Approved 2-17-83
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE

The meeting was called to order by Marvin Littlejohn at
Chairperson

1:30 ~~a.m.~~/p.m. on February 15, 1983 in room 423-S of the Capitol.

All members were present except:

Committee staff present: Emelene Correll, Research Department
Bill Wolff, Research Department
Bruce Hurd, Revisor's Office
Sue Hill, Secretary to Committee

Conferees appearing before the committee:

Carl Ossmann, former Legislator
Ms. Nadine Griffin, Health Systems Agency of Northeast Kansas (HSANK)
Melissa Hungerford, Kansas Hospital Association
Robert L. Goolsbee, M. D. of Day Surgery, P.A., Kansas City.
Don Flora, Day Surgery, P. A., Kansas City.
Richard Friedeman, Attorney, Great Bend, Kansas.

Visitor's register, see (Attachment No. 1.)

Chairman called meeting to order.

Fiscal note on HB 2105 was distributed to committee. (Attachment No. 2.)

Chairman noted that HB 2096 automatically comes off the table since this date is day certain for the motion made in a prior meeting. A motion had been made to table this bill until an amendment could be drawn to bring SRS back into investigative service. A balloon copy of this bill was distributed to committee, see (Attachment No. 3.).

Rep. Friedeman moved to have the amendment be added to HB 2096, as shown on balloon attached, at line 28, saying, The Court may use the department of Social and Rehabilitation Service to make the investigation and report if no other source is available for that purpose. The motion was seconded by Rep. Kline. Discussion followed. Committee then voted on this motion, and motion carried.

Rep. Niles moved for a conceptional amendment to read, the costs of investigation would be paid by the litigant. Motion seconded by Rep. Helgerson. Discussion on set costs by Courts, etc. Then a voice vote taken, and the conceptional motion was approved.

Hearings on HB 2014 began:---

Conferee Carl Ossman discussed how costs have increased over the years. Main view voiced by Mr. Ossman was that he feels new concepts should be considered in the language of the bill as it is acted upon now. Questioned has the CON really worked? Felt CON had contributed to rising health care costs.

Ms. Nadine Griffin, distributed a printed statement, see (Attachment No. 4.), outlining views of the Health Systems Agency of Northeast Kansas. Ms. Griffin cited needs for passage of this bill. Stressed that in-put coming from a local level on CON is vital. Health Systems helps in this manner by adapting guide-lines and standards so they can make sense to people at the local level.

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S, Statehouse, at 1:30 a.m./p.m. on February 15, 1983

Hearings on HB 2014 continue:--

Mr. Barretta-Vega replied along with Ms. Griffin to some of the questions put to her testimony.

Mr. Ron Schmidt also replied to questions at this point.

Melissa Hungerford from Kansas Hospital Association spoke briefly responding to statements made last week regarding practices at the Central Kansas Medical Center, Great Bend. She replied to a comment that elective surgeries and critical surgeries are not integrated. Patients are now separated. Further, Saturday surgeries are not done because the physicians involved have elected to have no Saturday surgery.

Ms. Hungerford commented, they feel that CON should be applied equally. If some have to operate under it, then all should be required to do so. They are concerned with the theory that ambulatory surgery can be provided at half the cost as some have stated. Ambulatory surgery is not required in hospitals she said, tho most hospitals in the state do provide this service.

Dr. Goolsbee, representing Day Surgery, P.A. in Kansas City offered a printed statement to committee, see (Attachment No. 5.)

Dr. Goolsbee spoke in favor of the CON, but in addition to the specifications currently required, stated that a terrible rise in medical/health care costs are of grave concern. Proposes that ambulatory surgery can be done much less expensively in free standing surgery units. Stated 50% of all surgery regularly being done on an in-patient basis 8 years ago could be done on an out-patient basis today. Further, real savings to the patient is when they can be treated in an ambulatory facility and released much quicker than in a hospital situation.

Dr. Goolsbee replied to some very difficult questions, and was very candid with his answers. For further details see his attachment No.5.

Mr. Don Flora, representing Day Surgery, P.A. in Kansas City supports the continuation of the CON. Further feels though that the way the CON is now structured is more punitive than positive. At this point is restricting new and inovative plans and services. It could and should permit creative inovative practices rather than being punitive. He supports the continuation of the CON, only until such time as the legislature and the third party payers are able to find a way to bring market forces to bear in the health care field.

Richard Friedeman, Attorney from Great Bend commented that the way the CON now reads, if parties wish to spend money to build a facility for health care to Kansan's why are they stopped? Why should someone else determine for you if this would be a wise expenditure or not? Those he represents feel very strongly about this and he reviewed their concerns with the CON as it is now written.

Mr. Friedeman commented that Blue Cross/Blue Shield is doing away with their cost-base reimbursement program as of the first of 1984, and are implementing a (MAPP) Maximum Approved Payment Plan, and this is of great concern that it will bring problems because of the time element involved, since it will be upon us by early next year. High percentages of Ambulatory Surgical Centers are denied CON, and other heal care centers are not. What is going on?

Hearings on HB 2014 concluded.

Meeting adjourned at 3:05 p.m.

Date: 2-15-83

GUEST REGISTER

HOUSE

LETTER

PUBLIC HEALTH AND WELFARE

Please ~~PRINT~~

NAME	ORGANIZATION	ADDRESS
Robert L Goolsby M.D.	Day Surgery P.A.	Mission Hills Ks
M. G. Kurby, M.D.	CKMP	Great Bend, Ks.
Richard L. Sandoval	Central Ks. Medical Tech	Great Bend, Ks.
CARL OSSMANN	SELF	TOPEKA.
STEVE SEYB	13th JUDICIAL DISTRICT	EL DORADO, KS
Marjorie Van Buren	Office of Judicial Administration	Topeka
ERIC W JOHNSON	SELF	TOPEKA
Guillermo Barreto-Vega	HSANEK	Topeka
DON FLORA	DAY SURGERY P.A.	MISSION HILLS KS
Ron Schmidt	KDH&E	Topeka
Joe Hollowell	"	"
Aileen Whitsill	SRS	Topeka
Rebecca Kupper	KHA	"
Harold Reifschneider	Central Kansas Medical Center	Great Bend, Kansas
Melissa Hungerford	Ks Hosp. Assn.	Topeka
Nadine Griffin	~~RR#3 Abilene~~ HSANEK	RR#3 Abilene
MICHAEL RODE	SELF	TOPEKA

(attachment no. 1.)

2

96 | 2105
Fiscal Note | Bill No.
1983 Session
February 14, 1983

The Honorable Marvin L. Littlejohn, Chairperson
Committee on Public Health and Welfare
House of Representatives
Third Floor, Statehouse

Dear Representative Littlejohn:

SUBJECT: Fiscal note for House Bill No. 2105 by Committee on Public Health and Welfare

In accordance with K.S.A. 75-3715a, the following fiscal note concerning House Bill No. 2105 is respectfully submitted to your committee.

House Bill No. 2105 amends K.S.A. 65-2422 to require the state registrar, Kansas Department of Health and Environment, to provide, without charge, certified copies of birth certificates and paternity consent forms to the Department of Social and Rehabilitation Services. The Department of Social and Rehabilitation Services would utilize the material as evidence for investigating and establishing paternity. The bill becomes effective upon publication in the state register.

The state registrar, Kansas Department of Health and Environment, estimates that 7,500 certified copies of birth certificates and paternity consent forms would be provided on an annual basis. The cost to the Kansas Department of Health and Environment to provide these copies is estimated at $5,330. For FY 1984, these costs could be financed from the vital statistics fee fund of the Kansas Department of Health and Environment. If not such expenditures would be financed from the State General Fund. Any expenditures which might arise from the passage of this bill would be in addition to amounts contained in the 1984 Governor's Budget Report.

Richard E. Koerth
Senior Budget Analyst
For the Director of the Budget

REK:dh

(Attachment no. 2.)

5

Session of 1983

HOUSE BILL No. 2096

By Committee on Public Health and Welfare

(By request)

1-25

AN ACT concerning domestic relations; relating to child custody investigations; amending K.S.A. 1982 Supp. 60-1615 and repealing the existing section.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 1982 Supp. 60-1615 is hereby amended to read as follows: 60-1615. (a) *Investigation and report.* In contested custody proceedings, the court may order an investigation and report concerning custodial arrangements for the child. The investigation and report may be made by court services officers; ~~the department of social and rehabilitation services~~ or any consenting person or agency employed by the court for that purpose.

The court may use the department of social and rehabilitation service to make the investigation and report if no other source is available for that purpose.

(b) *Consultation.* In preparing the report concerning a child, the investigator may consult any person who may have information about the child and the potential custodial arrangements. Upon order of the court, the investigator may refer the child to professional personnel for diagnosis. The investigator may consult with and obtain information from medical, psychiatric or other expert persons who have served the child in the past without obtaining the consent of the parent or the child's custodian. If the requirements of subsection (c) are fulfilled, the investigator's report may be received in evidence at the hearing.

(c) *Use of report and investigator's testimony.* The court shall make the investigator's report available prior to the hearing to counsel or to any party not represented by counsel. Any party to the proceeding may call the investigator and any person whom the investigator has consulted for cross-examination. In consideration of the mental health or best interests of the child, the court

Attachment No. 3.

~~3~~ 4

HEALTH SYSTEMS AGENCY

OF NORTHEAST KANSAS

TESTIMONY ON

HOUSE BILL 2014

PRESENTED TO THE

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

STATE CAPITOL, ROOM 423 S

TOPEKA, KANSAS

FEBRUARY 15, 1983

(attachment no. 4.)

Good Afternoon, Mister Chairman Littlejohn and members of the House Public Health and Welfare Committee. My name is Nadine Griffin, farmer, housewife and President of the Board of Directors of the Health Systems Agency of Northeast Kansas (HSANEK) and a member of the SHCC. I am testifying today as the President of the Board Directors of the HSANEK, of which some of you are familiar with, but for those of you who are new members of the committee, the HSANEK is a non-profit organization with a 50 member volunteer Board of Directors that serves the health plan development needs of a twenty-five county area in Northeast Kansas. The volunteer Board of Directors has 25 representatives appointed by each County Commission and the remaining Board members come from a wide range of rural and urban community groups and organizations.

One of the health planning functions of the HSANEK is to guide the development of the health care delivery system, through the Certificate of Need (CON) program, in such a manner that appropriate facilities, affordable health care and quality health care services are available to the residents of Northeast Kansas.

In view of the primary concerns of the HSANEK, I appreciate this opportunity to present the following testimony on H.B. 2014 concerning Certificates of Need for health care facilities.

A brief explanation of the dynamics of the health care market will facilitate an understanding of the Kansas CON Program. Health care costs in Kansas and the United States are rising too fast. While inflation has been contained in some aspects of our economy today, health care and related service costs are outstriping general inflation in an alarming fashion. For example the American Hospital Association's newsletter, Hospital Week, indicated that in December, 1982 overall Medical Care Inflation was 11% and the general inflation rate in the rest of the economy was 4.6%.

Economists have identified several requirements for a smoothly functioning market. These requirements describe the behavior of buyers and sellers in the marketplace itself. There are five broad characteristics of a market economy:

o First, buyers responsibility for the financial consequences of their actions

o Second, buyer knowledge concerning the product and the price of the product

o Third, sufficient sellers to provide the buyer a range of choices

o Fourth, freedom for sellers to enter and leave the market in response to financial considerations and

o Fifth, limiting size of single buyers or sellers to prevent their actions from influencing price.

How does the health care market fit these characteristics?

o First, the predominant methods for financing health care in the United states, which have evolved over the past 40 years, were designed to isolate consumers from the financial consequences of illness. All health insurance is based on the principle of spreading the risk of expensive care across a broad spectrum of the population. The insurance mechanism has placed a buffer between the individual and excessive medical expense, but it has also removed price as a consideration in using medical services. This problem is made worse because insurance premiums, which would reflect cost increases, are often paid by employers. Thus the consumers are again removed from the financial consequences of their decisions. Consumer consciousness of cost is further diluted by the consumer's isolation from decisions affecting costs. In purchasing medical care, unlike most purchases in our economy, the

consumer turns over financial decision-making to a provider. It is the physician who makes decisions concerning use of diagnostic tests, type of medication, and use of expensive health care facilities.

A second, another major deficiency in the health care economic system is in consumer information. The consumer has minimal opportunities to make judgements concerning quality, price and usefulness of medical care product. The consumer's only real decision is selection of a provider. After that selection is made, the provider is the major economic decision-maker. The consumer is also poorly prepared for the task of selecting a provider. There is little objective information available concerning relative merits of individual or institutional providers. The ethical constraint on medical advertising (which recently was dropped by the AMA) has been another factor in maintaining a relatively uninformed medical care consumers.

The third characteristic, number of sellers, is also constrained in the health field. In areas where there are adequate or even excessive numbers of sellers, there is still no real price competition. Indeed, there is some evidence that prices go up under such circumstances as providers attempt to maintain incomes with a smaller pool of patients. In other areas there are inadequate numbers of sellers, thus precluding a competitive market. This is true in many rural areas where only a single hospital or a single physician is available.

Fourthly, both market entry and market exit are restricted in the health sector. Individuals and institutions which propose to deliver medical care are subject to licensing or approval by state government. These requirements, originally designed to maintain high standards, also have the effect of restricting the number of individuals in the field. They may also restrict

the kinds of things one can do even though licensed, reserving certain tasks to particular categories of health workers. In addition to licensing or approval requirements, establishment of new health facilities is further restricted by the high costs of developing a facility and by requirements that capital expenditures take place only where a need can be demonstrated. On the exit side, the financing mechanism is structured so that an underutilized or inefficient institution can be "propped up" through reimbursement for the costs of maintaining unused services.

For the fifth characteristic: ability of single buyers or sellers to influence the market because of size, the health care system again falls short of ideal circumstances. In many communities, there may be only a single physician or hospital, and in such cases, the influence over the price can be substantial.

The medical care economic systems fails to meet the characteristics of a market economy in all five definitional areas: consumer responsibility; consumer knowledge; sufficient number of sellers; free entry and exit; and degree of influence over price by single providers. As a result, the existing medical care market is defective. Its defects underlie the costs problems experienced in the medical care sector.

Experience with other sectors of the economy, where economic principles do not maintain a market, and therefore control supply or price, suggest two broad types of solution strategies: applying external controls or restoring competition.

Until recently, most attention has been turned to regulation as a mechanism for compensating for these economic weaknesses in the medical care market. Regulation in the medical care market, through the CON program, has been pursued as a substitute for absent market forces.

Currently, the CON thresholds are $600,000 for Capital expenditures, $400,000 for major medical equipment, and $250,000 for annual operating budget of a new health service.

Since it's inception in Northeast Kansas in 1977, the CON program has had a definite impact on health care costs. The attached Table displays for you this impact. The Table reflects, on an annual basis and in total for the six years of the program, the dollar amounts withdrawn, the dollar amounts denied, and the dollar amounts approved. In essence, approximately 22%, or in excess of 16 million of a proposed 76 millon dollars, in expenditures of health care dollars has not been added to the costs of our already overburdened health care consumer.

The Certificate of Need (CON) process is an attempt to define the health care needs of a community within the limits of available resources and through this definition to maximize cost efficient health care for the consumer and the provider.

An idea is conceived by a group of people or an institution, which under current law may require a CON. The party or parties involved submit a formal document known as a Letter of Intent. The state agency will determine after consulting with the appropriate health systems agency if the project requires a CON and will notify the sponsor and the health systems agency.

The sponsor then schedules a preapplication conference with the health systems agency at which time an explanation of the CON procedures is given, along with the review objectives and criteria. This part of the process is simply an aid to the applicant in the process of application preparation and to point out to the applicant the rationale by which the proposed project will be evaluated.

The applicant is provided by the State Agency with an application form and instructions and must submit the application for completeness review by the second Monday of the month. It is reviewed by the health systems agency and the state agency with the aim of seeing if the application has the information necessary to reach findings. When the application is found to be complete, it is considered filed on the fourth Monday of the month it is submitted.

The filing of an application on the fourth Monday begins what is referred to as a 90 day review cycle.

The health systems agency notifies all directly affected parties that the application is filed and a staff analysis of the application is prepared by HSA staff, for the Plan Implementation Committee of the Board. A Public hearing is held by the Plan Implementation Committee in which proponents and opponents of the project have an opportunity to respond to the staff report or the application, and to present additional evidence. The public hearing is the official record for the application.

The Plan Implementation makes its determination and recommendations based on the official record which includes the application, the staff report and supporting evidence submitted by the staff, all written comments and evidence submitted to the HSA, all testimony presented at the public hearing and any relevant criteria and standards for review in addition to those of the State agency if any.

The findings of the Plan Implementation Committee are reviewed by the Board and the Baord will recommend a Certificate of Need be approved, disapproved, or approved with modifications.

The State reviews the application and the review record submitted by the health systems agency and may hold an additional public hearing for good cause

shown, but shall issue within 90 days from the filing date an order to approve, approve subject to modification, or deny the application. After the decision is rendered by the State agency a 30 day period is allowed for requests for reconsideration of the decision or appeals of the decision.

In summary, the CON program will benefit Kansans by ensuring that the appropriate needed facilities, affordable health care and quality health care services are available to both rural and urban communities, in the absence of market forces. Therefore, the HSANEK strongly supports the passage of H.B. 2014.

I would like to thank you for the opportunity to provide this testimony. I will be happy to respond to any questions that you may have.

CERTIFICATE OF NEED PROJECTS:
AMOUNTS WITHDRAWN, AMOUNTS DENIED, AMOUNTS APPROVED
IN HEALTH SERVICE AREA II, 1977-1982

Year	Project Amount Withdrawn	Amounts Denied HSAII	Amounts Approved HSA II
1977	$ 1,005,200	$ -0-	$ 7,650,000
1978	4,250,000	2,086,000	10,727,000
1979	1,820,000	-0-	28,423,123
1980	35,000	1,100,875	3,225,924
1981	3,461,202	400,000	6,198,550
1982	1,700,000	500,000	3,410,475
	$12,271,402	$4,086,875	$59,635,072

SOURCE: Health Systems Agency of Northeast Kansas

OUTLINE OF TESTIMONY REGARDING CON LEGISLATION

FEBRUARY 15, 1983

Robert L. Goolsbee, M.D. Mission Hills, Kansas 22 years

Board Certified Anesthesiologist
Graduate of the University of Texas Medical School, Galveston 1955
Interned at Kansas City General 1956-57
Medical Director of Surgicenter of Kansas City (5 years)
Former member MACPA and MAHSA, Kansas City Area, representing Jackson County Medical Society
Member Board of Directors of Freestanding Ambulatory Surgery Association (100 independent surgery centers throughout the United States)

Representing Day Surgery, P.A., a Kansas Corporation established in 1975

Testifying in SUPPORT of CON legislation recommending one (1) change.

The Problem:

The cost of medical care (all segments) to individuals in Kansas is too high!

Hospital per diem (average daily cost over 1 year)

$ 150 in 1975 rapidly approaching

$1000 in 1984. (verbal reference-John Barnard, President St. Lukes Medical Staff)

Reasons:

1) too many hospital beds (7+/1000)

2) too many hospital operating rooms (utilization 40-60%)

3) overutilization of all services

   a) 50% of all surgery regularly being done on an inpatient basis (two or more nights in the hospital) in 1975 can be done on an outpatient basis today.

   b) current reimbursement incentives (cost based/Blue Cross and Medicare = 80% of all patients) lead to overutilization of all services.

   c) the present practice of cost shifting in hospitals disguises the true cost of a given service and confuses the patient leading to easy and accepted overcharging.

(Attachment No. 5.)

d) no price competition among hospitals

e) no incentive for hospitals to offer services which take patients out of beds.

Comment:

The CON process in Kansas has directed its attention and justified its decisions based on statistics such as the number of beds and the number of operating rooms and the number of CAT scanners etc. as directed by current law. There has been little flexibility allowed by law to consider innovative alternative methods of health care delivery.

Everyone agrees that an empty hospital bed costs the State of Kansas citizens less money than an occupied bed (no nurses, food, "drugs", sheets, meals, lab tests, etc.).

Ambulatory surgery centers get patients out of hospital beds!

Recommendation:

1) Continue the current CON legislation until such time as a prospective reimbursement plan (DRG) for hospitals (or a cost cap) is in place for all third party payers (example: New Jersey).

2) Provide for a 4th category in the current law for freestanding (defined by Medicare Law) ambulatory surgery centers.

Comment:

A precedent has been set. 1) Hospital and 2) Nursing Home categories were expanded 3) HMO's.

This would allow CON staff members to consider only ambulatory surgery centers in their statistical analysis and open an otherwise closed opportunity in areas with overbedding and too many operating rooms and encourage the development of inexpensive cost-effective and competitive alternatives to traditional inpatient medical care. This will save the community as a whole significant medical care dollars.

Example:

One surgery center doing 5,000 cases per year that would otherwise have been done on an inpatient basis (one day before surgery and one day after) would save a community $4 million dollars a year plus the loss of time (1st day) to the patient.