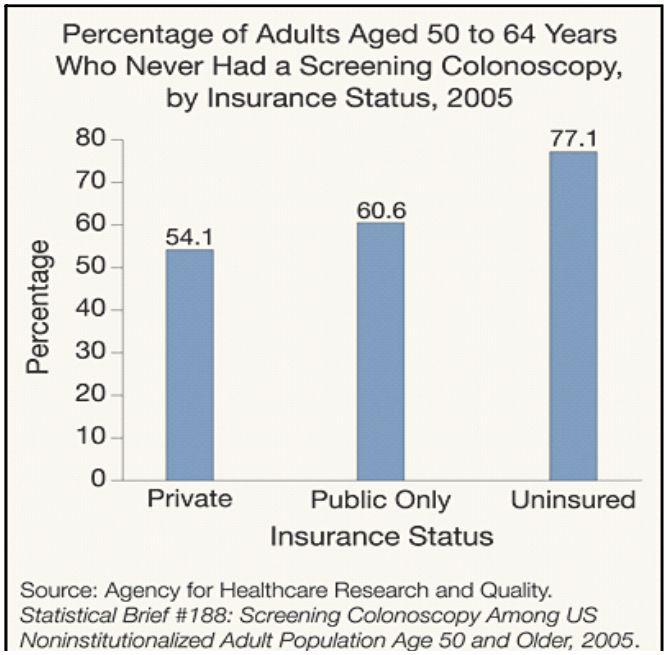
CRC incidence and mortality have decreased significantly over the last two decades. The decreases have been much greater among Whites than Blacks. The evidence is not conclusive, but many attribute much of the difference in the relative decreases in White and Black rates to higher CRC screening levels and earlier treatment among Whites. Even with significant decreases among both Whites and Blacks, CRC among Hispanics and Asian Americans remains substantially below White and Black levels. The need to address CRC mortality, and reduce underlying disparities, is evident.

### *CRC Prevention: Screening*

It is a widely held, if unproven, axiom that a large percentage of colon cancer deaths could be prevented if the cancer, or precancerous lesion, were detected early and excised. The American Cancer Society and other authorities maintain that colorectal cancer found and treated early (when the cancer is localized) has a "5-year relative survival rate" of 90%. Currently, less than 40% of colorectal cancers are discovered and treated early, and the rate of early detection varies widely demographically. When CRC is not detected until after it has metastasized, the five-year relative survival rate is estimated to be about 10%.

Given the demography of CRC, and the assumption that a significant number of premature deaths can be prevented with early intervention, the ACS recommends that, beginning at age 50, adults obtain a screening colonoscopy every 10 years.[2] In 2008, ACS and a number of interested medical groups added CTC to the list of preferred screening tests, with the recommendation that CTC be performed once every 5 years for asymptomatic adults over 50 years of age.

Currently, less than half of adults 50 years of age and older obtain screening colonoscopies. CRC screening varies considerably, demographically and geographically. New England, the upper Midwest, and east and west coast states report higher screening rates than the rest of the country; urban areas have higher rates than rural communities. Demographically, affluent, educated, and insured populations have higher rates than poor, undereducated, and uninsured populations, regardless of geographic location. More than three-fourths of uninsured adults over 50 years of age have never had a screening colonoscopy. CRC screening rates are, on average, 15 to 20 percentage points below prostate and breast cancer screening rates.




More than 80% of optical screening colonoscopies produce negative results (no detectable/excisable growths). Consequently, should CT colonography become the preferred CRC screening test, it has the potential of reducing demand for optical screening colonoscopies. An early study suggested that the number of screening optical colonoscopies could decrease by nearly 30% if CTC becomes the primary screening tool.[3] The growing acceptance of, and broader payment for, the procedure suggest that the reduction could be greater. For every five to six asymptomatic adults referred for screening CTC, on average, only one person subsequently is likely to be referred would be referred for optical colonoscopy and treatment.

An essential planning task is to make the introduction of CT colonography, and the transition from optical colonoscopy screening to CTC screening, as smooth and efficient as possible.

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# Massachusetts Health Reform: An Update

*Mara H. Yerow*

On April 26, 2006, Massachusetts signed into law its landmark health reform legislation, described as an act providing access to affordable, quality, accountable health care.[1] The legislation provided for a three-year phase-in of health reform. At the time, a study by the Urban Institute estimated that 12 percent of the state's population of approximately 6.4 million was uninsured. The goal of the law is to provide near-universal coverage of the Massachusetts population. Components of the plan include individual mandates, employer requirements, insurance market reforms, and preservation of a safety net.

The Act required all adults in Massachusetts (who can obtain affordable health insurance) to purchase health insurance by July 1, 2007. Individuals not having health insurance would receive financial penalties imposed through their income tax filings and the penalties increase each year as the law becomes fully implemented. In 2007, individuals without health insurance lost their personal income tax exemption ($219).

Second, employers of 11+ full-time equivalent employees in Massachusetts are required to make a fair and reasonable contribution toward coverage for full-time employees or pay a Fair Share Assessment of up to $295 annually per employee. They also must offer both full-time and part-time employees a pre-tax, payroll deduction plan for their own health insurance premium payments, or face a surcharge if employees make excessive use of uncompensated care.

Non-group and small-group health insurance markets are merged to effectively lower the price and offer more choices for individuals purchasing unsubsidized coverage on their own.

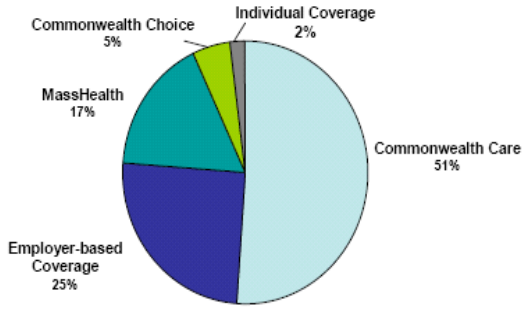
To accomplish the goal, several key actions were initiated:

- Expansion of MassHealth (Medicaid);
- Restructuring of the state Uncompensated Care Pool (UCP) into the Health Safety Net (HSN); and
- Establishment of a quasi-state agency, the Commonwealth Health Insurance Connector Authority (The Connector).

The Uncompensated Care Pool was established by Universal Health Care Legislation in 1988 to reimburse hospitals for uncompensated care. Subsequently, the UCP was also charged with reimbursing community health centers (CHCs). The UCP was administered by the state's Division of Health Care Finance and Policy (DHCFP), one of the goals of which "is to improve access to health care for the uninsured and the underinsured residents" of the state. The UCP was used to pay for medically necessary care and emergency services not covered by other insurance.

As CHCs became covered by the UCP, attempts were made to shift hospital outpatient care to CHCs. With the 2006 legislation, the UCP was converted to a Health Safety Net Trust Fund that combines the previous UCP funds with other Medicaid funds including Disproportionate Share Hospital funds. MassHealth now screens all applicants for HSN coverage and a new fee schedule was developed to standardize provider reimbursements. The intent of the new legislation is that as more uninsured obtain coverage, uncompensated care will decrease and the funds will be shifted to subsidized programs.

**Distribution of Newly Insured Under Massachusetts Health Care Reform Plan**




**Estimated Number of Newly Insured – 340,000**

Massachusetts was able to extend its waiver with the Centers for Medicare & Medicaid Services (CMS) for continued support and funding of the Health Reform effort that involves a collaboration of nine state agencies in the purchasing, regulating and monitoring of health care services to promote improved access, coordinated reimbursement and coverage.

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### *Massachusetts Health Care Reform: An Update*

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The Commonwealth Health Insurance Connector Authority offers two programs that each provide a range of health plans for legal residents who are not eligible for other public or employer-sponsored health insurance in the following consumer categories:

- Completely subsidized, comprehensive health insurance to adults earning up to 150% of the federal poverty level;
- Substantial premium subsidies to people earning between 150% and 300% of the federal poverty level; and
- Completely subsidized comprehensive coverage to children of parents earning up to 300% of the federal poverty level.

**Commonwealth Care** is a subsidized program for adults who are not offered employer-sponsored insurance, do not qualify for Medicare, Medicaid or certain other special insurance programs, and who earn no more than 300% of the federal poverty level. Plans are currently available for between $39 per month and $116 per month for individuals. There are no monthly premiums for the children of adults covered by Commonwealth Care, as the children are covered by MassHealth (Medicaid).

2008 Affordability Standards

| Individuals | | Families | |
|---|---|---|---|
| Income Range | Monthly Premium | Income Range | Monthly Premium |
| $0 - $15,612 | $0 | $0 - $26,412 | $0 |
| $15,613 - $20,808 | $39 | $26,413 - $35,208 | $78 |
| $20,709 - $26,016 | $77 | $35,209 - $44,016 | $154 |
| $26,017 - $31,212 | $116 | $44,017 - $52,812 | $232 |
| $31,213 - $37,500 | $165 | $52,813 - $70,000 | $352 |
| $37,501 - $42,500 | $220 | $70,001 - $90,000 | $550 |
| $42,501 - $52,500 | $330 | $90,001 - $110,000 | $792 |
| $52,501+ | Affordable | $110,001+ | Affordable |

Note, the dark line denotes the income cut-off for Commonwealth Care eligibility.

**Commonwealth Choice** is an unsubsidized offering of six private health plans that were selected through a competitive bidding process and are available through the Connector to individuals, families and certain employers in the state. The six plans are offered directly through the Health Connector by six Massachusetts-based, non-profit health insurance carriers. Together, these plans represent about 90% of the commercial, licensed health insurance market. Each of the plans offered through the Health Connector by the six carriers may also be purchased directly from the individual carriers. The six private plans have received the Connector's "Seal of Approval" to offer a range of benefits options, grouped by level of benefits and cost-sharing at different levels. There is also a special, lower priced Young Adults Plan offering from the same six carriers, exclusively for individuals between the ages of 18 and 26.

Small employers with 50 or fewer workers are also able to purchase directly through the Health Connector's Contributory Plan.

The cost of Health Reform has not been inexpensive. In FY 2008, $472 million was budgeted for the Connector and spending was $628 million due to higher enrollment in various programs than projected. This suggests that the original federal estimate of 650,000 uninsured in Massachusetts was more accurate than the state estimate of 400,000. For FY 2009, $869 million was budgeted and current projections estimate spending will be approximately $800 million. Budget (not yet passed) figures for FY 2010 now range between $750 and $880 million.

Since its passage in 2006, the health reform program in Massachusetts has been quite successful. A November 2008 study by the state's the Division of Health Care Finance and Policy found only 2.6% of the population of 6.5 million remain uninsured.

MassHealth now provides coverage to more than 1,000,000 of the Commonwealth's residents. The state's total Health Safety Net payments dropped as a result of more residents being insured. From Payment Fiscal Year (PFY) 2007 to PFY 2008, total payments dropped from $671 million to $410 million, hospital payments went down from $620 to $373 million, and CHC payments decreased from $41 million to $37 million. Likewise, service and volume have declined as the insured are able to access preventive and outpatient health care services not paid for by the HSN. For Commonwealth Choice, the Connector's unsubsidized health plans, the premium increase for the most recent year was five percent (5%), unlike the double-digit increases experienced for other plans in the state.

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# Policy Perspective

*John Steen*

## Public Health Research Neglected

As reported in the previous issue of this newsletter, scientists are challenged to alert the world to the growing impact of climate change on health.[1] Governments need to see the problem as the greatest threat to public health in this century.

Reinforcing that message, Angela Mawle, CEO of the UK Public Health Association, speaking at the World Congress on Public Health in Istanbul in April, said:

> "It is imperative that the public health community across the globe speak truth to power and ensure that politicians act to avoid the environmental and health crises that are developing before their eyes." She also said that "swine flu and climate change are inextricably related. Both are the end results of unbridled economic growth, environmental degradation and industrial agricultural practices. When will we ever learn that prevention is better than cure?"[2]

But climate change is still being underplayed here. A new report[3] published in the journal of the U.S. National Institute of Environmental Health Sciences states that federal funding of health research related to climate change is estimated to be less than $3 million per year, an amount "inadequate to address the real risks that climate change poses for U.S. populations" and that needs to be expanded to more than $200 million per year. It notes that "the health sector currently has no model (software tool) that can be used at the National, State, and regional levels to project the health risks of climate change," and that "developing such a model has been identified as a high priority by state and local public health officials." It concludes that research "that is directly linked to protective action at the local level is a wise investment, consistent with the goals of restoring economic stability, justice and environmental quality, and reducing healthcare costs," and "the costs of investing in climate change and health research will be offset by reduced healthcare costs resulting from improved public health preparedness and optimization of mitigation and adaptation policies."

The report notes that in March 2007, Dr. Howard Frumkin, the Director of the Division of Environmental Hazards and Health Effects at CDC, stated that the "public health effects of climate change remain largely unaddressed."

What is fundamentally different about climate change is explained as follows:

> "Climate change is not a pollutant in the classical sense used in public health; it is projected to fundamentally alter the natural and manmade systems on which our society relies, including air, water, agriculture, and ecosystems. Responses to climate change may alter energy, transportation, and other systems required for our societies to function. The health risks of climate change may arise from changes in any of these systems."[4]

## Community Health Planning in New York State

The New York State Department of Health is calling on its local health departments and its hospitals to involve a wide range of organizations and community members in developing community health plans that identify and address problems that affect the health of New Yorkers. Each local health department will describe community needs and program initiatives in its Community Health Assessment Plan and Municipal Public Health Services Plan for the period 2010-2013. Each hospital will show how it will meet community needs in its Community Service Plan for 2010-2012.[5]

Community health assessment is a core function of public health agencies and a fundamental tool of public health practice. Its aim is to describe the health of the community by presenting information on health status, including epidemiologic and other studies of current local health problems, community health needs, health care and community resources. It seeks to identify target populations that may be at increased risk of poor health outcomes and to gain a better understanding of their needs, as well as assess the larger community environment and how that can help play a role in addressing the health needs of individuals in the community.

## The End of Public Health (Week)?

Just three days after Public Health Week (4/6-12) ended, the first newspaper articles appeared in California about a proposed state ballot initiative that would

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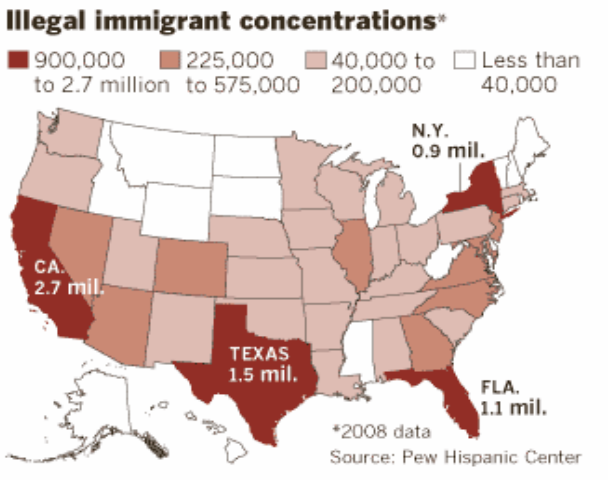
prohibit the children of undocumented immigrants from receiving public health and other benefits, and do so in a particularly divisive way by creating different classes of citizenship. (Illegal immigrants are not eligible for all public benefits,[6] but their citizen children are. Under the 14th Amendment, children born in the U.S. are citizens.) Calling themselves the "Taxpayer Revolution Group," its sponsors see it as necessary to deter illegal immigration. More rational Californians see it as discriminatory and unconstitutional. It should also be seen as the ultimate rejection of the very ethos that inspires public health, and of those values that created our nation out of immigrants. It has to be seen as evidence of the threat posed by "the culture wars" to solidarity, the sense of what we hold in common, the kind of "thinking" (i.e., hating) that threatens to tear our nation apart.




It is also reminiscent of the state's 1994 Proposition 187 that attempted to deny a public education to the same children. The latter was approved by almost 60% of state voters, but declared unconstitutional by a federal court.

Local public service budget constraints have already caused several counties in California to bar illegal immigrants from receiving nonemergency health care at county clinics. Neither federal nor state funding supports counties in providing these services, so they are funded out of local property tax revenues. The result adds to the burden of hospital emergency rooms, and creates new risks for local public health.

### Regionalization of Cancer Surgery

A study reported in the current issue of the American Cancer Society's journal[7] performed a statistical meta-analysis of 101 primary publications reporting 137 studies on surgical case volume and mortality for more than one million patients with six different types of gastrointestinal cancer (esophageal, gastric, hepatic, pancreatic, colon, or rectal). A significant volume-associated effect on mortality was found for five of the six cancer types (not rectal). Overall, each doubling of hospital case volume decreased the risk of short-term perioperative death by between 10% and 23% depending on cancer type. The authors calculated that between 10 and 50 patients per year, depending on cancer type, needed to be moved from a "low-volume" hospital to a "high-volume" hospital to prevent one additional volume-associated perioperative death. They failed to find a threshold volume effect, writing that "hospital volume appeared to be associated inversely with mortality across the volume spectrum in this analysis, and therefore the exact volume of cases that a hospital needs to manage to achieve acceptable outcomes remains a value judgment in most instances."

But not all of the studies found that relationship. One probable reason adduced by the authors for that is that outcomes may also depend on an individual surgeon's case volume, a factor not examined in most of those studies. A large center where many surgeons each do a low volume of procedures, for example, may have higher mortality rates than a small practice where a few surgeons have higher volumes for particular operations. And a high-volume surgeon may practice in more than one low-volume center. The authors found that higher volume per center and higher volume per surgeon each contributed to lower mortality, but they were unable to determine which was more important. However, they concluded that "on the basis of mortality outcomes alone, it appears prudent to support volume-based referral and high-volume centers."

### On the Relationship Between Volume and Quality

One of the many questions raised by the apparent improvements in patient safety attendant upon increased procedure volume, the relation between volume and quality of care, was addressed by researchers at the University of California, San Francisco and Baystate Medical Center at Tufts University in Massachusetts.[8] The research team examined how volume among individual

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surgeons, volume differences between hospitals, and differences in quality of care measured by adherence to quality measures, each differentially influenced outcomes following coronary artery bypass surgery. The study examined administrative, not clinical, data on 81,289 patients cared for by 1,451 surgeons at 164 hospitals in the U.S over a 23-month period in 2003-2005. They found that the best outcomes ensued when patient care teams strictly followed a routine of individual quality measures, independent of the volume of procedures performed. Study results suggested a strong association between the number of quality measures missed and mortality rates, and that the association held regardless of volume. They concluded that patients should make use of publicly reported quality measures and are likely to benefit from seeking care at hospitals with higher quality scores.

### Specialty Hospitals on a Level Playing Field

In an attempt to answer the question whether specialty hospitals weaken the financial viability and ability of general hospitals to play their role as part of a local "safety-net," the Center for Studying Health System Change (HSC) looked at the relationships between the two in three markets – Indianapolis, Phoenix, and Little Rock – between March and June 2008. This issue is a moving target in that Medicare reimbursement rates have been readjusted to better reflect the severity of patient treatment and to level the playing field in an effort to support competition based on price and quality.

The new HSC Research Brief[9] reports that the ability of general hospitals to compensate for the competition in various ways in the three markets has prevented "dramatic, adverse effects on the financial viability of general and safety net hospitals and their ability to provide care to financially vulnerable populations."

However, it concludes on a cautionary note:

> "In the context of the current economic recession, however, it is unclear whether general hospitals will be able to continue cost-shifting to private payers that must balance the demands for provider payment rate increases with employer-purchaser pressures to contain escalating health care costs and insurance premiums. General hospitals will likely experience an increased burden of uncompensated care as job losses in the worsening economy are accompanied by the loss of health insurance.
>
> … The continued effort by Medicare to accurately price inpatient services based on patient acuity will be integral to future policy regarding specialty hospitals.
>
> Moreover, it will be important for policy makers to continue to track the impact of specialty hospitals on the ability of general hospitals — more so than

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**The Pros and Cons of Specialty Hospitals**

| Pros | Cons |
|---|---|
| ▪ Drawing on the theory of focused factories, proponents contend that specialty hospitals can secure high volumes, thereby improving quality and reducing costs. | ▪ Specialty hospitals tend to treat lower- acuity, well-insured patients while avoiding uninsured and Medicaid patients. |
| ▪ Specialty hospitals may raise the bar for quality and encourage general hospitals to implement quality improvement strategies to compete effectively. | ▪ Opponents contend that specialty hospital competition threatens the ability of general hospitals to cross-subsidize less-profitable services and patients. |
| ▪ Specialty hospitals offer patients better amenities and achieve higher patient satisfaction. | ▪ Specialty hospitals may be unable to manage emergencies effectively as some do not have physicians on site at all times. |
| ▪ Specialty hospitals offer physicians greater control over management decisions affecting productivity and quality. | ▪ Ownership structure of specialty hospitals may encourage physician self-referrals and overutilization of services. |

Sources: Department of Health and Human Services: Office of the Inspector General, OEI-02-06-00310, *Physician-Owned Specialty Hospitals' Ability to Manage Medical Emergencies* (January 2008); Choudry, Sujit, Niteesh K. Choudry, and Troyen A. Brennan, "Specialty Versus Community Hospitals: What Role for the Law?" *Health Affairs*, Web exclusive (Aug. 9, 2005); Cram, Peter, et al., "Insurance Status of Patients Admitted To Specialty Cardiac And Competing General Hospitals: Are Accusations Of Cherry Picking Justified," *Medical Care*, Vol. 46, No. 5 (May 2008); Devers, Kelly, Linda R. Brewster and Paul B. Ginsburg, *Specialty Hospitals: Focused Factories or Cream Skimmers?* Issue Brief No. 62, Center for Studying Health System Change, Washington, D.C. (April 2003); Greenwald, Leslie, et al., "Specialty Versus Community Hospitals: Referrals, Quality, and Community Benefits," *Health Affairs*, Vol. 25, No. 1 (January/February 2006).

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safety net hospitals — to serve financially vulnerable patients and provide other less-profitable but needed services."

## Defining "Health Care Reform"

As planners, we all see that "health care reform" is a political label for renewal of the opportunity to create a national health care system. It must at a minimum be equitable and universal in its coverage. A key question we must answer in creating it is about the relationship between universality and equitability. Researchers in Harvard Medical School's Department of Health Care Policy have looked into this by examining the impact of Medicare coverage on the health outcome disparities of various demographic groups.[10] They found that for these groups between 1999 and 2006, gaps in disease control for people aged 40 to 85 either remained unchanged or widened. However, among individuals age 65 and older who were eligible for Medicare, the gaps narrowed substantially. The study supports the need for universal coverage to achieve equity. Among their findings of racial, ethnic, and educational gaps closing under Medicare coverage are the following:

- For systolic blood pressure, racial disparities decreased by 60%;
- For diabetes risk factors, educational disparities decreased by 83%, while racial and ethnic disparities fell by 78%;
- For total cholesterol levels, educational disparities disappeared altogether.

***"And most egregiously of all, all previous attempts to deliver a national health care system have totally ignored public health."***

— John Steen, in a presentation in a webinar sponsored by the Community Health Planning and Policy Section of the American Public Health Association.

[1] "Health & Climate Change: A Challenge to Scientists," *Health Planning TODAY*, 1st Quarter 2009.

[2] Source: UKPHA Press Release

[3] Kristie L. Ebi *et al*., "U.S. Funding Is Insufficient to Address the Human Health Impacts of and Public Health Responses to Climate Variability and Change," *Environmental Health Perspectives*, published online 27 February 2009; accessible at http://www.ehponline.org/members/2009/0800088/0800088.pdf.

[4] *Ibid*., p.24.

[5] Information about this state initiative is accessible at http://www.health.state.ny.us/prevention/prevention_agenda/.

[6] Federal law states that undocumented and illegal immigrants, and certain legal immigrants, including refugees and those seeking asylum, who have been in the United States for less than five years are not eligible for Medicaid, but the Emergency Medical Treatment and Active Labor Act states that any patient who presents to a hospital emergency department requesting an examination or treatment for a medical condition must be given an appropriate medical examination to determine whether he or she has an emergency condition. If an emergency is evident, the facility is obligated to provide treatment or transfer the patient to another hospital. Furthermore, the professional ethics of nurses requires them to provide emergency treatment regardless of payment or citizen status and to protect the confidentiality of that status. The five-year requirement makes it far more expensive for states to provide health care to these populations in that, unlike services for all others, there is no federal dollar-for-dollar match for such state spending.

[7] Russell L. Gruen *et al.*, "The Effect of Provider Case Volume on Cancer Mortality: Systematic Review and Meta-Analysis," CA Cancer J Clin 2009; 59: 192-211. Accessible at http://caonline.amcancersoc.org/cgi/content/full/59/3/192.

[8] Peter Lindenauer *et al*., "Shop for Quality or Volume? Volume, Quality, and Outcomes of Coronary Artery Bypass Surgery," *Annals of Internal Medicine* 150:10 (19 May 2009) pp. 696-704. Accessible at http://www.annals.org/cgi/content/abstract/150/10/696.

[9] *General Hospitals, Specialty Hospitals and Financially Vulnerable Patients*, Research Brief No. 11, April 2009. Accessible at http://www.hschange.org/CONTENT/1056/.

[10] J. Michael McWilliams *et al.*, "Differences in Control of Cardiovascular Disease and Diabetes by Race, Ethnicity, and Education: U.S. Trends From 1999 to 2006 and Effects of Medicare Coverage," *Annals of Internal Medicine* 150:8 (21 April 2009) pp.505-515. Accessible at http://www.annals.org/cgi/content/full/150/8/505.

## *Virtuous Planning … Virtually*

*Continued from page 4*


### *Market, Economic Interests*

With an estimated 94.1 million people in the U.S. 50 years of age and older in 2008, CRC screening is not just a preventive health question of consequence.[4] It is big business and highly profitable. The CRC screening colonoscopy market already exceeds $10 billion annually. It has the potential to grow by more than half over the next decade.

With or without CTC, and any associated increase in CRC screening rates, the CRC screening market will grow steadily for the next two decades, as the "baby boom" generation ages. Recent estimates suggest that about 14 million colonoscopies, and between 2 and 3 million sigmoidoscopies, are performed annually. The number of sigmoidoscopies is in significant decline, in favor of full optical colonoscopies.[5] Fewer than half of the colonoscopies performed are for CRC screening. With widespread use of CTC, the market could reach 10 million annually.

Over the last two decades much of the endoscopy market, including screening colonoscopies, has migrated from community hospitals to surgery centers and private physician offices. CRC screening colonoscopies are now provided in three settings: private physician offices, surgery centers, and community hospitals. A noticeable shift from optical colonoscopies to CTC will add diagnostic imaging centers to the mix. This poses a serious challenge to gastroenterology endoscopy centers, surgery centers, and community hospitals.

Where available, gastroenterologists now do most screening colonoscopies. Surgeons and general practitioners do most of the procedures where specialists are not available. The advent of CTC opens the field to radiologists. To the extent CTC becomes the preferred screening tool, the balance could shift decisively to radiologists and imaging centers.

The battle for the CTC market is already underway. It promises to intensify. Those who now have high speed CT scanners (16 slice or faster) have an initial advantage. Recognizing this, entrepreneurs are entering the field, offering gastroenterologists artfully structured multi-tiered corporate arrangements which, through the helpful opacity and pliability of interrelated limited liability corporations (LLCs), enable them to acquire and operate CT scanners and avoid running afoul of Stark self-referral and anti-kickback restrictions. One such entity, Colon Health Centers of America, LLC, already operational in Newark, Delaware, and coming soon to Philadelphia, PA, has trademarked the term Integrated Virtual Colonoscopy™ ("the most progressive and patient-friendly CRC screening available"), as part of its strategy to enlist gastroenterology centers in its network.[6]

**Ready For Your Virtual Colonoscopy Closeup?**

When suspicious growths are detected in a virtual colonoscopy, patients must undergo a standard colonoscopy to have them removed. At some medical centers, this conveniently can be done the same day.

| Hospital or clinic | Price | Standard colonoscopy available same day, if needed |
|---|---|---|
| **Invision Sally Jobe** Denver | $800 | Limited availability |
| **Johns Hopkins Hospital** Baltimore | 1,000 | Coming in January |
| **M.D. Anderson Cancer Center** Houston | 1,500 | Yes |
| **Virginia Commonwealth University Medical Center** Richmond, Va. | 750 | Yes, same-day referral to nearby endoscopy center |
| **Mayo Clinic** (Rochester, NY, and Scottsdale, Ariz.) | 1,400-1,500 | Possibly; ask when booking an appointment |
| **Ronald Reagan UCLA Hospital** Los Angeles | 505 | No |
| **University of Chicago Hospital** Chicago | 1,153 | Yes |
| **University of Wisconsin Hospital** Madison | 1,200 | Yes |
| **Beth Israel Deaconess Medical Center** Boston | 1,017 | Yes, starting this week |

**Source: Wall Street Journal Research, October 28, 2008.**

### *Planning Opportunities*

The contest for the CTC market offers planning opportunities. Planners should try to ensure that those proposing to offer CTC, especially those considering establishing new CTC services with dedicated CT scanners, understand and take into account the following considerations:

- ***Community CRC demography***: Reliance on national data and averages is inadvisable. The size, composition, and location of the at-risk population – the target screening population – varies from community to community.
- ***CRC incidence and mortality***: Data are available for nearly all communities to assess the relative risk of CRC in that Community. Service area spe-

*Continued on page 12*

## *Virtuous Planning … Virtually*

*Continued from page 11*

cific analysis can identify high risk populations and target screening and treatment programs.

- ***Early detection rates***: The stage at which CRC is detected varies among and within communities. Rather than rely on national data, estimates, and assumptions, local data should be analyzed.
- ***Community CRC screening levels***: Screening levels vary widely. Most of the screening data reported are estimates of questionable reliability, usually derived from Behavioral Risk Factor Surveys. Local colonoscopy procedure volumes and rates, though difficult to document, are needed to permit meaningful analysis of local markets and to determine community need.
- ***CRC screening rates are range bound***: CRC screening rates are well below those for prostate and breast cancer, which range between 65% and 80% of the target population in most communities. Even with wide application of CTC, it is unlikely the CRC screening levels will exceed rates for other conditions. Projected demand should reflect this underlying reality. Beware of entrepreneurs who plan to screen the entire at risk population. Under the best of circumstances the response to increased CRC screening efforts will be asymptotic.
- ***Procedure time differential***: Understand and take fully into account the procedure time differential for CTC and optical colonoscopy. This is essential for rational planning of services planning to offer same session optical colonoscopy for those with positive CTC findings.

Planners should be especially active in facilitating, and where possible insist upon, cooperative arrangements between local gastroenterologists and radiologists. Such arrangements would help avoid wasteful capital investment in unnecessary CT scanners. Given the current diffusion of high-speed CT scanner technology, there is likely to be little, if any, justification for the addition of high-speed CT scanners to gastroenterology offices in order to make CTC readily and conveniently available.

[1] The principal risk with optical colonoscopy is intestinal puncture, resulting in the need for open surgery to prevent systemic infection, which can result in death. The serious intestinal injury rate is estimated to be between 0.01 and 0.03 percent, or between 1 and 3 patients per 1,000 colonoscopies. The principal arguments against CTC are that it increases radiation exposure and it may produce clinical data for other body organs and tissues that lead to additional tests and higher medical costs in the aggregate.

[2] Less sensitive tests, e.g., sigmoidoscopy, barium enema, fecal occult blood tests, are recommended more frequently for some and for those not getting screening colonoscopies. Colonoscopies are recommended at more frequent intervals for high-risk individuals.

[3] C. Hur, M.E. Gazelle Zalis, and D.K. Podolsky, "An analysis of the potential impact of computed tomographic colonography (virtual colonoscopy) on colonoscopy demand," *Gastroenterology*, 2004 November; 127(5):1312-21.

[4] Nearly 60% (55.2 million) of the population over 50 years of age are between 50 and 64 years. About 35% are between 65 and 84 years of age. The U.S. Preventive Services Task Force (USPSTF) does not recommend routine CRC screening for asymptomatic adults between 76 and 85 years of age, and recommends against screening in the population over age 85. See U.S. Preventive Services Task Force (USPSTF), *Screening for Colorectal Cancer Recommendation Statement*, AHRQ, 2008 October; http://www.ahrq.gov/clinic/uspstf08/colocancer/colors.htm

[5] L.C. Seeff, T.B. Richards, J.A. Shapiro et al., " How many endoscopies are performed for colorectal cancer screening? Results from CDC's survey of endoscopic capacity," *Gastroenterology*, 2004 December; 127(6):1670-7.

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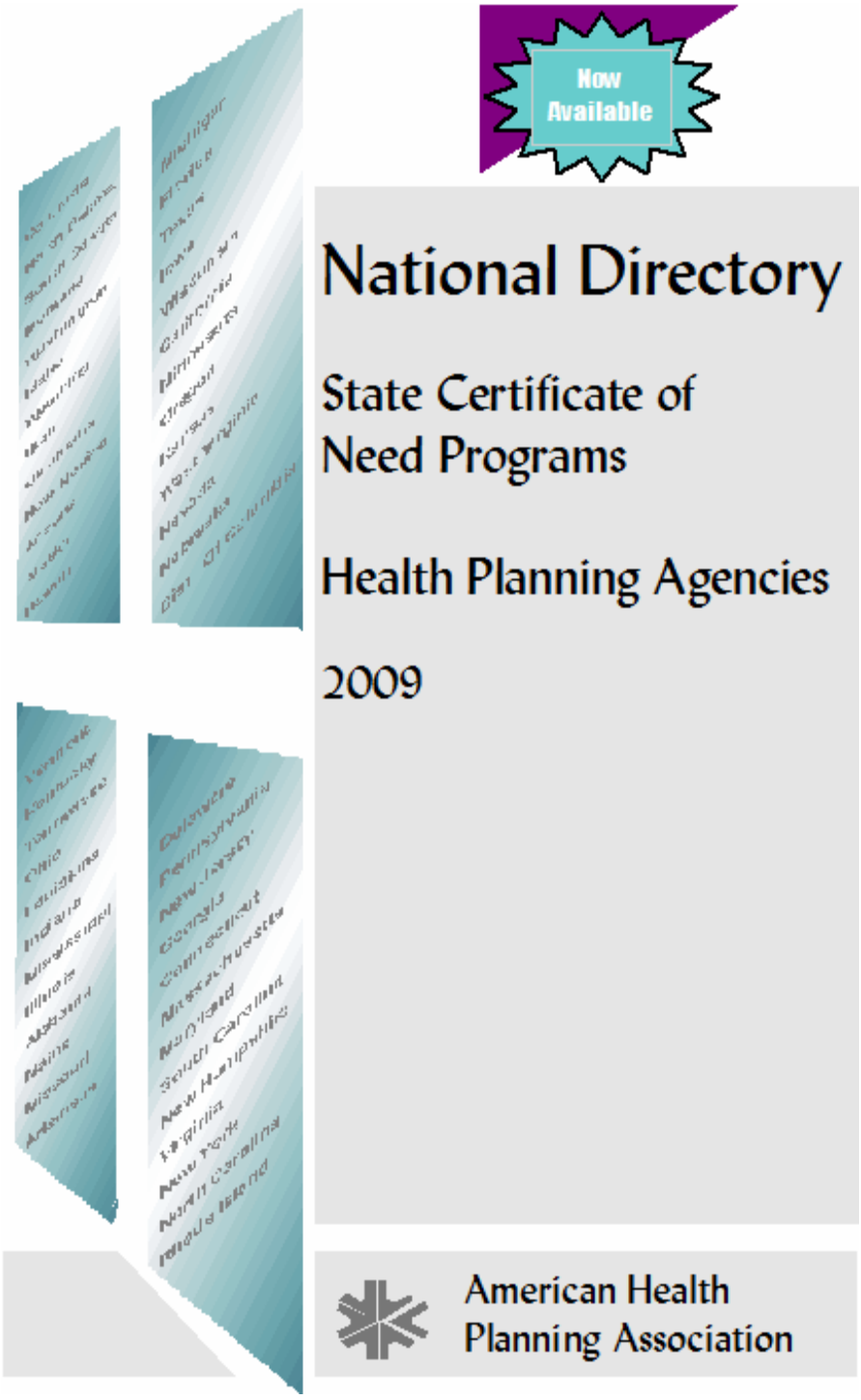
## *Massachusetts Health Care Reform: An Update*

*Continued from page 6*

Like other states, Massachusetts is iaffected by the current economic climate, but the state remains committed to the Health Reform effort and maintaining existing health care services in the state. The Governor has committed a portion of the federal stimulus fund received to health care, which will include $225 million to restore or prevent cuts in eligibility for services faced with increasing enrollment due economic circumstances of the population. Use of stimulus funds will increase the Federal Medicaid Assistance Percentage for Massachusetts from 50 percent to approximately 60 percent. Some stimulus funds will also be used to protect the Health Safety Net.

Health reform in Massachusetts has been successful and is a model that merits consideration and study by others. Areas that remain to be addressed in Massachusetts are affordability and cost control.

[1] Chapter 58 of the Acts of 2006.




**AHPA released the 2009 edition of the *National Directory: State Certificate of Need Programs and Health Planning Agencies* in June 2009. The table of contents and ordering information are available on the Association's website: www.ahpanet.org.**

## Save the Date

**October 8 and 9, 2009**
Hyatt Regency Crystal City • Arlington, Virginia

# Symposium on **Quality Improvement** to **Prevent Prematurity**

This Symposium will explore the present state of quality initiatives to prevent preterm birth and develop an agenda for action to decrease the rate of those preterm births that are not inevitable or medically necessary. The Symposium will bring together a multidisciplinary group of health care Practitioners, health insurers, policymakers, health purchasers, regulators, and concerned citizens to discuss quality improvement as an essential component in the strategy to prevent prematurity, promote health and save costs. It will be a forum where experts and stakeholders can share ideas and challenges, describe model programs that have successfully improved the nature and quality of patient care and services targeted to prematurity prevention, and recommend quality improvement action plans.

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