Approved March 23, 1983
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Senator Jan Meyers at
Chairperson

10 a.m./~~p.m.~~ on March 22, 1983 in room 526-S of the Capitol.

All members were present except:

Senator Bogina

Committee staff present:

Emalene Correll, Legislative Research Department
Norman Furse, Revisor of Statutes office

Conferees appearing before the committee:

Dr. M. G. Kirby, Great Bend, Kansas
Richard Friedeman, Attorney, Great Bend, Kansas
Melissa Hungerford, Kansas Hospital Association
Nadine Griffin, President, Board of Directors, HSANEK
Carl Ossman, Architect, Topeka
Jerry Slaughter, Kansas Medical Society
Dr. Joseph Hollowell, Director, Division of Health, DH&E
Dr. Lois Scibetta, Kansas State Board of Nursing

Others present: see attached list

Senator Meyers called the meeting to order and said the committee would hear conferees on HB 2014.

HB 2014 - Certificate of need for health facilities applied to reductions in beds and services

Dr. M. G. Kirby, Great Bend, Kansas, testified in opposition to HB 2014, and stated that his interest is in the application to ambulatory service. He distributed an outline of Ambulatory Surgical Facilities, giving the definition, scope of service, advantages, and disadvantages of such service. Dr. Kirby stated that the Certificate of Need law is counter-productive, and eliminates competition, promotes cost-plus pricing, and protects hospital monopoly. (Attachment #1).

Richard Friedeman, Attorney, Great Bend, Kansas, testified in opposition to HB 2014 and submitted testimony stating that this is a bad bill, and the Certificate of Need is a bad law. It stifles competition, encourages over-utilization of services, supports wholesale cost shifting within existing facilities, and drives up the cost of health care. Mr. Friedeman recommends that this bill not be passed. If it is passed, an exemption should be granted for ambulatory surgical units, and the criteria for granting Certificates of Need should be changed. (Attachment #2).

Melissa Hungerford, Kansas Hospital Association, testified in support of HB 2014, except for one revision in Section 2 (a)(10), page 4, line 135, which they cannot support. KHA does support the amendment to delete lines 128 and 129 on page 4, which was proposed to the House Committee by Secretary Sabol of DH&E. Testimony was submitted giving reasons for their support, along with areas of concern. (Attachment #3). Ms. Hungerford also distributed copies of testimony from KHA stating their support of HB 2012 and HB 2013. (Attachment #4).

Nadine Griffin, President, Board of Directors, HSANEK, testified in support of HB 2012, 2013, and 2014, and distributed testimony stating reasons for their support of each bill, along with Certificate of Need Statistics for HSA II, 1977-82, and copies of letters from Henry Waxman, Chairman, Subcommittee on Health and Environment, Washington, D. C., to Georgia State Senate and Alabama's Governor. (Attachment #5).

Carl Ossman, Architect, Topeka, testified in opposition to HB 2014. He stated that he has been involved with this issue since the original bill went through the House, and the Certificate of Need law, instead of helping health care, has added to health care costs. Mr. Ossman declared that the Certificate of Need law as it is now operated is not receptive to new ideas, and has cost the people of Kansas too much already. He advocates modifying it so that new approaches to health care can be made.

Jerry Slaughter, Kansas Medical Society, testified in support of HB 2012 and 2014, and submitted testimony stating that Kansas needs to take a look at the process of health planning, and the concept of a Health Planning Review Commission makes sense. Mr. Slaughter stated that HB 2014 makes no substantive changes in the Certificate of Need law, but merely brings us into compliance with federal requirements. (Attachment #6).

Dr. Joseph Hollowell, DH&E, testified in support of HB 2012, 2013, and 2014, and submitted testimony stating reasons for their support of each bill. DH&E suggested that HB 2014 could be more effective if any person proposing to purchase major medical equipment were required to obtain a Certificate of Need, and also suggested deleting the reference to in-patient hospital use in lines 127-129. (Attachment #7). Dr. Hollowell also distributed copies of the Certificate of Need Program. (Attachment #8).

HB 2012 - Health planning review commission created

Dr. Lois Scibetta, Kansas State Board of Nursing, testified in support of HB 2012, and distributed testimony stating that the KSBN is delighted to see that nurses are being included in the evaluation of health planning activities for the state. Dr. Scibetta expressed concern about lines 69-71, which give the commission only a few months to study the issue and prepare a report. (Attachment #9).

HB 2013 - Kansas Health Planning and Development Act expiration. Re Proposal No. 27

Senator Meyers asked if there were any further conferees on HB 2013. There were none, and the hearing on HB 2012, 2013, and 2014 was concluded.

Senator Gordon moved that the minutes of March 21, 1983, be approved. Senator Vidricksen seconded the motion and it carried.

The meeting was adjourned.

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 3-22-83

| (PLEASE PRINT) NAME AND ADDRESS | ORGANIZATION |
|---|---|
| JERRY SLAUGHTER | KS. MEDICAL SOCIETY |
| HAROLD E. KLEMM | KS. ASSN OSTEOPATHIC MED |
| Bill Friedman | Legislature |
| EARL G. OSSMANN | SELF |
| Richard L. Friedeman | Capitol Ks. Medical Pac |
| Melissa Hungerford | Ks Hospital Assn |
| Gerald Reifschneider | Cent. Kans. Med. Ctrs. |
| Rebecca Kuppu | Ks. Hospital Assoc. |
| Mary Fischman | Div of Budget |
| Nadine Bunch | KSHNEK |
| Nadine Griffin Abilene KS | HSANEK |
| Guillermo Barreto-Vega | HSANEK |
| Ron Schmidt | KDH&E |
| Joe Hollowell | " |
| Dr Lois Rein Scibetta | KSBN Topeka |
| Nickie Stein | Ks State Nurses' Assn. |
| Joan Kemp | observer |
| LAVERNE A. FALK | KCOA |
| Evelyn Falk | KCOA |

3-22-83 #1

TESTIMONY OF MERLIN G. KIRBY, MD

Re: HB 2014

Ambulatory Surgical Facilities

I. Definition - Freestanding

a. Surgical techniques
b. Anesthesia techniques

II. Scope of Service

a. 40% of all U. S. surgery
b. Types of procedures

III. Advantages

a. Cost 40% - 5 day week - no shifts
b. No administrative expense
c. Faster and convenient for patients and physicians
d. Separates inpatient and outpatient surgeries
e. Psychologically more pleasant
f. Permits parents with children
g. Strong recruitment tool
h. Actually complements hospital

IV. Disadvantages

a. None

V. Comments

Con law counterproductive. It eliminates competition, promotes cost-plus pricing, protects hospital monopoly.

Atch. 1

3-22-83

#2

TESTIMONY OF RICHARD L. FRIEDEMAN

Central Kansas Medical Park

Re: H. B. 2014

H. B. 2014 is a very bad bill, the Certificate of Need Program is a very bad law. It stifles competition in the health care field, encourages over-utilization of services, supports wholesale cost shifting within existing facilities and drives up the cost of health care.

It is basically a mechanism for restricting entry into the health care field. And there lies the key to understanding why some existing facilities like the Certificate of Need law. They don't want the competition.

Price competition would cut consumer costs. Competition in the area of quality and convenience of service would force many providers to enter the 1980's, sometimes against their will. The market would force them to make decisions on the basis of sound economics, which runs against the grain of many who have for too long been steeped in the economically unreal world of cost-based reimbursement.

Cost-Based Reimbursement

"But there is no competition," say proponents of the Certificate of Need law, and to an extent they are correct. The culprit is a system of reimbursement based on facility

Att. 2

costs. If a facility has high costs, too much equipment, too many rooms - it simply spreads that out among the patients it does have. The incentive to forego unnecessary and uneconomic purchases and hospital additions were once nonexistent, because you could build or buy almost anything with a guarantee that it would be paid for. At least that's the argument.

However, if you look carefully, you will see what should be a welcome sight to proponents of competition. You will see cost-based reimbursement flying out the window. Starting the first of the year, Kansas Blue Cross/ Blue Shield will be implementing a non-cost-based reimbursement system tentatively labelled "Maximum Approved Payment Program" or MAPP. Basically, if you want a CATscan, you had better be certain that you will have enough business to pay for it, or else. Likewise, it appears that toward the end of the 1984, Medicare will be going to a non-cost-based reimbursement system based on "Diagnostic Related Groupings" or "DRG." The theory is about the same.

In short, a new day is dawning in which medical facilities will be forced to make procurement and construction decisions based on economic cost and real need. Blue Cross/ Blue Shield and the Federal Government will not automatically pay for anything you want to do. Unrestrained empire building by facility administrators will have to come to a

screeching halt.

## One Question

"Why should we stop people from building medical facilities with their own money?" You see, that's what the Certificate of Need is all about. The answer, up to this point, has been that anything that is built will be paid for by the general public through 3rd party payers. As indicated above, this will no longer be the case.

I have learned about the Certificate of Need program in connection with an application made on behalf of the Central Kansas Medical Park for a freestanding ambulatory surgical unit in Great Bend, Kansas. Our unit would have competed with our local hospital and, as is usually the case in such applications, our local hospital opposed our application. The didn't want the competition.

## Why Ambulatory Surgical Centers?

People concerned about health care costs are promoting outpatient, or ambulatory care. Too many people are in hospital rooms that do not need to be there. Too many tests and bureaucratic procedures bog down what should be simple. A facility that is not selling bed space is unlikely to fill them unnecessarily. Further, ambulatory

surgery, where possible, is more convenient for the patient. Current procedures permit a quicker turn-around time in a facility geared for outpatient surgery and this saves everyone time and money. Unfortunately, this innovation is being stymied by the Certificate of Need program.

"CATscans yes, Ambulatory Surgical Units no."

One of the major failures of the Kansas Certificate of Need program is the proliferation of CATscans. Contrast this with the record on Ambulatory Surgical Center approvals. There were 4 applications for ambulatory surgical centers from 1977 through 1982. Only 1 was granted, and this was for an ambulatory surgical unit which was constructed prior to the grant of a Certificate of Need, with the acquiescence of the State Office of Health Planning. In addition, I am personally and rather painfully aware of one other denial. The bottom line - 5 applications, 1 approval, and the 1 approval shouldn't count. Contrast this with the overall picture, where 229 applications were made for hospitals, hospital additions, CATscans, etc. Only 12 were finally denied. The bottom line - 229 applications, only 12 denials.

Of course, this suits some elements of the health care community just fine. If you want a CATscan - you get it, if you want to compete with a hospital-you don't.

Without going into great detail, I would like to discuss the theory behind these bad decisions. First, it should be stated that the criteria for making these decisions are entirely subjective, and unquantifiable. Although the criteria includes quality of care and cost effectiveness, it turns out that these criteria are ignored if one cannot prove "community need." That would be OK, except that they have narrowly defined community need to mean either (1) the existence of overwhelming problems, or (2) unavailability of service.

In our particular case, there is no doubt that surgical services are now available. We cannot point to anyone dying on the streets of Great Bend for want of surgical services. But we can provide these services cheaply, more efficiently and more conveniently. However, short of unavailability of service, none of these factors enter into the consideration at all.

## FEDERAL REQUIREMENT

There is, of course, a federal requirement that we have a Certificate of Need program. Theoretically, there are sanctions to back this up. However, the continuing resolution passed by Congress late last year prohibits the imposition of sanctions throught September of 1983. Further, it is entirely likely that changes in the law, anticipated during this year, will eliminate the sanctions altogether.

Further, it is my understanding that the current sanctions are entirely discretionary.

## THE FINAL ABSURDITY

The bill which you have before you today does basically two things. One, it extends the Certificate of Need law for one more year. Two, it requires hospitals who wish to reduce the number of hospital beds to acquire a Certificate of Need. Some of us had thought that a large part of the problem was that we had too may hospital beds in Kansas. If this bill is passed, before you can help that problem by reducing the number of hospital beds, you have to ask permission. This is absurd.

## WHAT TO DO

We would recommend that the Committee not pass this bill. Failing that, it should grant an exemption for ambulatory surgical units to encourage innovation in the health care field, to encourage out-patient surgery and cut down on health costs. Failing that, it should change the criteria for granting Certificates of Need, to focus attention on criteria relating to health care costs rather than unavailability of service.

3-22-83 #3

TESTIMONY TO THE SENATE PUBLIC HEALTH
AND WELFARE COMMITTEE

From the Kansas Hospital Association

HB 2014

Presented by Melissa Levy Hungerford

March 22, 1983

The Kansas Hospital Association supports HB 2014 which extends the Certificate of Need Law in Kansas. For the most part, the revisions made to the existing legislation simply clarify and streamline the program. There is, however, one revision which KHA cannot support and one additional revision which we believe should be made.

KHA cannot support the revised language in Section 2(a)(10) beginning on page 4, line 135, which brings the termination of unwanted health facility services under the auspices of the CON process. In an era where all aspects of the health care system are encouraging efficiency and business-like decisions about the services to be provided, adding the closure of unnecessary services to the regulatory process will do nothing but add to the cost of health care. If an institution or community cannot utilize a service enough to support the service, it should not be there. Even if the CON process determined that the service or facility was not to be closed, the questions of who pays for it and how the decision could be enforced remain unanswered. The intent to assure accessibility to hospital services is excellent, but this approach is unworkable.

We understand that this section is a federal requirement and that the Department of Health & Environment has appealed this issue. We also understand that all sanctions related to non-compliance with P.L. 93-641 have been waived. The Kansas

Att. 3

Hospital Association strongly encourages this Committee to delete this contradictory section from this bill.

KHA would also like to voice its support of the amendment to delete lines 128 and 129 on Page 4, Section 2(a)(8) proposed to the House Committee by Secretary Sabol. The question before this committee is whether or not to take action to continue health planning and Certificate of Need in Kansas. The Certificate of Need process is intended to be a cost containment mechanism. Its goal is to reduce the duplication of expensive equipment and services. The law applies to hospitals and nursing homes, but neglects other providers who may offer similar and, therefore, competitive health care services. The concept of competition requires that Certificate of Need be applied equally or not at all. In a transitional phase, all of the actors in the system should play by the same rules. It is for this reason that the Kansas Hospital Association can support the continuation of Certificate of Need for major medical equipment only if it applies to all providers, including physicians. With the current threshold, this process would not prevent rural physicians from establishing a basic office.

Currently, the only instance in which the law requires physicians to obtain a Certificate of Need is when major medical equipment is being purchased to provide services to inpatients. Again, the evolution of health care delivery has made this provision less than effective. In the current climate, insurance carriers and government are limiting their coverage to procedures which can be done on an outpatient basis. Much of the diagnostic technology is included in this shift. The competition between hospitals and physicians as they provide identical equipment is heightened. Hospitals who will also make this equipment available to inpatients must obtain a Certificate of Need, while physicians are exempted from this time-consuming and costly process. Even though the health care industry is over-regulated, hospitals understand the need to be accountable to their communities. Hospitals cannot, however, support a process which singles

out one provider group and fails to regulate others. Hospitals have a responsibility to provide services to their communities at the lowest possible cost. This cost is currently affected by both the cost of obtaining a Certificate of Need and the cost the community pays to support duplicate services. Without consistent regulation for all providers, Kansas consumers will pay higher health care costs.

That concludes our comments related to this bill. Thank you very much for the opportunity to voice our concerns.

3-22-83 #4

KANSAS HOSPITAL ASSOCIATION

**Donald A. Wilson**
President

TESTIMONY OF THE KANSAS HOSPITAL ASSOCIATION
SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
March 22, 1983

House Bills 2012, 2013

The Kansas Hospital Association supports House Bill 2012, which creates a Health Planning Review Commission.

We also support House Bill 2013, which continues the Kansas Health Planning and Development Act for another year.

We urge the Committee to recommend both bills favorably for passage.

Thank you for the opportunity to comment on this legislation.

1263 Topeka Avenue • P.O. Box 2308 • Topeka, Kansas 66601 • (913) 233-7436

Att. 4

3-22-83 #5

HEALTH SYSTEMS AGENCY

OF NORTHEAST KANSAS

COMMENTS ON THE

KANSAS HOUSE BILLS #2012, #2013 and #2014

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

STATE CAPITOL, ROOM 526 S

MARCH 22, 1983

Att. 5

Good Morning, Madam Chairperson Meyers and members of the Senate Public Health and Welfare Committee. My name is Nadine Griffin, farmer, housewife, President of the Board of Directors of the Health Systems Agency of Northeast Kansas (HSANEK) and a member of the Statewide Health Coordinating Council (SHCC). I am testifying today as the President of the Board of Directors of the HSANEK, with which some of you are familiar, 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 county appointed representatives, one by each County Commission, and the remaining Board members come from a wide range of rural and urban community groups and organizations.

The HSANEK's functions are to guide the development of the health care delivery system through the area health systems plan and 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 these primary concerns of the HSANEK, I appreciate this opportunity to present the following testimony on House Bill 2012, an Act creating the Health Planning Review Commission, House Bill 2013, an Act concerning the expiration of the Kansas Health Planning and Development Act and on House Bill 2014, an Act relating to health facilities and concerning the Certificates of Need for such facilities.

H.B. 2012

First, I will address my comments to H.B. 2012. It is promising and refreshing to observe the Kansas Legislature take a leadership and visionary

role in Kansas Health Planning issues by establishing a Health Planning Review Commission (HPRC).

A brief overview of the health planning activities during the 97th U.S. Congress will assist in understanding the importance of the proposed HPRC. During this session two health planning bills were introduced. H.R. 7040, the "Health Planning Block Grant Act of 1982" in the U.S. House of Representatives, passed by a vote of 302 in favor and 14 opposed. The net effect of this bill would have been to extend the health planning federal legislation for two more years and to increase the Certificate of Need (CON) review thresholds on Capital Expenditures to $5 million; on Major Medical Equipment to $1 million; and on new Health Facility Services to $1 million. Further, this Bill would have transferred the administration of the Health Planning Program to the States through Block Grants. Each state would have had the perogative to request Federal funds to conduct state and local health planning programs tailored to meet their individual needs.

On the other hand, the U.S. Senate introduced S-2720 the "Deregulation Health Planning Act of 1982". However, a last minute hold on the Bill by the HHS Secretary stopped a compromise amendment to the Bill from passing the U.S. Senate. Since the Senate did not pass a Health Planning Bill, the House-Senate Conference Committee was not able to deal with the Health Planning Program during the ending days of the 97th Congress, the program was extended through FY 1983 by the continuing resolution.

It is important to point out that in a letter to the Georgia State Senate Representative Waxman (D-Calif.), Chairman of the Subcommittee on Health and the Environment states:

"1. The federal government will continue to provide substantial funds to the States and local agencies to support health planning activities; and

2. In order to be eligible to receive such funds, States and local agencies will have to meet certain standards of organization and operation necessary to ensure their effectiveness.

3. States will be required to conduct a certificate of need program which covers hospital and nursing homes and otherwise complies with Federal law."

Consequently, it is very crucial for the State of Kansas to take a hard look and examine the health planning program structure and priorities during FY 1983-84. However, national health planning legislative developments should be taken into consideration, by the proposed HPRC, when designing the health planning program for Kansas and preparing recommendations to the governor and the legislature.

Finally, the HSANEK Board of Directors has acquired expertise in rural health planning issues. Our Agency's Board of Directors would be delighted to nominate one of their members to represent the Kansas rural health care consumer interests in the proposed Health Planning Review Commission.

For the above cited reasons, the Health Systems Agency of Northeast Kansas strongly supports the passage of H.B. 2012.

H.B. 2013

Second, I will address my comments to H.B. 2013.

All the actions by the 97th U.S. Congress previously cited, indicate positive support for the Health Planning Program at the National level.

Further, the Kansas Interim Committee on Public Health and Welfare, composed of Senate and House members, considered and studied the Kansas Health Planning Program during the summer of 1982. One of the recommendations

of that Committee is H.B. 2013, which is to extend the Kansas Health Planning and Development Act for one more year, until July 1, 1984. This extension will enable the proposed Kansas HPRC to study the program and submit recommendations to the governor and the legislature by January, 1984, on the orderly transition of the Health Planning program.

For the above reasons, the HSANEK supports the passage of H.G. 2013.

H.B. 2014

Third, I will address my comments to H.B. 2014 concerning Certificates of Need for health care facilities. The HSANEK supports passage of H.B. 2014, in order to change the Kansas Certificate of Need Law to be in compliance with Public Law 96-79.

The net effect of this bill would be to amend existing Kansas CON Law. The bill will add a termination of services clause, which will require health care institutions, which are contemplating the discontinuation of a health care service or closing down an institution, to go through the CON process. This will ensure that needed health care services in rural and urban areas will not be eliminated overnight. The Bill would guarantee that access to these services would continue to be received by residents of these areas.

Since the State of Kansas CON Law does not address this issue properly, the CON Law was deemed out of compliance by the U.S. Department of HHS. Consequently, the Kansas State Health Planning and Development Agency was out of compliance, and therefore was conditionally designated. In order to require State compliance with the CON Law, the PL 96-79 states that: "During the first twelve months after the date of the expiration of the applicable period, the secretary shall reduce by 25% the amount of each allotment, grant, loan, and loan guarantee made to and each contract entered into with an

individual or entity in such state...". Annual reductions at the rate of 25% would follow until the fourth year when no funds for Public Health services would be forthcoming to the state.

However, in the last few months, as far as the SHPDA penalty is concerned, the picture has improved considerably. States that have SHPDAs which are conditionally designated, because they have not complied with Federal requirements no longer face the penalty that calls for 25% cut in their Public Health Service grants. The reprieve is based on the assumption that even though the continuing resolution postpones the penalty only for the length of the resolution, the 98th Congress will resolve the issue permanently.

In summary, H.B. 2014 will make sure that Kansas is not in jeopardy of losing 25% of its public health funds.

For the above cited reasons, the HSANEK supports the passage of H.B. 2014

ATTACHMENT A: CERTIFICATE OF NEED STATISTICS FOR HSA II, 1977-82

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.

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

U.S. House of Representatives
Committee on Energy and Commerce
Room 2125, Rayburn House Office Building
Washington, D.C. 20515



February 2, 1983

Pierre Howard, Chairman
Senate Human Resources Committee
The State Senate
Atlanta, Georgia 30334

Dear Senator Howard:

Thank you for your letter concerning the consideration of Certificate of Need legislation by the Georgia Senate.

I can appreciate your interest in CON legislation. It is clear that without a strong health planning program, hospital and nursing home expansion will wildly inflate State and private, as well as Federal, health care payments. I suspect that Georgia, and Georgia's employers and employees, can ill afford to waste their resources on unnecessary or over-priced health services.

I am pleased to report to you that there is a firm Federal commitment to support a health planning system throughout the nation. A bill to extend Federal assistance to State and local health planning agencies was passed by the House of Representatives last year by a vote of 302 to 14. Although it was not possible to work out an agreement with the Senate in this regard at the end of the 97th Congress, the program was extended through FY 1983 by the Continuing Resolution.

As the 98th congress begins its work, I am sure that health planning legislation will again be on the agenda. While it is not possible to predict what the exact result of the legislative process will be, I think it is reasonable to assume:

1. The Federal government will continue to provide substantial funds to the States and local agencies to support health planning activities; and

2. In order to be elgible to receive such funds, States and local agencies will have to meet certain standards of organization and operation necessary to ensure their effectiveness.

3. States will be required to conduct a certificate of need program which covers hospital and nursing homes and otherwise complies with Federal law.

In this context, I would suggest that the prudent course for Georgia, or any other State, at this time is to maintain the current program without any major change. This will insure that both State and local agencies remain eligible for Federal support this year under the FY 1983 Continuing Resolution. It will also mean that, once all of the details of the Federal legislation are settled, Georgia can, in a single step, make changes in its CON program with a clear understanding of what its effect on eligibility for Federal support may be. If Georgia revises its CON program this year, further revisions, even contradictory changes, may be necessary next year or the year after.

With specific regard to the provisions of SB 121, I can report that they are not consistent with the current requirements of the Federal statute. I cannot guess whether these provisions will or will not be consistent with that legislation that will be developed this year. I can point out, by way of example, that the legislation endorsed by the House last year did include detailed requirements for State CON programs and that the provisions of SB 121 are not consistent with all of the provisions of that bill.

Again, I appreciate your interest in the future of the health planning program. As a Federal-State partnership, planning can only be successful with the understanding and support of State officials throughout the nation.

My best regards to you and your colleagues in the Georgia Senate.

Sincerely,

HENRY A. WAXMAN
Chairman, Subcommittee on
Health and the Environment

HAW/bbg

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

FEB 3 1983

RECEIVED FEB 16 1983

The Honorable George C. Wallace
Governor of Alabama
Montgomery, Alabama 36104

Dear Governor Wallace:

This is in response to your letter requesting that the Department reinstate the health systems agencies in Alabama.

Former Governor James requested designation under Section 1536 of the Public Health Service Act for the State of Alabama. On December 24, 1981, this request was granted and the designation agreements and grant awards of Alabama's agencies were not renewed when they expired during 1982. Presently, all agency agreements in Alabama have been terminated.

The process of designating an agency is preceded by the designation of health service areas which the agency would serve. These areas were abolished when the State of Alabama was designated under Section 1536. If you wish to establish agencies in Alabama, we would first have to designate the areas and then act upon your request for agency designation. Since the process involves public hearings, as well as internal Departmental review, we would anticipate these successive actions would be of several months' duration. As you may be aware, the health planning program extended by the Continuing Resolution expires on September 30, 1983.

In view of the difficulty of completing the designation processes prior to that date and the fact that at best Federal funds would be available for HSAs only for a short period of time, you may wish to postpone your request until the reauthorization issue is resolved. However, if you still wish to proceed, please notify Secretary-designate Heckler in writing.

Sincerely,

Richard S. Schweiker
Secretary

U.S. House of Representatives
Committee on Energy and Commerce
Room 2125, Rayburn House Office Building
Washington, D.C. 20515

January 28, 1983

The Honorable Richard S. Schweiker
Secretary
Department of Health and Human Services
330 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Schweiker:

I have recently received a letter from Mr. Andrew Chaffin, the Executive Director of the Health Systems Agency of Alabama Area IV (enclosed). In his letter, Mr. Chaffin indicates that the newly elected governor of Alabama, George Wallace, has written to you requesting that health service areas be reestablished and Health Systems Agencies redesignated in Alabama.

I am writing to urge the Department to move expeditiously on Governor Wallace's request. The provisions of Section 1536 of the Public Health Service Act, as amended in 1981, allow a governor to request that Federal support for HSAs be terminated. The 1981 amendments did not, however, amend the provisions of Sections 1511 and 1515 which require the Department to establish health service areas and HSAs throughout the nation. Because the current governor has so requested, the Department should now proceed to reestablish HSAs in the State of Alabama as soon as possible.

I would appreciate receiving a description of the Department's plans in this regard on or before February 11, 1983.

With best regards, I am,

Sincerely,

HENRY A. WAXMAN
Chairman, Subcommittee on
Health and the Environment

HAW/bbc

3-22-83 #6

# Kansas Medical Society

*Incorporated 1859*

March 22, 1983

TO: Senate Public Health and Welfare Committee

FROM: Jerry Slaughter
Director of Governmental Affairs

SUBJECT: HB 2012 and 2014; Concerning Health Planning and Certificate of Need

The Kansas Medical Society supports both HB 2012 and HB 2014.

Our support is based largely on our belief that Kansas needs to take a new look at the process of health planning. Since 1974, we have been saddled with a program which was imposed federally, and enforced with the threat of loss of funds for noncompliance. The concept of a Health Planning Review Commission makes sense. It will be the first opportunity for elected officials and lay persons to cooperatively work towards a new direction in health planning for our state.

HB 2014 makes no substantive changes in our CON law. It merely brings us into compliance with federal requirements. We support the idea of extending our CON law one additional year, as we await the outcome of the Health Planning Review Commission's deliberations, and evaluate action at the federal level. We do not support any significant policy changes in the CON law at this time.

We appreciate the opportunity to appear on these two bills, and appreciate your consideration of our comments. Thank you.

JS:mjp

Atch. 6

1300 Topeka Ave. • Topeka, Kansas 66612 • (913) 235-2383

3-22-83 #7

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

TESTIMONY ON HOUSE BILLS 2012, 2013, and 2014

PRESENTED MARCH 22, 1983

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

This is the official position taken by the Kansas Department of Health and Environment on House Bills 2012, 2013, and 2014. All three bills deal with the health planning activities currently operating in Kansas.

House Bill 2012. This bill creates an 11-member Health Planning Review Commission that would evaluate current health planning activities and propose future activities and funding. The Department supports this legislation. Further, the bill, as amended by the House, requires the Governor to appoint five of the members and also requires that they be representatives of six separate categories.

House Bill 2013. This bill extends the expiration date of the Kansas Health Planning and Development Act from July 1, 1983 to July 1, 1984. It is clear that this program has been useful to the state, as well as meeting federal requirements that allow the state to receive $25 million in federal public health service grants. This program aided the Legislature in the study of health care personnel credentialing, local public health service financing, and health care costs. The program should be continued. The Department recommends the bill be passed.

House Bill 2014. This bill amends the Kansas Certificate of Need Program. It brings the Kansas statute into compliance with current federal law and regulations and extends the expiration date from July 1, 1983 to July 1, 1984. Essentially, the bill maintains Kansas' compliance with federal regulations which in turn abolishes any risk that federal officials will take action to reduce the level of federal public health funding in Kansas, if we did not have a complying Certificate of Need Program.

The one area which this bill does not address is the purchase of major medical equipment by any person. The briefing paper on the Certificate of Need Program which is attached to this testimony highlights the major factors that increase health care costs. The increases in the number of new physicians and related increases in biomedical

Atch. 7

research and technology have now and will continue to have a growing impact on increases in health care expenditures in Kansas. This is not equipment needed to start up a primary care practice in a rural area, but rather sophisticated equipment that is usually found in a regional hospital. After you read the briefing paper you may want to consider amending Section 2(a)(8), lines 128 and 129 by deleting the reference to inpatient hospital use.

In general, however, the Department supports this bill and recommends it be passed.

CONCLUSIONS:

The Department of Health and Environment supports all three bills. Perhaps some minor changes could be made to enhance effectiveness and efficiency:

- House Bill 2014 could be more effective if any person proposing to purchase major medical equipment were required to obtain a Certificate of Need. Delete the reference to inpatient hospital use in lines 127-129.

Presented by: Joseph G. Hollowell, Jr., M.D., M.P.H.
Director, Division of Health
Kansas Department of Health and Environment

3-22-83 #8

# THE KANSAS CERTIFICATE OF NEED PROGRAM

A Briefing Report
for the
Senate Public Health and Welfare Committee

March 22, 1983

Prepared by:

Office of Health Planning
Kansas Department of Health and Environment

Atch. 8

KANSAS CERTIFICATE OF NEED PROGRAM

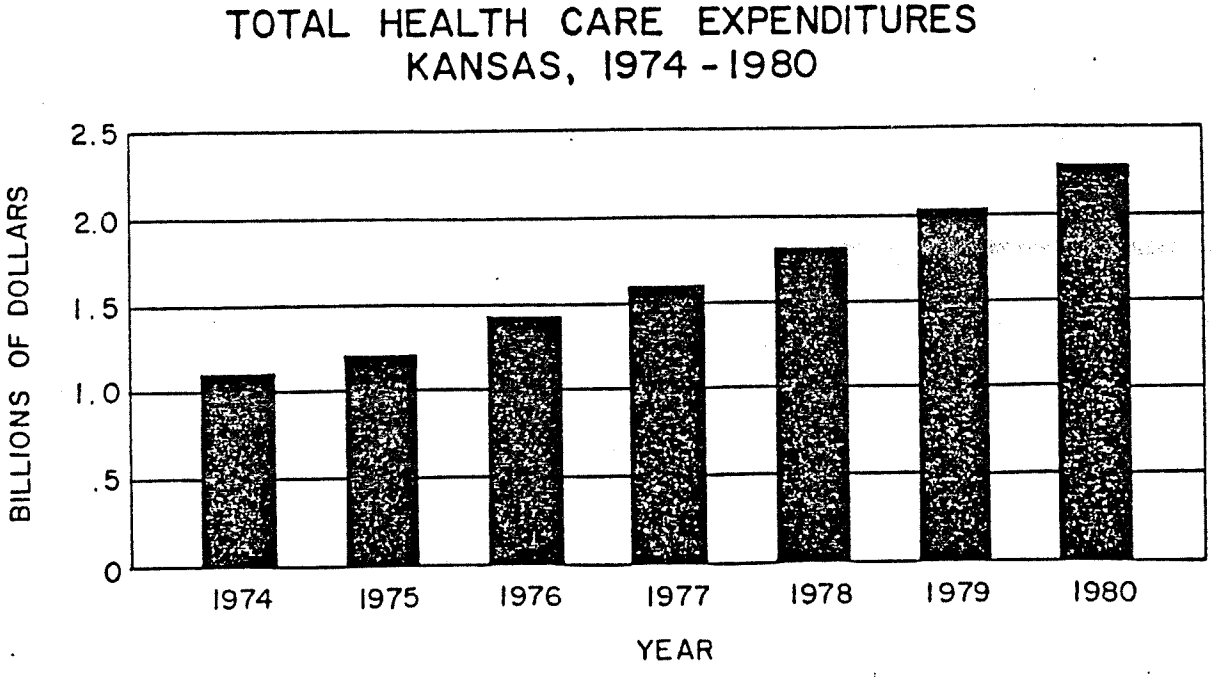
INTRODUCTION

Why would a state decide to restrict entry of new health care institutional services into the marketplace? There are a number of reasons for this choice that have been discussed over the years, but the primary reason is to help restrain unnecessary increases in health care costs and expenditures.

First, let us look at the trends in health care costs and why the increases have occurred. Then, let us look at the Kansas Certificate of Need Program, and examine how it affects expenditures and what its performance has been.

The Department has just completed an update of the Kansas Health Care Expenditures Report. Clearly, we continue to have dramatic increases in health care costs. Kansans spent nearly $2.6 billion in 1981, up 14 percent from 1980. This amounts to $1,079 per capita.

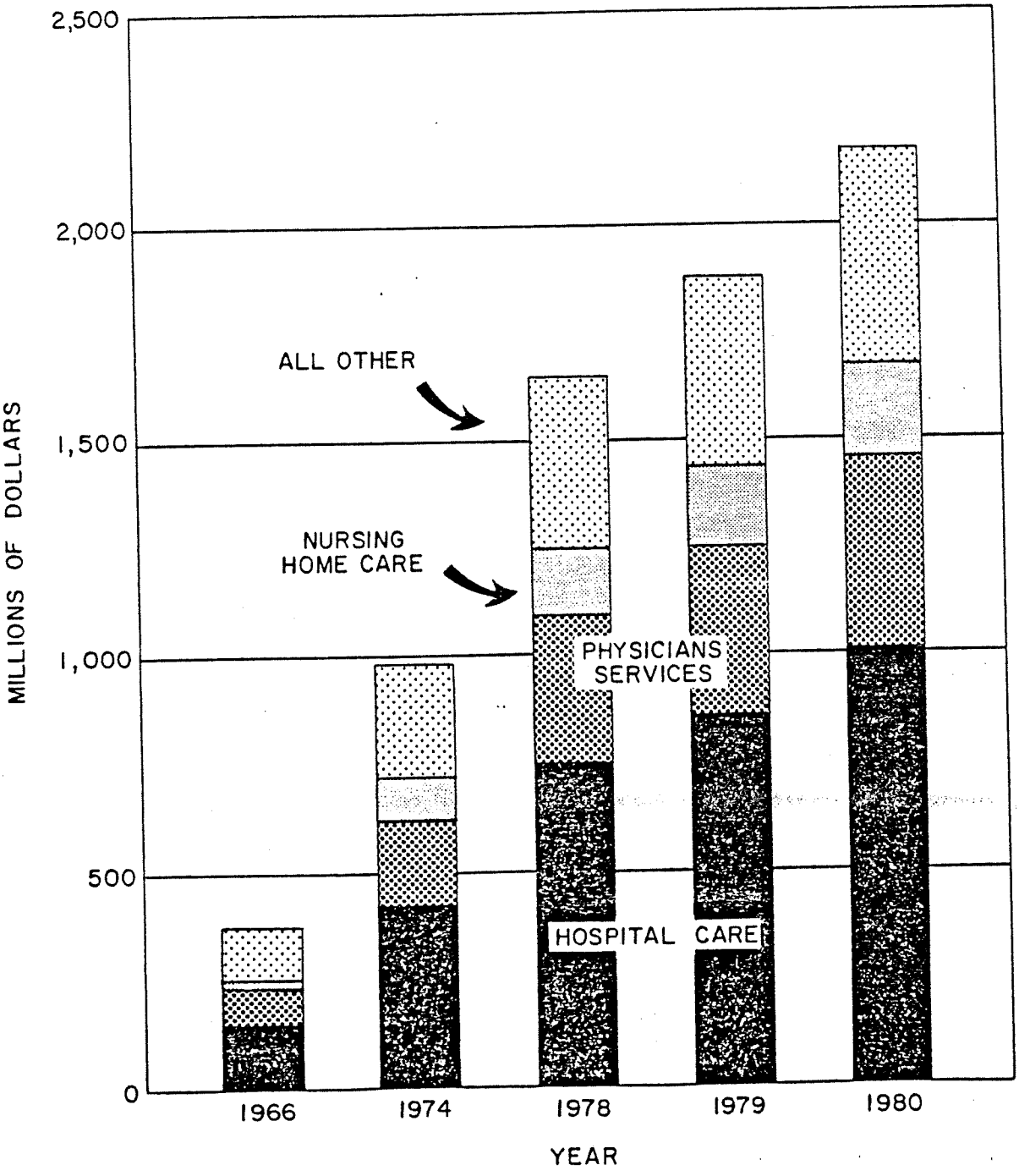
The greatest portion of dollars goes to hospital care; 46 percent, or nearly $1.2 billion. This amounts to $491 per capita, up more than 15 percent from 1980. Spending for physicians' services came in second; 19 percent, or $469 million, up nearly 12 percent from 1980. Nursing home care came in third; ten percent, or $241 million, up nearly 14 percent from 1980. The following two charts graphically display the increases and how the dollars were spent from 1974 to 1980.




Note: Gross State Product in 1980 - $26 Billion (preliminary figure)

Source: Office of Health Planning
Kansas Department of Health and Environment

# PERSONAL HEALTH CARE EXPENDITURES BY TYPE KANSAS, SELECTED YEARS, 1966 - 1980




Source: Office of Health Planning
Kansas Department of Health and Environment

Why Have These Increases Occurred?

The factors that cause continued increases in health care expenditures include: 1) changes in the population and disease trends; 2) government financing of health care research, facilities, and direct care; 3) the general financing system for health care, both government and private; 4) overutilization and lack of price competition; and 5) excess supply of services.

1. Population and Disease. Historically, much of the population died young; the major problem was how to survive the first few years of life. In 1900, only four percent of the population was over age 65. Through basic public health research producing vaccines to immunize the population, coupled with improved personal and community hygiene and better nutrition, many more people are living longer lives. Today nearly 13 percent of the population is over age 65.. However, while we have essentially conquered infectious diseases, the problems people now face result from life-style, environmental threats, and aging. While the major cripplers and killers (cancer, heart disease, strokes, and accidents) generally occur as our physical machine starts wearing out, they are exacerbated by life-style choices such as smoking, excessive eating and drinking, and a general lack of physical fitness. Further, chronic diseases and accidents can use extensive amounts of medical care resources in efforts to diagnose and treat the problems over a lifetime. Consequently, some increase in expenditures comes from our success in solving one problem and creating another. Clearly, people could control the demand for health care resources through improved health behaviors.

2. Government Involvement. National public policy in health affairs changed dramatically with the passage of Medicare and Medicaid in 1966. Through these programs, the federal and state governments became major third-party purchasers of health care, infusing billions of new dollars into the health care market. Nationally, expenditures for personal health care rose from $36.0 billion in 1966 to $132.1 billion in 1976, and to $217.9 billion in 1980.

   This distribution of personal health care expenditures by source of funds changed dramatically after 1966. The federal, state, and local government share of expenditures increased from 21 percent in 1966 to 40 percent in 1980.

   In addition to direct payments for personal health care, the government subsidizes medical research, education, and construction of health facilities. Subsidies are also provided through income tax exemptions for health insurance premiums and tax deductions for medical expenses; the federal tax revenue loss for these items is estimated at $7.8 billion in Fiscal Year 1977. The total annual level of direct government support to the health industry accounts for nearly half of the total health expenditures. The major shift from private to public funding of health care services underscores the importance of rising health care costs as a public policy issue.

Government spending for medical education that began in the early 1970's is now producing the striking increases in medical manpower, both nationally and in Kansas. Nationally, over 16,000 physicians are educated annually. Kansas has increased its supply of physicians by over 20 percent in the last four years. This means there are more providers competing for the dollars that are being spent for medical care. This is one of the reasons why physicians are willing now to invest in major medical equipment and facility services.

Further, research in the field of human biology has dominated our quest for improved health for decades and the results of this emphasis are appearing in the many (expensive) technological changes in medical care. As a nation, we are spending huge sums of money on biomedical research, one effect of which has been to increase the complexity and cost of medical care services.

The lack of balance in the support of research in the area of life-style is striking. The strong emphasis on biomedical research may partially explain the current tendency to rely on medical science to lead us to improved health. This is not to disparage the obvious contributions of biomedical research and medical care to our current health status, but only to point out the increasingly apparent imbalance in our research efforts aimed at improving health.

3. Health Care Financing. Two features distinguish the health care marketplace from other sectors of the economy: a) directed demand for services, and b) payment to the provider by a third party on behalf of the consumer.

First, the demand for services is said to be "directed" since the physician/provider makes the purchase decisions. In the area of hospital care, there are four participants: the physician, hospital, consumer, and third-party payer, but the physician makes the expense-generating decisions for all of them. The physician decides the types and amounts of medical goods and services which will be purchases. A number of studies have demonstrated that providers are relatively ignorant of costs associated with medical care.

Second, to complicate the situation further, the consumer frequently does not directly pay the provider for the goods or services. Instead, a "third party," either private health insurance or government, pays the provider on behalf of the consumer. Both the consumer and the physician are effectively insulated from the costs of the care they consume by the prevailing third-party payment mechanisms.

Third-party payments have become the dominant financing method in the health sector; they now pay for more than two-thirds of all personal health care and more than 90 percent of all hospital care.

The widespread use of "first-dollar" coverage where all expenses for hospital care and surgical fees are covered up to a predetermined ceiling is a major factor affecting consumers' decisions. Under such coverage,

there is literally no relationship between cost and the consumer's decision to seek care, nor the physician's decision to prescribe care.

Another major factor in escalating cost under the third-party payment system is the method of reimbursing providers. Frequently, these payments are made retrospectively, on the basis of actual costs incurred by the provider. This system, combined with first-dollar coverage, limit the provider's incentives to be cost conscious or to practice efficient management.

Finally, the patterns of insurance coverage have been shown to encourage strongly the unnecessary utilization of the most expensive forms of service. The first-dollar coverage for high-cost inpatient services provided by private insurance and government programs promotes their use, while lower cost ambulatory services are either not covered or are subject to high deductibles or shared payments. This extensive coverage for complex and expensive medical services has understandably promoted the availability of complex facilities and services, regardless of the potential for more economical alternatives.

4. Overutilization and Lack of Competition. Increases in the quantity of medical care services have traditionally been assumed to increase the quality of care provided. Research is beginning to question this "more is better" thesis and indicates that some part of the utilization of services is unnecessary or cost-ineffective. The fact that health maintenance organizations experience hospital utilization rates 30 percent to 50 percent lower than traditional fee-for-service arrangements supports the contention that hospital utilization can be safely reduced.

   Price competition in the medical care sector is extremely limited. Since the third-party system removes price as a consideration in the decision to seek or prescribe medical care, hospitals have tended to compete by increasing in size, technological sophistication, or prestige. The lack of effective price competition has diminished incentives for management efficiency and increased incentives for additional expenditures. Effective price competition in the medical care sector would introduce significant new incentives for improved management efficiency and market control of available services. Prepaid alternative delivery systems are a feasible method of intervention in this factor.

5. Excess Supply of Institutional Services. There is considerable evidence of an excessive supply of hospital beds and services nationally and in Kansas. The Institute of Medicine, in a major study of the problem in 1976, concluded:

   > The evidence clearly indicates that significnt surpluses of short-term general hospital beds exist or are developing in many areas of the United States and that these are contributing significantly to rising hospital costs...

   According to the Kansas health systems plans, approximately 1,700 out of the 13,521 hospital beds will not be needed.

The oversupply of hospitals and beds generates excessive costs in two ways: a) either the productive capacity is underutilized, thereby generating unnecessary fixed operating costs; or b) the productive capacity is overutilized for care that is not medically necessary or cost-effective.

This excess in supply with no disincentive to stop building more medical facilities led Kansas and the nation to the development of the Certificate of Need Regulatory Program: to prevent further unnecessary duplication of expensive medical care facilities and services.

Legislative History in Kansas

In 1967, Kansas enacted a State Health Planning Program (K.S.A. 65-190). In 1972, the first Certificate of Need Program was enacted (K.S.A. 65-2a01, et seq.). This program was administered primarily by voluntary, unstaffed local planning bodies called "comprehensive areawide health planning councils." Kansas had two federally-funded agencies in Kansas City and Wichita which had staff assistance. This Certificate of Need Program provided review of new institutional services where capital expenditures were the lessor of $350,000 or five percent of the previous year's operating budget.

In 1975, through Public Law 93-641 (National Health Planning and Resources Development Act), Congress created a national network of regional and state planning agencies which were charged with implementing several planning and regulatory programs. One of these programs was Certificate of Need. In order to comply with the requirements of the National Health Planning and Resources Development Act, the 1976 Kansas Legislature passed the Kansas Health Planning and Development Act (K.S.A. 65-4701, et seq.) and the Kansas Certificate of Need Act (K.S.A. 65-4801, et seq.) which parallel Title XV of the federal law. The Kansas Certificate of Need Program is administered according to procedures and criteria authorized by these three laws, and regulations promulgated pursuant to them. Nearly every year since the program was established, the Kansas Legislature has reviewed the Certificate of Need Act and adopted amendments to keep the Kansas program in compliance with federal laws and regulations, or to improve program administration.

The Kansas Certificate of Need Act specifies which health facilities and services will require Certificates of Need and specifies that a determination of need will be based on criteria specified in the State Health Plan. The Kansas Statewide Health Coordinating Council (SHCC) was created by the Kansas Health Planning and Development Act and is responsible for approving the State Health Plan and, therefore, the criteria for determining community need.

PROGRAM PURPOSE

The primary purpose of the Certificate of Need Program is to prevent further unnecessary duplication of expensive health care resources.

This purpose is fulfilled by:

1. Requiring sponsors of new health care services to complete a plan for the development of the service that documents need and feasibility.

2. Providing a public process for sponsors of proposed projects to demonstrate that community need exists for additional new health care services.

3. Requiring that the Kansas Department of Health and Environment's decisions be based on health policy established in the State Health Plan, which is developed in a public forum.

Therefore, this program keeps the expansion of expensive health care resources, that will later be heavily financed through tax dollars, in a public decision-making process.

PROGRAM ADMINISTRATION

The Kansas Certificate of Need Program is administered by the Kansas Department of Health and Environment through the Office of Health Planning. The review of Certificate of Need applications is performed in cooperation with the state's health systems agencies, where they exist. Other consulting agencies include the Department of Social and Rehabilitation Services' Mental Health and Retardation Services, and Alcohol and Drug Abuse Services for review of mental health and alcoholism and drug abuse treatment facility projects; the Commissioner of Insurance for review of health maintenance organizations; and the Department of Health and Environment's Office of Facilities and Services Licensure for review of hospital and nursing home projects.

The Department of Health and Environment's Certificate of Need Program Manual for Applicants details the Certificate of Need review, criteria, standards, and procedures, and is sent to all prospective applicants. The Kansas Certificate of Need review process begins with a Letter of Intent submitted by an applicant wanting to undertake a health-related project. From this letter, the State Agency determines whether the project will require a Certificate of Need before implementation. If a Certificate of Need is required, the applicant then meets with local health systems agency staff (or the state health planning staff if there is no operational health systems agency in the area) for a preapplication conference to discuss the proposed project and the Certificate of Need review process. The sponsor must then complete and submit an application which is reviewed and analyzed by the health systems agency staff, or the state health planning staff, according to the following six review objectives adopted by the Statewide Health Coordinating Council:

- Community Need
- Quality of Care
- Community Support
- Financing
- Cost Containment
- Accessibility

In the early years of the Certificate of Need Program, a public hearing on each application was held by the health systems agency, usually in a community near the proposed site. During 1981, changes in the law allowed accelerated reviews with public hearings only upon request of the applicant or other affected parties. The health systems agency's board of directors and staff are allowed 60 days after the official filing of an application to review it and recommend approval, denial, or modification to the State Agency. This

recommendation and the public record of review proceedings are reviewed by the State Agency staff during the remaining 30 days of the 90-day review cycle.

At the end of 90 days, the Secretary of the Department of Health and Environment must render a decision to approve, deny, or modify the application. The applicant, or any affected party, may choose to request a reconsideration hearing from the Secretary or appeal the Secretary's decision to the appropriate district court.*

CERTIFICATE OF NEED PROGRAM RESULTS

The following table overviews the program activities between the date of program commencement, February 16, 1977, and December 31, 1982. The Kansas Department of Health and Environment has reviewed 229 Certificate of Need applications, totaling $351,485,006 in proposed capital expenditures. Of the 229 applications reviewed, 119 were submitted by hospitals, 83 by nursing homes, four were for ambulatory surgical centers, two for health maintenance organizations, eight for alcohol treatment facilities, four for mental health treatment facilities, three for a psychiatric hospital, and six for kidney treatment facilities or programs.

FINANCIAL IMPACT

The Certificate of Need Program approved 197 projects; approved nine projects with modification, one of which is currently pending; and denied 23 projects, of which six decisions were reversed and four are still pending. Therefore, a total of 211 projects were eventually approved, resulting in the addition of $287,222,833 in new capital investment for health care resources.

The Certificate of Need Program reduces the amount of capital investment in health care resources in a number of ways. First, by requiring sponsors to plan projects which must, in the end, document community need as established in the State Health Plan. After sponsors complete this plan, many times applications are not filed, or they are later withdrawn. Over the years of program operations, 64 official withdrawals have taken place, resulting in $41,841,013 in projects that were not undertaken.

Further, the Department of Health and Environment has authority to approve a modified project. The Department has exercised this authority nine times, and has deleted $11,547,426 for portions of projects that were overdesigned.

Finally, the Department can deny a project. The Department has denied 23 projects; subsequently, 15 denials were appealed and six denials reversed, five were upheld, and four are pending. Therefore, 13 projects were finally denied, resulting in $14,812,407 of projects determined not to be needed.

---

*Originally, Certificate of Need Program appeals were first heard by the Statewide Health Coordinating Council. Later, the review agency changed to the Kansas Corporation Commission. Effective July, 1982, all appeals go directly to district courts.

A total of $68,200,846 in proposed new capital expenditures for health care resources have been saved through either modifications, denials, or withdrawals.

Clearly, the Certificate of Need Program has played a role in restraining unnecessary increases in health care costs. Particularly, when one considers that capital investments saved will mean an even greater savings in personal health care expenditures to operate the facilities if they had been built. In a national study recently completed, capital investment was linked to increases in operating costs. A dollar spent on equipment will generate greater future operating expenses than a dollar invested in nonequipment capital. On the average, each dollar invested in capital improvement resulted in $1.84 additional operating costs over a ten-year period, with present value held constant, not counting depreciation or debt service. Debt service alone in some projects we have reviewed over the past year would increase room rates by $100 per day.

CERTIFICATE OF NEED PROGRAM SUMMARY
1977 THROUGH 1982

| | | APPROVALS | | MODIFICATIONS | | | DENIALS | |
|---|---|---|---|---|---|---|---|---|
| PROJECT CLASS | TOTAL # | # | Capital Expenditure | # | Capital Expenditure | $ Deleted | # | Capital Expenditure |
| Hospitals | 119 | 105 | 157,787,207 | 7 | 51,579,858 | 10,542,552 | 7 | 14,640,300 |
| Adult Care Homes | 83 | 73 | 53,145,892 | 1 | 3,066,126 | 683,874 | 9 | 7,751,823 |
| Psychiatric Hospitals | 3 | 1 | 35,310,825 | - | — | — | 2 | 12,584,000 |
| Kidney Disease Treatment Facilities | 6 | 3 | 223,365 | 1 | 321,000 | 321,000 | 2 | 503,210 |
| Ambulatory Surgery Centers | 4 | 1 | — | - | — | — | 3 | 925,374 |
| Alcohol & Drug Abuse Programs | 8 | 8 | 654,100 | - | — | — | - | — |
| Mental Health Programs | 4 | 4 | 1,444,500 | - | — | — | - | — |
| Health Maintenance Organizations | 2 | 2 | — | - | — | — | - | — |
| TOTAL | 229 | 197 | 248,565,889 | 9 | 54,966,984 | 11,547,426 | 23 | 36,404,707 |

APPEALS OF DEPARTMENT OF HEALTH AND ENVIRONMENT
CERTIFICATE OF NEED DECISIONS
1977 THROUGH 1982

| | DENIALS | | | | | | APPROVALS | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PROJECT CLASS | # | $ Upheld | # | $ Reversed | # | $ Pending | # | $ Upheld | # | $ Reversed | # | $ Pending |
| Hospitals | 2 | 9,350,000 | 4 | 3,288,300 | 1 | 2,002,000 | 4 | 13,572,008 | - | — | 1 | 22,927,340 |
| Adult Care Homes | 2 | 1,416,000 | 1 | 2,729,000 | - | — | 1 | 6,590 | - | — | - | — |
| Psychiatric Hospitals | - | — | - | — | 2 | 12,584,000 | - | — | - | — | - | — |
| Kidney Disease Treatment Facilities | 1 | 114,210 | - | — | 1 | 389,000 | - | — | - | — | - | — |
| Ambulatory Surgery Centers | - | — | 1 | 600,000 | - | — | - | — | - | — | - | — |
| TOTAL | 5 | 10,880,210 | 6 | 6,617,300 | 4 | 14,975,000 | 5 | 13,578,598 | - | — | 1 | 22,927,340 |

Throughout the Certificate of Need Program's history, 21 of the Department's decisions were appealed: 15 were decisions to deny, and six were decisions to approve. Five of the decisions to deny were upheld, six were reversed, and four are pending. Five of the decisions to approve were upheld, and one is still pending.

The Department also received 64 letters of intent which were later withdrawn. These potential projects totaled $41,841,013.

PROGRAM IMPACT ON ACCESSIBILITY AND DUPLICATION OF SERVICES

The State Health Plan and federal guidelines for health planning emphasize accessibility for rural and low income individuals, as well as preventing duplication of services. Thus, special concerns in conducting reviews often occur due to the geography of Kansas. Only four counties in the state have populations over 150,000 and are considered urban areas. Another 16 counties have populations between 25,000 and 70,000. The remaining 85 counties all have populations under 25,000 and thus, can be considered rural counties.

Examination of the Certificate of Need record for adult care homes indicates that six of the nine denials and the one modification occurred in urban counties or intermediate sized counties where, in addition to an excess of adult care home beds established in the State Health Plan, a number of long-term care continuum programs exist which reduce the need for institutional services. The remaining three denials, although occurring in rural counties, were to be located in areas where the available adult care home bed-to-population ratio established in the State Health Plan exceeds the standard of 90.0 beds per 1,000 persons age 65 and older.

Approvals for adult care home Certificates of Need show that 75 percent (1,996) of additional beds approved were in counties that either had not previously had nursing home care available or were far below the standard of 90.0 beds per 1,000 age 65 and older. Further, many of the bed additions resulted in skilled nursing home services for areas previously underserved, or established intermediate care facilities for the mentally retarded.* The remaining 25 percent largely represent relatively minor bed additions (ten beds or less) to existing nursing homes. In these cases, the bed additions brought the applicant's total number of nursing home beds to 60, which represents the maximum per nursing unit allowed by licensure regulations. The remaining additions generally represented skilled facility services, services for the mentally retarded, or facilities operated in conjunction with retirement communities.

The Certificate of Need record for hospitals and all other projects indicates that there were 136 approved applications and five denials. Two denials duplicated services in the urban Kansas City area, while the others duplicated services in counties with a medium-sized population. The location of the denials indicates that care for rural and low-income Kansas residents clearly has not been decreased by the program.

Access to sophisticated new medical technology in every Kansas county is neither expected nor financially feasible. Generally, primary care services are provided in rural areas; both primary and secondary services are provided in medium sized counties, and urban facilities provide tertiary care services for all state residents, as well as primary and secondary care services. Based on this distribution, it appears that applicants within each population category have requested and been granted Certificates of Need which appropriately increase accessibility to new medical technology.

---

*The need for skilled adult care home beds and intermediate care facilities for the mentally retarded is discussed in the State Health Plan.

Requests for equipment generally reflect health care's expanding technology. Therefore, it is not surprising that the largest number of approvals for equipment, approximately 70 percent, were granted to urban hospitals.

Conversely, rural hospitals requested the fewest number of Certificates of Need for equipment. However, they showed the greatest need for construction, as 44 percent of the expansion, renovation, and new construction projects were approved for these hospitals. Examination of these approved projects, on an individual basis, indicates that with few exceptions, the approvals involved construction of facilities to house primary care services or renovation and expansion of existing facilities for primary care services.

With regard to the new services, the largest number of all Certificates of Need for new services, 41 percent, were granted to regional health care centers found in counties in the intermediate population range. These approvals have frequently enabled Kansas residents to receive needed services on a regional, rather than tertiary level. Further, these approvals document the increasing availability of specialized physician manpower.

EFFECTIVENESS OF THE PROGRAM

The Certificate of Need Program has generally achieved its purpose. Rampant expansion of health care services has been curtailed, and accessibility of necessary services for rural and low income residents has been maintained. Duplication of services, in most cases, has been avoided, and costs have been restrained to some degree.

If we continue to see about $80 million annually in proposed capital projects; some proposals will represent critical needs. However, we must begin recognizing the difference between amenities and quality medical care and draw a distinction between proposed medical care projects which are desirable and those which are seriously needed and those which we can afford.

Further, while the program will to become more effective at preventing duplication; we must remember that other factors will continue to be at work to increase health care expenditures:

- The increase in government expenditures for health care and health care resources since 1966 has been a primary source of inflationary pressure in the health system.

- The increased percentage of elderly who require medical care.

- The changes in disease trends from infections to chronic disease.

- The health implications of individual life-styles are dramatic. Compared to other possible interventions, changes in health-related behavior patterns offer the greatest potential for reducing chronic disease and improving health, as well as hopefully reducing the demand for costly medical care services.

- Heavy financial support of biomedical research and related increases in supply of physician specialties have led to an emphasis on super high technological medicine. We must seek a new balance of research resources devoted to all the determinants of health (life-style, environment, heredity, and medical care).

- The system of third-party reimbursement has created a health care market where neither providers nor consumers bear sufficient responsibility for the prices of the services they provide or consume. The financing system replaces management incentives for efficiency with incentives to increase the costs and supply of services beyond defined need.

- The supply of hospital and nursing home beds and in the not too distant future, physicians, exceeds the need. This excess supply contributes to unnecessary utilization and rising costs.

- Hospital and nursing home services are overutilized in preference to other, lower cost alternatives. New efforts to determine the appropriateness of utilization must be implemented. Alternatives to costly institutional care must be encouraged.

- Normal price competition in the health care market is extremely limited. Prepayment financing alternatives should be developed to improve the climate of price competition.

- A "loop-hole" in the current Certificate of Need Act exists that contributes to increases in health care expenditures. Major medical equipment purchases are only covered if a health facility is the sponsor or if the equipment will serve inpatients.

3-22-83 #9

# KANSAS STATE BOARD OF NURSING

BOX 1098, 503 KANSAS AVENUE, SUITE 330
TOPEKA, KANSAS 66601
Telephone 913/296-4929

TO: Senator Jan Meyers, Chairperson, and Members of the Senate Public Health and Welfare Committee

FROM: Dr. Lois Rich Scibetta, Executive Administrator

RE: House Bill 2012

DATE: March 22, 1983

Thank you Madam Chairman, My name is Dr. Lois Rich Scibetta and I am the Executive Administrator of the State Board of Nursing. I am here today to speak in support of House Bill 2012. House Bill 2012 creates an eleven member health planning review commission, which includes participation by the nursing profession. The Board of Nursing is delighted to see that nurses are being included in the important task of evaluating health planning activities for the state.

There is only one area of concern the Board would raise and that is on lines 0069-0071 which give the commission only a few months to study the issue and prepare the report.

As noted, the Board would support passage of House Bill 2012. Thank you. I will be happy to answer any question you may have.

Att. 9