Approved _____
Date

MINUTES OF THE SENATE COMMITTEE ON WAYS AND MEANS.

The meeting was called to order by Senator Paul Hess at
Chairperson

4:45 ~~a.m.~~/p.m. on March 21, 1984 in room 123-S of the Capitol.

All members were present except:
Senators Harder and Talkington

Committee staff present:
Research Department: Mary Galligan, Lynne Holt, Julian Efird, Alan Conroy
Revisor's Office: Norman Furse
Committee Office: Mark Skinner, Doris Fager

Conferees appearing before the committee:
Barbara Sabol, Secretary, Department of Health and Environment
Charlie Beall, Hospital Surgical Centers
Richard Friedeman
Dr. Bob Goolsbee, Surgi-Center, Kansas City, Missouri
Dr. Warren Abbot, Podiatrist, Topeka
Shea Bonhag, Executive Director, Mid America Health Care Coalition
Jeanette Livingston, AARP
Marlon Dauner, Blue Cross-Blue Shield
Frank Gentry, Kansas Hospital Association
Melissa Hungerford, Kansas Hospital Association
Howard Chase, Kansas Hospital Association Board of Directors

SB 827 - Certificate of need for health care facilities; concerning ambulatory surgical centers

The Chairman explained that SB 827 would allow ambulatory surgical centers to be constructed in counties of over 50,000 population as long as the capital expenditure did not exceed $600,000, without a Certificate of Need. He added that it is his understanding a hospital or clinic can now do this, and SB 827 would provide that anyone can construct facilities under the above circumstances.

Ms. Sabol presented written testimony. (Attachment A) Following her presentation, there was extended discussion. Senator Gaines indicated he felt the Statewide Health Coordinating Council (SHCC) is composed only of hospital people and consumers who are strictly on the side of the hospitals. There was discussion concerning hospitals getting Certificates of Need while Ambulatory Surgical Care Centers are turned down. Senator Hess suggested repealing the Certificate of Need Law and let competition determine the market place. Ms. Sabol said she is not sure the uncontrolled market place principals apply to the health care system. For instance, a health care trip cannot be postponed, but a trip on an airline can be postponed.

Ms. Sabol further stated that when the health care planning and certificate of need process was put in place it was needed, and there is still duplication of services. She stressed the purchase of expensive equipment and the duplication of such equipment. When a committee member noted that length of hospitalization is diminishing, Ms. Sabol indicated this is not a new concept.

When asked if she would object to the statute providing that cost containment be considered in terms of Certificates of Need, she said she would not.

Mr. Beall distributed his written testimony (Attachment B). Committee members questioned him following his testimony. In answer to a question about comparative costs at hospitals and ambulatory centers, Mr. Beall said that generally there is a savings of about 40% at the latter over inpatient charges and 20% over hospital outpatients.

Answering a question from Senator Hess, Mr. Beall said that he feels there will never be a certificate of need issued under present legislation.

Mr. Goolsbee indicated he is an anesthesiologist, and has become aware that there is a better way to give care than can be given in the hospital. Insurance companies set up guidelines that there would be no reimbursement for surgery performed outside a

SB 827 - Continued

hospital. Consequently, surgery performed outside hospitals was stopped. Several groups began working on the problem so that surgery could be performed outside hospitals. First, hospitals were asked to provide this kind of care in a separate environment, and that proved to be a better arrangement. He reminded the committee that in the early 1960's there was not so much concern about costs.

Dr. Goolsbee said that the stumbling block in Kansas is the fact that if you do not have a license you cannot operate a facility, and if you are a new provider you must get a Certificate of Need. The hospitals can go ahead and expand their operating rooms. The certificate of need law did not address operating room capacity, and has not regulated that. There is now a surplus of operating room capacity in the state.

Dr. Goolsbee said his organization has a surgical center in Kansas City, Missouri, which has been in operation for six years. He indicated the safety of the centers has been well established. In answer to a question from Senator McCray regarding the policy of surgical centers for taking people without ability to pay, Dr. Goolsbee said it is his organization's general policy that if the surgeon indicates he will not charge the patient, the surgical center will do the same thing.

Mr. Friedeman distributed his written testimony (Attachment C) and read from that statement. Following his presentation, there were several questions from members of the committee. Senator Gaines asked if any problems would be answered if a cost containment provision were included in the statute. Mr. Friedeman said he thought it would be an improvement, but that the bias in favor of existing providers is now in statute.

Dr. Abbott stated he is a podiatrist licensed by the State of Kansas. He is limited because he cannot give any anesthesia or perform amputations. He indicated he can prescribe the same as a medical doctor, and has nine years of training. He stressed that there are certain procedures and conditions that exist that are available to his patients that he cannot give them. The ambulatory surgical center would help create these services in the podiatrist's office. He told the committee that SB 827 would help him do his job better. At the present time, he cannot use an anetheseologist in the Topeka area, but in an ambulatory surgical center he could do this.

Ms. Livingston stated the following reasons why AARP is recommending SB 827: (1) it would be much more acceptable because driving becomes more difficult with age; (2) it is a less threatening sort of experience; (3) it would be much less expensive. She further stated it would be helpful to have the personal care facilities at nursing homes. She said she lives in an independent environment, with a health center available for 24-hour a day care; and there is nothing between. Florida, Arizona and California have this type care without a certificate of need.

Mr. Bonhag distributed Attachment D. He indicated his organization is made up of chief executive officers and unions officers in the Kansas City area. He suggested the certificate of need is acceptable if there is a growth situation, but there are large areas in the country where there is an over-supply of beds. He said his organization has tried through the private sector to support health care planning. His coalition is trying to get information concerning physicians and hospital costs to provide to employees, etc. He said there is discussion concerning increased deductibles and co-insurance.

Mr. Bonhag said his organization supports SB 827. He said there are plenty of hospital facilities in the Kansas City area and there is no incentive to get into more cost effective patterns. He further stated that he is concerned with some of the hospital surgical problems and feels it is time to look at hospitals as a business. He said there are alternatives needed in the Kansas City metropolitan area.

There followed a brief discussion and committee members questioned Mr. Bonhag about other aspects of cost containment. Senator Steineger asked Mr. Bonhag if he is aware of hospitals which have developed the equivalent of an ambulatory surgical center within the hospital or as part of the hospital. Mr. Bonhag said that Shawnee Mission Hospital has a separate facility and it should be treated as one. He added that there are many hospitals across the country that are moving out into that area.

SB 827 - Continued

Mr. Dauner said Blue Cross-Blue Shield is neutral on the bill, but wanted to make some comments which might be helpful. He suggested that (1) the role of physicians generates supply and demand and (2) the element of reimbursement by third parties is important. He said that in the past his company had reimbursed hospitals on the basis of costs, and out-patient services have been similar. He stated that as BC-BS began cost-containment programs, hospitals started transferring costs to the outpatient department and the latter cost more than inpatient services.

Mr. Dauner said new arrangements bring up the issue of whether certificates of need are necessary. He asked what hospitals will do if they can't make it, and if they need a certificate of need to go out of business. He stressed that this issue needs to be studied. He further suggested that if it is determined that certificates of need should continue, all providers should have the same chance.

Mr. Dauner said the impact of cost and availability of service is important, and noted these are not determined by Blue Cross-Blue Shield in the State of Kansas. His company is only responding to a demand. He stated his company had lost some of their market and are now responding to the needs of the public, based on competition. He said that future health care services may be more costly, but that his company does not know if ambulatory surgical centers will be more cost effective. When asked by Senator Gaines if he felt subrcgation is important, Mr. Dauner answered in the affirmative.

Mr. Gentry introduced Ms. Hungerford and Mr. Chase, and asked Mr. Chase to present testimony from the Kansas Hospital Association. Mr. Chase distributed an outline of his presentation (Attachment E). He said that one of the benefits of the current law (at least in the Topeka Area) is that hospitals are going together in a joint venture to bring about technology. He said if the proposal before the committee is passed there will be four or more new units in Topeka, because it is big business in the area. He suggested that 35% of surgeries done at Stormont-Vail are out-patient surgeries, and it is his opinion that is higher than the national average.

Mr. Chase said if a free standing unit is permitted without the certificate of need, his hospital will have the same kind of service, because it is competitive in nature. He said a certain amount of dollars must be generated to keep hospitals open, and if it is not developed in one area it will be made up in another area. He said that hospitals with existing operating rooms will keep them open, since they are in the core of the buildings and do not adapt to different usage.

Mr. Chase concluded by stating that Kansas Hospital Association is opposed to SB 827 or any exception to the present certificate of need law that singles out one element for a free market and still controls the balance. He indicated that if the Legislature wants to evaluate the entire certificate of need issue, that makes more sense than taking one element out.

No action was taken on SB 827, and the meeting was adjourned by the Chairman.

KANSAS STATE DEPARTMENT OF HEALTH AND ENVIRONMENT

Testimony on S.B. 827

by

Barbara J. Sabol, Secretary

Before

Senate Committee on Ways and Means
March 21, 1984

Background

S.B. 827 amends K.S.A. 1983 Supp. 19-101a and 65-4805 to allow the development of an ambulatory surgical center, or hospital-based ambulatory surgical service, without first obtaining Certificate of Need approval.

Currently, proposals to establish free-standing ambulatory surgical facilities must receive Certificate of Need approval in order to be licensed. Hospital-based facilities must be preceded by Certificate of Need approval if the capital expenditure required to develop them exceeds $600,000.

1. The proposed exemption would apply only to counties with a population base of at least 50,000 residents; these include Butler, Douglas, Johnson, Leavenworth, Reno, Riley, Saline, Sedgwick, Shawnee, and Wyandotte counties. 1982 utilization data for hospitals in these counties is as follows:

Hospital	# Beds	Occupancy	# OR's	Surgery Suite Utilization Rate
Susan B. Allen (Butler)	103	59.4	3	46.1
Lawrence Memorial (Douglas)	200	61.7	5	89.5
Suburban (Johnson)	400	41.3	11	52.7
Shawnee Mission	379	86.4	11	90.3
Olathe	100	82.8	5	66.9
Gardner	25	62.5	1	19.9
St. John's (Leavenworth)	76	66.8	2	69.7
Cushing	114	54.6	4	27.7
Hutchinson (Reno)	230	72.8	5	113
St. Mary's (Riley)	99	58.2	4	44.2
Memorial	81	35	3	38.5
St. John's (Saline)	173	70.9	6	56
Asbury	200	62.8	6	80.65
St. Francis (Sedgwick)	886	62.5	20	99.6
St. Joseph	600	68.8	13	81.8
Wesley	760	83.7	19	134
Osteopathic	149	50.8	5	44.5
St. Francis (Shawnee)	325	74.3	15	46.0
Stormont Vail	506	62.4	15	70.2

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Hospital	# Beds	Occupancy	# OR's	Surgery Suite Utilization Rate
Memorial	179	59.2	5	68.7
KUMC (Wyandotte)	620	62.9	23	50.1
Bethany	426	71.1	10	79.9
Providence St. Margaret	400	67.1	8	58.0

It should be noted that the utilization of the operating room capacity is based on a standard of four operations per eight hour day, and 250 days per year; obviously, the utilization could be expanded beyond this time. In addition, these figures assume that all surgeries were an average of two hours long; this does not reflect the outpatient utilization. Thus, these figures are somewhat inflated.

2. This bill bring into sharp focus the question of whether to promote competition or to allow only the planned development of health resources. The pro-competitive people argue that surgery in an ambulatory surgical facility costs less than a hospital based program; one reason this could occur is cost shifting in hospitals. The competition proponents also state that free-standing facilities make the service more convenient and a more pleasant experience for the consumer. Finally, they argue that allowing competition to flourish will make hospitals operate more sensitively to price.

   Opponents of the de-regulated approach argue that hospitals are community resources; that is they provide a range of services to people, some of which are not adequately supported by a volume of patients, and therefore lose money. However, these proponents argue that hospitals price some services to make money, and others will lose; the overall effect will be for the hospital to service and continue to meet a range of community needs. If ambulatory surgical centers are built, they may cause hospitals to lose money.

3. The Statewide Health Coordinating Council (SHCC) recently rejected a proposal to exempt ambulatory surgery centers from Certificate of Need requirements. The SHCC stated that, "An unregulated approach would result in unnecessary service duplication and does not address overall system concerns related to an excess of surgeons and the performance of unnecessary surgery." (SHCC, March 4, 1984) (Attached)

   The SHCC is currently developing guidelines which include all surgical capacity (inpatient, outpatient) in a Certificate of Need analysis for additional surgical capacity; however, these guidelines will not prevent hospitals from adding to their capacity if their expenditures do not exceed $600,000. Similarly, existing free-standing facilities would be

able to add capacity if their costs did not exceed $600,000. One way to address this problem would be to license operating rooms like beds; a Certificate of Need would then be required to add even one operating room.

4. The long-term costs of ambulatory surgery are unclear. The SHCC states that the current costs in free-standing ambulatory care facilities are generally less, however, the overall long-term cost to the community may be greater if unnecessary duplication results.

   To support this, Blue Cross/Blue Shield has testified at Certificate of Need hearings that the development of ambulatory surgical facilities in areas where existing capacity is under utilized could result in higher costs. This is particularly true under cost-based reimbursement; however, the prospective system is attempting to eliminate payment for excess capacity. Thus, if hospitals do not use surgical capacity, it will likely be shut down. From a pro-competition perspective, this may be a desirable policy objective; however, it is also possible that other necessary services will be shut down.

5. If this bill is passed, the Kansas Certificate of Need Program will be out of compliance with the Federal Program Requirements (42 CFR §123.401 and §123.404). Failure to maintain a complying program could mean the loss of State Public Health Service funds.

   Some of these grants include the Child Health Block Grant ($3,802,000), a Preventive Health Services Grant ($769,371), Medicare ($283,000), Tuberculosis ($22,000), Migrant Health ($236,000), Immunization ($36,000), Health Planning ($246,000), and Family Planning ($929,000). These grants are only to Kansas Department of Health and Environment, and do not include other agencies. The Federal Government has never imposed any sanctions on states, although some states fail to maintain a complying program.

6. Another concern may be that this bill may violate the concept of equal protection. Article 2, Section 17 of the Kansas Constitution requires that laws be applied uniformly to all counties. This issue needs further investigation.

DRAFT FOR PUBLIC HEARING RELEASE

March, 1984

AMBULATORY SURGERY

PROBLEM IDENTIFICATION

The health care delivery system challenge of the 1980's is to provide high quality care in the most cost effective setting possible. To this end, attention is increasingly focused on various forms of ambulatory care as alternatives to inpatient hospital care. Ambulatory care, broadly defined, includes primary care, hospital outpatient care, ambulatory and neighborhood health clinics, emergency room services, and ambulatory surgery.[1] Although each type of ambulatory care has been studied during the last decade, ambulatory surgery proposals have perhaps generated the most interest.

Ambulatory surgery* has been defined in a number of ways:

> Surgery of an uncomplicated nature that was traditionally done on an inpatient basis but can be done with equal efficiency without hospital admission.[2]
>
> Surgery requiring anesthesia or a period of post-operative observation, or both, to patients whose admission for overnight stay is not anticipated as being medically necessary.[3]

It is widely recognized by the medical community today that a large percentage of surgical cases do not require hospitalization. Thus, ambulatory surgery is hailed as a viable cost containment proposal. However, to be of value, plans for expansion of any ambulatory service must be viewed as an integrated part of the health care system. Confusion then arises because there are actually several ways to deliver ambulatory surgery: freestanding ambulatory surgery centers; hospital-based outpatient surgery departments; hospital-affiliated ambulatory surgery programs; and outpatient surgery performed in general surgical suites.[4] Given these variations, concerns exist because of the potential for service duplication.

Over 24 million operations were performed in the United States in 1980; the estimated rate of surgery equaled 109.8 procedures per 1,000 population.[5]** In Kansas, 228,082 operations (96.5 per 1,000 population) were performed in 1980; in 1982, the number and rate increased slightly (234,194 and 97.2 per 1,000, respectively).[6] Nationally, it has been estimated that 60 percent of all hospital expenditures are due to surgery.[7] This would yield over $702

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*Also referred to as outpatient surgery, day surgery, same day surgery, not-for-admission surgery, and in-and-out surgery.

**Males had a lower surgical rate (79.0 per 1,000) than females (169.1 per 1,000). The rate of surgery increases with age, from 35.9 per 1,000 under age 15, to 193.2 per 1,000 age 65 and older.

million in hospital surgical expenditures in Kansas. Obviously, proposals which could help reduce surgical expenditures could have a major impact on health care costs.

Since 1971, it is estimated that surgery rates have increase four times faster than the overall growth in the population.[8] In medical literature, a number of possible explanations for this increase have been offered. First, advancements in medical technology and knowledge have made many ill health and disease conditions amenable to surgical intervention. Examples of advancements include organ transplants, open heart surgery, and laser treatments.

Second, the number of surgeons in the country has increased substantially, from 92,000 in 1970 to over 100,000 currently.[9] Some studies indicate the country now has 30 percent more surgeons than are needed; further, by 1990 it is estimated that the number of surgeons may increase by one-third.[10]* A recent report in the New England Journal of Medicine indicated that one of the major forces leading to increased surgery rates is the oversupply of physicians.[11] In 1982, there were approximately 900 physicians practicing surgery in Kansas.[12] With the exception of some western and northeastern areas of the state, the surgeon supply is considered more than adequate.

The surgeon issue relates to a third explanation offered: unnecessary surgeries are being performed. Utilization review does not address this concern because it occurs after surgery. There has been a growth in second opinion programs, however, which offer promise. Results from one such program indicated that the second opinion did not support the initial diagnosis in 18 to 33 percent of all cases.[13]

Although some surgical procedures are complex and involve substantial recovery time (hospitalization) for patients, a large percentage are labeled "simple," "common," and/or "elective." It is to this latter category that ambulatory surgery directs itself. Data from Blue Cross/Blue Shield indicates that the top eight ambulatory surgical procedures, in terms of total cases, are sigmoidoscopy, gastroduodenoscopy, arthrocentesis, dilation and curettage, simple wound repair, incision and drainage of an abcess, diagnostic cystourethroscopy, and intralesional injection. When examined in terms of benefits paid out, procedures such as colonoscopy, vasectomy, laparoscopy, and excision of breast cysts are added to the list.[14]

Research studies indicate that between 20 and 40 percent of all surgeries could be adequately and safely performed on an ambulatory basis.[15] Kansas data for 1982 indicate that 29.7 percent of all surgeries were performed on an outpatient basis; this is a dramatic increase from the 14.5 percent noted in 1980.[16]** Numerous factors can influence the use of ambulatory surgery, including: patient status, consent, and prognosis; physician preference and decisions on procedures and anesthesiology; and insurance coverage.

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*An estimated 3,800 new surgeons enter the health system each year.

**Kansas data further indicates that approximately 70 percent of the outpatient surgeries were performed at hospital-based or affiliated ambulatory surgery programs.

It is interesting to note that whereas ambulatory surgery is often viewed as a recent cost containment concept, its establishment actually dates back to the turn of the century.[17] The first reported discussion of ambulatory surgery was in 1909 before the British Medical Society. The first reported program in the United States was in 1918 at Sioux City, Iowa. However, it was not until the 1960's that the concept began to gain acceptance in the medical community. This change in attitude was primarily due to medical developments in the field of anesthesiology, blood loss control, and pain management. In 1971, the American Medical Association formally endorsed ambulatory surgery for the first time; the American College of Surgeons endorsed the concept the next year, but recommended that all programs should be hospital-based or affiliated.[18] Numerous insurance plans followed suit and provided reimbursement for outpatient surgery. One result of such support has been that 70 percent of urban hospitals are now involved in ambulatory care; further, there are over 100 freestanding centers in the country.[19]

In 1980, Congress enacted the Omnibus Reconciliation Act, P.L. 96-499, which further promoted ambulatory surgery.[20] Basically, the Omnibus Act provided Medicare reimbursement incentives for physicians to use certain ambulatory surgical procedures* and provided reimbursement to freestanding facilities for the first time. This legislative change may be responsible for the American College of Surgeons reversing its position in 1981 and supporting ambulatory care in all settings.

To receive Medicare reimbursement, freestanding facilities (including distinct unit, hospital-affiliated programs) must meet certain conditions of participation.[21]** One condition is compliance with any existing state licensure laws. Twenty-two states, including Kansas, have enacted specific legislation for ambulatory surgery center licensure.[22] K.S.A. 65-425 defines an ambulatory surgery center as: an establishment with an organized medical staff of physicians; a permanent facility equipped and operated primarily for the purpose of performing surgical procedures and providing continuous physician services and registered professional nursing services whenever a patient is in the facility; and not providing services or other accommodations for patients to stay overnight. The Kansas statutes further define ambulatory surgery centers as medical care facilities which require state licensure; in order to be licensed, Certificate of Need approval is required.[23]

The Certificate of Need approval issue has generated much controversy. It has been called the greatest hurdle to the development of freestanding centers, and therefore has been criticized for not promoting health care competi-

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*Physicians receive 100 percent reimbursement for reasonable charges, as opposed to 80 percent of reasonable charges for inpatient surgery. Only certain procedures are covered and in general, the surgery should not exceed 90 minutes in operating time and four hours in recovery.

**The conditions of participation cover: governing body and management; surgical services; evaluation of quality; physical environment; medical staff; nursing service; medical records; and pharmaceutical services.

tion.[24] To date, the Kansas Department of Health and Environment has reviewed seven proposals for ambulatory surgery centers; total capital expenditures equaled $4,953,570. Six projects were denied by the Department. Two decisions were appealed, but the Department's decisions were upheld ($1,267,764); one decision was appealed and reversed ($600,000). The one project approved involved licensure of a previously unlicensed center; no expenditures were involved. Currently in Kansas, there are three licensed freestanding centers; one center predated the Certificate of Need Act.

PROBLEM ANALYSIS

The Acute Care Hospital Section of The 1983 Plan for the Health of Kansans discusses the general problem of excess health services supply and unnecessary utilization of inpatient services. A resulting recommendation states: Reduce the demand for inpatient hospital services by encouraging outpatient services as an alternative to inpatient care when cost-effective.[25] Although ambulatory surgery centers provide an alternative to inpatient care, there are additional issues raised in the Certificate of Need Program review criteria and standards which must also be addressed. These include:

- determination of community need, including an analysis of existing health facilities and services; and
- determination of cost-effectiveness (containment), including an analysis of alternatives for correcting the health problems, and the impact of the proposal on patient charges in the health care industry.[26]

Determination of Community Need

In reviewing Kansas ambulatory surgery center proposals, the determination of community need has taken into account all existing surgical capacity in a service area, and the utilization of that capacity. There are reports which justify this position as the only way to prevent potentially unnecessary and costly duplication of health care resources.[27]* The former Mid-America Health Systems Agency was the only local planning agency to address utilization of surgical services. Based upon a review of the literature and the opinions of medical experts, the health systems agency adopted several utilization standards.[28]

- Potentially attainable and desirable utilization of the operating room is between 75 to 85 percent.

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*A similar situation exists in Kansas health planning and Certificate of Need reviews related to institutional long-term care services. In determining resources available, freestanding skilled, intermediate, and personal adult care home beds are included in the count with hospital long-term care unit beds.

- Operating room utilization is considered to be the percentage of time available for scheduled surgery that the room is actually in use, including the time a patient is in surgery and time for preparation and clean-up.

- Based on an average surgical case time of 1.5 hours and 75 percent utilization in an eight hour scheduled surgery period, four surgical cases per operating room per day represents an efficient average case load. If surgery is scheduled 250 days per year, 1,000 surgical cases could be performed annually.*

In 1982, there were 433 surgical suites in Kansas hospitals and surgery centers.[29] Given the previously reported 234,194 surgeries performed during 1982, statewide utilization of surgical capacity would equal 54.1 percent. These data indicate that the state as a whole has excess operating room capacity. When counties in the state are analyzed by population subgroupings,** however, it is noted that rural areas have the greatest excess (1982 utilization equaled only 25.8 percent), while urban areas have the highest (1982 utilization equaled 80.9 percent). Utilization of intermediate-sized counties equaled 50.5 percent.

Critics of this position argue that freestanding ambulatory surgery centers are substantially different from the other delivery methods for ambulatory surgery and should not be evaluated with dissimilar programs, in particular, with outpatient procedures done in general hospital surgical suites.[30] To make such a comparison is said to give an unfair advantage to already existing hospital programs which could expand services while remaining under Certificate of Need thresholds.[31] Thus, critics argue that the current system does not promote service competition. It is, in fact, the case that legitimate debate exists between the two positions: prevent unnecessary duplication versus promote service competition.

Determination of Cost-Effectiveness

Kansas Certificate of Need reviews have looked closely at the impact of ambulatory surgery center proposals on patient charges and health expenditures in general. There are a number of studies that indicate substantial cost savings connected with ambulatory surgery, especially those performed in

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*This would represent a minimum utilization standard because it does not account for evening or weekend surgeries performed.

**The groupings include: counties with populations in excess of 150,000 (Johnson, Sedgwick, Shawnee, and Wyandotte); counties with 1980 populations between 25,000 and 150,000 (Barton, Butler, Cowley, Crawford, Douglas, Ellis, Geary, Harvey, Labette, Leavenworth, Lyon, McPherson, Montgomery, Reno, Riley, and Saline); and 85 counties with respective populations less than 25,000.

freestanding units. A late 1970's study by the Orkand Corporation* indicated that freestanding centers had costs 42.5 to 61.4 percent lower than hospital inpatient surgery; 11.6 to 14.7 percent lower than that for hospital-based outpatient surgery units; and 14.3 to 44.9 percent lower than hospital-affiliated ambulatory surgery units.[32]** A North Carolina study by Blue Cross/Blue Shield showed savings of 49 to 77 percent for all ambulatory surgery compared to inpatient surgery.[33]

One reason that hospital programs show higher costs has to do with the cross-subsidization of procedures; that is, it is sometimes the case that charges for simple operations are inflated to help cover the substantial costs of more complex surgery.[34] Also hospitals have higher overhead costs due to the "stand-by" services they provide.

Although freestanding ambulatory surgery programs reduce the inequity problem caused by cross-subsidization, several cautions are in order. First, the new Kansas Blue Cross/Blue Shield and Medicare diagnostic-related grouping (DRG) prospective payment systems will address this issue. Hospital reimbursement will, within certain limits, be standardized. If a hospital should incur costs in excess of an allowable limit on a case, it will not receive extra reimbursement, nor will it be able to shift costs to another case. Second, to the extent that a freestanding facility might take lower risk/lower cost patients from the hospital, it may lead hospitals to have higher costs for higher risk patients at a time when revenues are declining. In facilities already experiencing low occupancy and utilization, particularly in rural areas, this could result in a reduction or termination of services.[35] In some cases this could be detrimental to a community if access to needed services was impaired; residents might go without care, or travel substantial distances to receive care in other sites, thereby increasing overall costs. Similarly, costs to the community could increase unnecessarily if both types of services (freestanding centers and hospital programs) continue to function, but all are underutilized, or if utilization is unnecessarily increased to fill available capacity, i.e., unnecessary surgery.[36]*** In such cases, the greatest economy of scale may be achieved with a single provider who has a wide service scope. Thus, the economic principles at work are not pure, and debate exists over the cost implications of ambulatory surgery.****

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*The study was funded by the former Department of Health, Education, and Welfare.

**The ranges resulted from the different types of surgery being compared.

***A study of 1976 to 1977 changes in Colorado Medicare rates indicated that as reimbursement rates declined, physicians increased the intensity (mix) of medical/surgical services and quantity of surgical services.[37] Thus, the report concluded that physicians responded to reduced reimbursement with higher levels of induced demand which may or may not have been necessary.

****Some researchers do indicate that the most potentially cost-effective freestanding facility has four surgery suites and a minimum population base of 100,000 people within 30 minutes travel time.[38]

Additional Considerations

Debate over the relative value of various forms of ambulatory surgery also extends to quality of care issues. Proponents of freestanding facilities cite benefits of: reduced possibility of post-operative infection; less waiting time to receive surgery; reduced patient anxiety and less disruption to the patient's life-style; more productive use of physician time, etc.[39] It is interesting to note that the first major freestanding center in the nation, Surgicenter of Phoenix, Arizona, has performed 30 operations per day for the last decade and has not recorded one fatality.[40] Further, proponents cite that innovations in surgical techniques now allow freestanding facilities to treat more seriously ill patients, thus countering the low risk/low cost argument previously cited.

Other evidence indicates some quality concerns with ambulatory surgery in general. The potential exists for less patient compliance with post-operative treatment plans; one study found two-times the post-operative complications in hemorrhoidectomies.[41] Concerns are raised, but no studies have examined, the potential burden placed on families to provide in-home nursing care.[42] Further, the question has been raised as to whether freestanding facilities can provide the type of quality control through peer review as hospitals can.[43] Finally, the issue of the surgeon surplus again surfaces; the role which physicians play cannot be underemphasized because they have substantial control over the critical decision to operate while the patients have little involvement in the decision. The extent to which the surplus factor coupled with expanded ambulatory surgery capacities may lead to increased numbers of unnecessary surgeries is unknown. Also unknown is the extent to which physicians who currently perform some procedures cost-effectively in their offices would substitute those settings for ambulatory surgery facilities.

SUMMARY

Substantial points of debate exist when addressing the subject of ambulatory surgery center treatment under the Certificate of Need Program. In determining policy directions for the future, the benefits and drawbacks of all positions must be carefully examined. A basic review consideration is the cost-effectiveness of proposed projects. As discussed previously, the long-term cost impacts of ambulatory surgery are unclear; whereas the current cost of ambulatory surgery in a free-standing facility is usually less for any given individual, the overall, long-term cost to the community may be greater if the project represents unnecessary duplication. Therefore, community need determinations must be balanced with short-term and long-term cost containment considerations.

RECOMMENDATIONS

Goal: Promote ambulatory surgery programs in a variety of settings to prevent expenditures related to unnecessary inpatient surgery and hospitalization.

Objective

The development of new or expansion of any existing ambulatory surgical capacity, regardless of setting, should be covered by the Kansas Certificate of Need program.

Recommendation

Certificate of Need applications for the addition of any new surgical capacity regardless of setting in a service area should take into consideration:

a. Quality of existing and proposed services, including staffing issues and access to support and emergency services.

b. Utilization of all surgical capacity in the service area. If utilization of all resources falls below 75 percent (based on a standard of 1,000 cases per operating room per year), consideration should be given to:

- the current and proposed mix of outpatient/ambulatory procedures to inpatient surgeries. The desired mix should be between the current state average of 30 percent ambulatory procedures and 40 percent ambulatory procedures.

- the utilization of similar ambulatory surgical resources based on a standard of 1,500 cases per suite per year.

c. A service area population of at least 75,000 people within 30 minutes travel time.

d. Consideration must be given to the short-term and long-term cost impact of proposed projects.

In proposing the above recommendation, the Statewide Health Coordinating Council considered several other alternatives.

- Cover all operating room capacity under Certificate of Need, develop one utilization standard,* and apply the standard to all capacity when any application is under review.

This option was felt to equalize treatment of all surgical resources under Certificate of Need, but also was felt to be overly rigid in terms of possible new service development.

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*Utilization for all surgical resources would equal 75 percent based on a minimum standard of 1,000 cases per operating room per year.

- Applications for the addition of new surgical capacity would only take into consideration like resources,* and one utilization standard (75 percent based on a minimum standard of 1,000 cases per operating room per year) would be applied.

The option was not considered to be desirable because it ignored the fact that ambulatory surgery could be safely, adequately, and appropriately performed in several different settings. To make an assumption that a community was ill-served because it lacked one setting in which a service could be delivered is not necessarily correct. Further, the one standard for utilization ignores the fact that ambulatory procedures are usually of a much shorter duration.

- K.S.A. 65-425 could be amended to remove Certificate of Need approval prior to licensure of ambulatory surgical facilities.

The option would allow free market competition in the establishment and operation of ambulatory surgery centers. To the extent that an unregulated approach would result in unnecessary service duplication and does not address overall system concerns related to an excess of surgeons and the performance of unnecessary surgery, the option was not desirable.

- Continue to apply the recommendation from the 1983 State Health Plan Acute Care Hospital Section which states: Reduce the demand for inpatient hospital services by encouraging outpatient services as an alternative to inpatient care when cost-effective.

This option does not specifically address ambulatory surgery; therefore, it was desirable to develop a new recommendation which set forth specific utilization standards.

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*Freestanding centers would only include consideration of other freestanding centers, etc.

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TESTIMONY

OF

CHARLES E. BEALL, PRESIDENT

HOSPITAL SURGICAL CENTERS, INC.

ON

S.B. 827

AN ACT RELATING TO CERTIFICATE OF NEED FOR HEALTH FACILITIES

BEFORE

SENATE WAYS AND MEANS COMMITTEE

SENATOR PAUL HESS, CHAIRPERSON

WEDNESDAY MARCH 21, 1984

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My name is Charles Beall, I am the President of Hospital Surgical Centers, Inc., based in Topeka, Kansas. Our Company was formed to develop, operate and manage ambulatory surgical centers, on our own behalf, and also in association with physician groups, and/or hospitals. First of all, I wish to thank the Committee for giving me this opportunity to present our views as concerns S.B. 827.

We support this bill. We support it because we feel that the changes encompassed in 827 are needed to right a wrong. A wrong that is being perpetrated on private enterprise concerns such as ours, a wrong being perpetrated on a great number of physicians who wish to become actively involved in cost containment efforts and in restructuring a basically non-responsive system, and most importantly, a wrong being perpetrated on the consumers of the State of Kansas, by unduly and unnecessarily restricting freedom of choice.

I would like to analyze the specific changes, as relates to exemption from C.O.N., contemplated in this bill. First of all, we must recognize the fact that there are already exemptions allowed under the present C.O.N. legislation. For example HMO's, Hospices and Home Health Agencies are excluded from C.O.N. requirements. Their intent is the same as ours, to keep people out of the acute care environment. In addition, physicians are free to establish, in their offices, whatever type of ambulatory surgical facilities they wish, without the requirement of a C.O.N.

Hospitals are free to establish and/or expand Ambulatory Surgical Facilities, at will, as long as they stay under a cost threshold of $600,000.00. For all practical purposes, this exemption for the hospitals, precludes forever the establishment of free standing Ambulatory Surgical Facilities, by companies such as ours, in the State of Kansas. As long as a hospital is free to expand their facilities, the establishment of need, which is defined by the Kansas Department of Health and Environment only in terms of space availability, can never be accomplished. If "need" parameters, for example, are set at a 75% utilization trigger, and existing facilities in the acute care hospital reach, say 73%, all the hospital has to do is convert more rooms to ambulatory surgery and the "need" is satisfied. (Remember, they do not need a C.O.N. to do this.) How then, can a company, such as ours, ever hope to obtain a C.O.N. under such a discriminatory law. And, senators, we are being discriminated against.

All we are seeking with this bill is to be treated the same as other providers. We do not seek special privileges - we want only fairness and equity.

If the hospitals can establish such facilities without a C.O.N., if the doctors can establish without C.O.N., then we want to be able to establish without a C.O.N.

Now we have heard the comment that doctors are not establishing such facilities. Let us put that statement to rest immediately. The doctors are doing it. Here in Topeka, for example, there are two sizable construction programs going on right now, where such facilities will be established. I am sure this is the case in other cities.

And what is the posture of hospitals as we contemplate this bill. Let me cite two examples. In 1982, there were four applications for C.O.N.'s for Ambulatory Surgical Facilities. All four were denied by the Department of Health and Environment, based on their determination that need was not proven, because there was "excess capacity" in the applicable systems. One of those applications was from Shawnee Mission Medical Center, located in Johnson County, and as I stated, their application was denied. Another of those applications was submitted by Dr. Bob Goolsbee, also in Johnson County, his application was also denied. Two weeks ago I was informed by Dr. Goolsbee that Shawnee Mission Medical Center had broken ground and was constructing an Ambulatory Surgical Facility. I called the Department of Health and Environment to make inquiries about the accuracy of the report. I was informed that such activity was taking place - that the position of S.M.M.C. was that they did not need a C.O.N., because they were doing it for less than $600,000. The excess capacity determination obviously had little impact on the decision makers at Shawnee Mission. I was informed by Health and Environment that they were going to review the situation, but that if the project was indeed under the $600,000 threshold, there was nothing they could do to stop the project. I might add that Dr. Goolsbee was not afforded the luxury of being able to proceed with his project. The hospital can build - the physician cannot.

I was also informed within this same time frame, by a [illegible]tor in Wichita, that Wesley Medical Center, which had purchased a privately owned Ambulatory Surgical Facility several years ago, had in turn sold that facility to a for-profit ambulatory surgery company located in Texas. Wesley, of course, is free to continue providing and expanding such services and facilities in-house, but I question the fairness of a system that allows such activity to take place, without public scrutiny, and without C.O.N. implications, given the Department of Health and Environment posture, relative to C.O.N. for new facilities.

I would now like to take a few minutes to address some of the opposition comments that relate to this bill. The most frequent observation that I have heard is that we should not do anything at the present time, other than extend the present C.O.N. legislation, because the hospitals are in a very trying period, that the DRG's, the COST CAPS, the problems in and with the economy, are placing hospitals under immense financial strains - that some hospitals may even be forced to close their doors. Consequently, we should "let the dust settle" and maybe in a year or two some action may be called for. I call this the "Status Quo" argument.

A second observation that I have heard is that while the establishment of an Ambulatory Surgical Facility, free of hospital control, may well indeed provide services at less expense, when

compared to a hospital based program, the "total" costs to community may increase. This would be because the hospital facilities would still be present, the overhead costs would continue, and those costs would be passed on to the consumer in the form of higher hospital bills.

A third observation that I have heard is that allowing competitive F.S.A.S.C. may force some hospitals out of business, and this might impede or completely eliminate access to needed medical services for some segments of our society.

I would like to respond to these arguments in reverse order. First, as to access. This bill allows for C.O.N. exemption only in those counties with a population base of 50,000 or more. Consequently, there will be no impact on the small rural hospital, which in many cases is indeed fighting for its financial survival, and in many cases is the sole provider of care in a county, or in some cases, multiple counties.

These institutions, in my opinion, should not be impacted upon, and we have no intention of doing so. The larger population centers that we would be focusing on however, are normally multi-institutional environments and those hospitals are financially quite strong. In single hospital provider environments, we again are normally looking at exceptionally strong institutions, from a financial viability standpoint. In either case, patient accessibility to acute care services should not be jeopardized or impeded in any sense of the word, because of the passage of this bill.

Now as to the second observation, that total costs to community may increase, I would like to make these comments:

1) The argument that allowing the establishment of facilities such as ours will drain revenue out of the hospital and consequently raise total community costs, is, in my opinion, subjective and non-provable. Moreover, it is based on bad logic - for if we carry such a premise to its logical conclusion then this body should move to outlaw H.M.O.'s, Hospices, Home Health Agencies, Utilization Review, etc.; the intent of all of which is to keep people out of hospitals. The impact of the revenue drain from these efforts, dwarfs any potential impact that our effort might have.

2) Any cost transfer by the hospital to the consumer will be extremely difficult to accomplish. The advent and expansion of reimbursement based on D.R.G.'s, The Blue-Cross CAP Program, the Preferred Provider Movement, etc., will for the most part preclude cost shifting. It has been estimated that up to 80% of all Kansans will be covered by D.R.G.'s in 1984. In addition, reimbursers such as Blue-Cross of Kansas, and Medicaid, have a fixed fee schedule for out-patient surgery.

3) Given the above, and given the fact that we envision physician participation in our effort, the hospital may well conclude, as we have, that the acute care hospital environment is an inappropriate one for the provision of minor surgeries, just as it would be an inappropriate one for the delivery of say general dental care.

I do not believe that anyone would argue with the fact that the acute care hospital is the most expensive modality in the provision of service spectrum. If this fact is accepted, then it must follow, that the hospital is indeed an inappropriate deliverer of such services, and that the applicable facilities should be used for alternative purposes. This may well result in a cost savings to the community, rather than cost increases as our opponents have been arguing.

4) Please remember, the physician can establish such facilities in their office without a C.O.N. Given this fact, this cost shift argument becomes moot - the patient out-flow from the hospital is taking place anyway, and if the increase in community cost argument is indeed valid, the cost increase will take place whether the change envisioned in this bill is adopted or not. Consequently, you have nothing to lose and everything to gain by adopting this exemption.

Now, given the fact that physicians have the right to establish such facilities in their office, and given the fact that they will indeed exercise such right, would the consuming public not be better served if we allowed the physicians to consolidate such services in a centralized location, at a much reduced cost, with better staffing, better anesthesia coverage, peer review, quality assurance, etc.. In other words, are you better off with 15 physicians establishing 15 separate office facility centers, which they have the right to do, or are you better off allowing

them to consolidate into one centralized location. I think the answer is an obvious one.

5) As I have already indicated, hospitals are free to expand at will. If additional capacity does indeed increase cost, would not the people of Johnson County be better off with a Dr. Goolsbee facility, and competition, instead of a Shawnee Mission Medical Center facility, which the people of Johnson County are getting anyway. Again, however, one must ask the question, with capacity being increased - will total costs to the community really go up? I am sure that S.M.M.C will argue that not only will costs not increase, they will decrease because of these out-patient efforts. If this be true, then one must conclude that there would have been no increase in costs to the community had Dr. Goolsbee been allowed to establish his facility. In other words, under present legislation, facility expansion can take place unencumbered now - why not balance the scale and allow free enterprise competition?

Now let us take up the first observation, the "Status Quo" argument - that the hospitals are under such immense financial pressure that a moratorium should be declared until "the dust settles".

First of all, please remember we are talking about hospitals in large population centers, not the small rural hospital. If these hospitals are seeking protection from competition because of financial hardship, then it appears reasonable to me that they should be asked to present their certified financial statements,

and applicable budgets, so that this body can weigh the significance of their financial plight argument. How many of you have ever seen the financial statements of the hospitals located in these larger population centers? In my opinion, I think you will find hospitals that are making hundreds of thousands of dollars in profits, with millions of dollars of reserves being reflected on their balance sheets. I think you will find these hospital monopolies, or oligopolies, seeking protection for protection sake. They just do not wish to face the rigors of competition.

Over and above this, however, I believe that the Status Quo argument is invalid and self-defeating. I do not believe that waiting a year, or two, or even three, will accomplish anything, other than a delay in correcting the basic underlying problems facing the health care delivery system; problems of over-capacity and duplication of equipment and services. Waiting will not correct these problems, waiting will not, in my opinion, see an increase in hospital admissions - the trend is firmly set to the reverse. Waiting will not eliminate the duplication.

These problems of over-capacity and duplication are responsible, in my opinion, for much of the continued hospital cost escalation that we have suffered over the past many years. It does no good, in my opinion, for the state to set up the Kansas State Health Employees Health Insurance Commission to review insurance policy coverages, rearrange deductibles and co-insurance, solicit bids, etc., and then leave the hospitals free to set their rates in this environment of excess capacity and duplication.

In my opinion, there are two alternatives, or approaches to shrinking, or reducing, this problem of over-capacity and this problem of duplication. One is the governmental control approach. A K.C.C. type agency, or the K.C.C. itself, be empowered to apply the same review procedures, and be given similar powers, as relates to utility review, with the power to set hospital rates.

The other approach, and the one we favor, is competition. I find it ironic, in my opinion, that the health policy of the federal government is moving forcefully in one direction, promotion of competition, while the State of Kansas is moving in the opposite direction, continued control and preservation of the "Status Quo". I find this ironic because being a native Kansan I would have assumed just the reverse, with Kansas leading the way to a system of cost containment and competition.

This contrast is reflected in the "Report of the Health Planning Review Commission." As noted in that report: "In 1979, PL 93-641 was amended to revise the description of national health priorities to <u>emphasize cost containment and competition</u> through: (1) identification and discontinuance of unneeded, duplicative facilities and services, (2) elimination of inappropriate institutionalization, (3) promotion of outpatient care, when appropriate, and (4) other policies which would foster appropriate and efficient use of the health care system."

Please note the legislative thrust on the federal level (1) cost containment and (2) competition. In Kansas, on the other hand, the C.O.N. legislation and applicable regulations continues

to focus on square footage, space available, facilities, e
The hands of the people at the Department of Health and Environment are tied to an antiquated, outdated and largely ineffective piece of legislation. Our legislation is fighting the facility expansion wars of the past, and not the dynamics of cost containment of the 1980's and 1990's.

One must be candid, competition in the health field has not worked in the past, but, in my opinion, this was because of retrospective cost reimbursement. This no longer applies, and in this new reimbursement environment, I think competition will work. The government, private insurance, the consumer, will not, in my opinion, allow a retrogression in the D.R.G., Cost CAP, approach to hospital reimbursement. In fact, I think the trend to this form of reimbursement, will accelerate. Competition will work. This bill is but a small step in that direction, but I feel that symbolically it is a very important step in establishing the concept of the free enterprise system in the health field. It establishes the fairness and equity lacking in the present system. It will be, in my opinion, an effective cost containment measure. We ask for your support of this consumer-oriented legislation.

Thank you.

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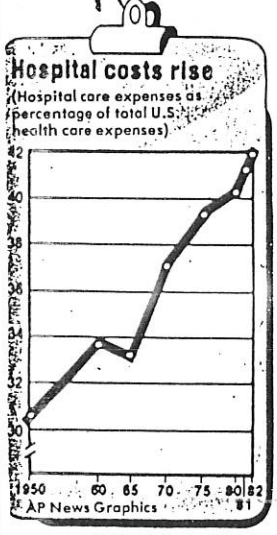

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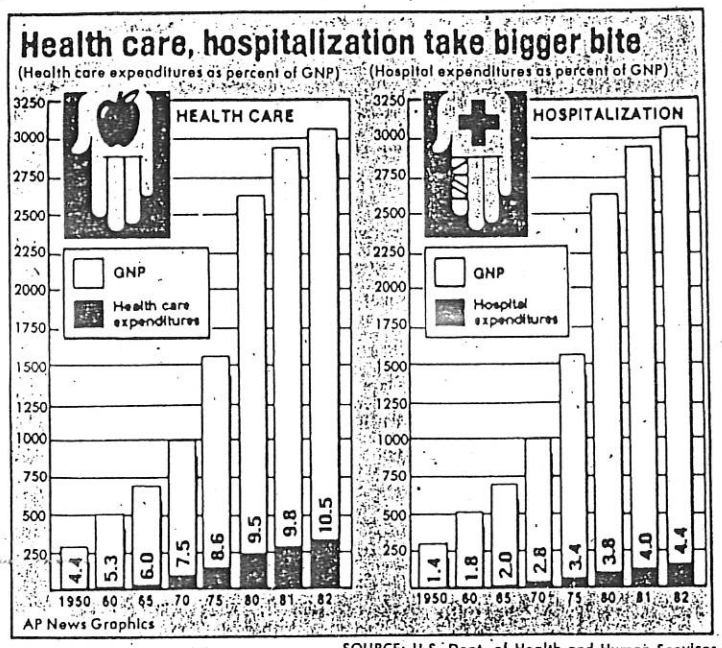

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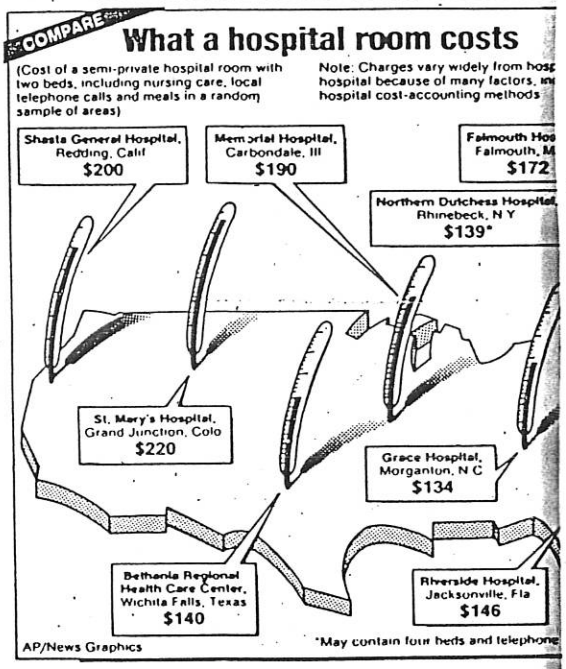

Vital signs: Cost of hospital care still going up

By LOUISE COOK
Associated Press Writer

From aspirin at a few cents a pill o an operating room at a few hun-red dollars an hour, America's ospital bill is soaring. It is rising aster than the rate of inflation and aster than the gross national pro-uct. It is even rising faster than

"If you charged the actual amount for that, room rates would be $350 or more and there would be a public outcry," Maroney said. "So you take some of the costs and shift them over, charge in other areas. For instance, charging $17 (more than the actual cost) for a CBC, a complete blood count. Most hospitals do it. You take the cost

MANY HOSPITALS also offer what they call a "convenience kit," including basic toiletries like toothpaste, at a price of $5 to $10. In some cases, it's provided only if the patient asks; in other places, the kit — and the charge — are automatic.

Surgeons' and anesthesiologists' fees are generally billed separate-

sule. A typical surgeon's fee is $667.

— St. Mary's Hospital, Grand Junction, Colo.: Wayne Allen, financial director of the 222-bed hospital, said the hospital bill for a routine appendectomy would be about $1,500 with charges by the surgeon and anesthesiologist adding $840. A semi-private room, in-

intravenous solutions, and medical supplies, including bandages and surgical packs, would be $103.

— GRACE HOSPITAL, Morganton, N.C.: Gary Shull, controller of the 161-bed facility, said an appendectomy would cost about $1,500, including anesthesia; the surgeon's fee would boost the total

medical and surgical for medicines, and anesthesiologist and ing drugs.

— Northern Dutche Rhinebeck, N.Y.: A Mazzarella said a rece the 120-bed hospital p for a five-day stay pendectomy; the s

star/Legislature

House cuts off funding for Certificate of Need Board

By GREG BEAN
Star-Tribune staff writer

CHEYENNE — In a move that shocked even the sponsor of the amendment, the House voted Monday to do away with the Wyoming Certificate of Need Board, which authorizes new institutional health services in the state.

During second reading debate on Senate File 7, a $226 million appropriations bill that contains funding for various state agencies, Rep. Scott Ratliff, D-Fremont, proposed an amendment to delete $72,981 in state funds and $247,541 in federal funds that would have supported the certificate of need board and staff.

In explaining his amendment, Ratliff said it would kill the board by taking away funding, but he said he did not expect the amendment to pass.

Ratliff said the board has failed to help keep health care costs under control because it has approved every expansion proposal brought before it.

"They just can't say no to some of the growth in costs," Ratliff said. "And hospital costs are severe.

"If you defeat this amendment, the next time the Legislature meets you'll have to put some meat behind the people on the board to make them say no," he said.

Ratliff told the House he expected the amendment to fail, but hoped its introduction would make legislators aware of the problem.

But Ratliff said later he did not anticipate the reaction of the other legislators to his proposal.

Rep. Dr. Harry Tipton, R-Fremont, supported Ratliff's amendment, because he said the Certificate of Need Board has often authorized new institutional health services, even after its own staff has suggested that the authorization be denied.

"This amendment would save us all money," Tipton said.

REP. WALTER URBIGKIT, D-Laramie, opposed the amendment, because he said he was concerned about "abolishing the police force because the system hasn't worked as well as we would have liked."

But Rep. Ron Micheli, R-Uinta, enthusiastically supported the amendment.

"The ... Board has never reduced the cost of medical care," he said. The board has instead created needless bureaucracy and delay of necessary projects, he said.

When it became apparent that the amendment had considerable support, Ratliff urged the legislators not to act in haste and pass his amendment, and he was surprised when they approved in with a 37 to 25 vote.

CC: John G. Herbert
Charles E. Beall
Gary Keller

TESTIMONY OF RICHARD L. FRIEDEMAN
CENTRAL KANSAS MEDICAL PARK

HEARING ON SENATE BILL NO. 827
BEFORE THE SENATE WAYS AND MEANS COMMITTEE

Perhaps the most exciting change in the means of providing medical care is outpatient surgery. Due to major advances in anesthesiology, it is now possible to do a great many surgeries, at least 40 percent of all procedures, on an outpatient basis.

Since the patient is not put to bed, does not receive the volume of care or go through the standard procedures of an inpatient hospital, the cost savings are tremendous. Further, offering the service in this way saves the patient time, and improves doctor and nurse efficiency. Of course, this benefits everyone.

A number of things have made the move to ambulatory surgery possible. First of all, new anesthetic agents reduce the side effects of anesthesia. It is also possible to release patients much earlier. Further, advances in surgical techniques are expanding the range of appropriate procedures.

Until recently, many types of surgery which might otherwise be done on an ambulatory basis, were forced into inpatient hospitals because of the reimbursement structure. However, the reimbursement system is being changed in a way that will encourage ambulatory surgery and to encourage free-standing - i.e. independent - ambulatory surgical centers.

Ambulatory surgical units can offer a wide variety of pro-

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cedures, including many pediatric procedures, which formerly would have required hospitalization. Obviously, allowing children to go home on the same day as their surgery limits the trauma which children frequently face when they are in an inpatient situation.

SPECIAL FACILITIES

Of course, there is no law that says that you cannot let a patient out of an inpatient hospital on the same day. However, there are many tremendous advantages to offering this service in facilities designed for this purpose. Mixing ambulatory cases requiring a few minutes with surgery requiring large blocks of time can cause unnecessary delay and inefficiency. Segregating the two makes for greater efficiency in the use of staff. A specially designed facility results in a faster "turn around" time - and lowers the cost in the process.

Also, there is something to be said for having ambulatory surgery done by people who are not in the business of selling inpatient care.

STATISTICS

Unfortunately, the development of ambulatory surgical centers has been stifled in the State of Kansas by the Certificate of Need program. The statistics speak for themselves. As of June, 1983, there had been 123 hospital applications for Certificates of Need. These included a great many applications for CATscanners, as well as for hospital additions and other things. After all appeals,

there were only 2 denials out of those 123 applications. There were 6 modifications. In the same time period, there have been 7 applications for ambulatory surgical units. 1 certificate was granted after the facility had been built, a situation different from what most applicants face. Another was granted a certificate after pursuing a route of appeal which is no longer available under the law. Of 5 normal applications, all 5 have been denied.

CRITERIA

At least a part of the problem can be found upon a careful reading of the criteria by which they grant Certificates of Need. The criteria focuses principally upon "unavailability" or, stated another way, upon "duplication" of services. If a service is already available, one does generally not get a Certificate of Need. Of course, eliminating duplication of services is generally a valid goal. However, with ambulatory surgical centers there are many situations where a service can be "duplicative" but also be more efficient. To be sure, full surgical suites equipped for major, inpatient surgeries by people who are principally in the business of offering inpatient services, can provide ambulatory surgery. However, designing a facility for this purpose, and operating it independently, can result in tremendous cost savings. In short, it is possible to be both "duplicative" and "cost effective." However, proving cost containment in a situation where the service is already "available" in a less efficient

setting, will not get you a Certificate of Need in this state. It seems to me that something needs to be done for ambulatory surgical centers to encourage their development.

DRGs

I would like to answer one question which may have occurred to some members of the committee. Under the cost-plus reimbursement system, what is to stop the development of unnecessary ambulatory surgical centers? There is a major revolution going on in the world of medical reimbursement. We are eliminating cost-based reimbursement. Under the previous system, a medical facility could put up any kind of building or buy any equipment, and it would basically be paid for by the medical reimbursement system, which operated on a cost-plus basis. However, those days are over, and Blue Cross/Blue Shield, Medicare and Medicaid and others are deciding what the fair price is for a particular procedure, and paying only that price, regardless of costs. Before buying equipment or putting up a CATscanner, a facility had better have the use volume to pay for it. If not, third party payers will not pick up the slack. In short, sound economics is being reintroduced into the medical care system.

POPULATION LIMITS

The bill which you have before you grants an exemption for ambulatory surgical centers in all counties with a population of

more than 50,000. While I believe that this is an excellent approach, I take a grimly ironic view of the 50,000 limit.

I am involved with a group in Barton County, Kansas that wishes to develop such a facility. I think it is fair to say that this group has been leading the charge on this issue, along with Doctors Gibbons and Goolsbee in Johnson County. We have compiled a great many facts and statistics and arguments, and have made many appearances before legislative committees, study commissions, and the Statewide Health Coordinating Council. However, the 50,000 population limit does nothing for Barton County.

Of course, Barton County has a significant trade area. Until very recently it had the 5th highest retail sales among counties in the state, which indicates our significant trade area. Certainly, a great many people in our area look to Great Bend already for the provision of medical service. We serve a significant area outside of our own county, but still the 50,000 population limit would not take care of us.

I would ask that, at a minimum, the 50,000 population limit be lowered to 30,000, which would take care of Barton County. However, I would hasten to add that I don't believe that any limit is necessary. Obviously, a specially designed ambulatory surgical facility makes it necessary to have a volume business. In smaller areas, the volume simply isn't there. Barton County, with an

official population of about 32,000, may be about the smallest county in the state that could support an ambulatory surgical facility, and this only because of a substantial service area beyond the limits of our county. I would recommend to the committee that this lower limit be eliminated altogether, or at least be lowered to 30,000.

I know that we can save significant medical care costs in Barton County if only we can be given the go ahead.

Are Your Employee Health Care Costs Crippling You?

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Mid-America
Coalition on
Health Care

PROBLEM:

HEALTH COSTS ARE OUT OF CONTROL—AND THAT HURTS YOUR PROFITABILITY

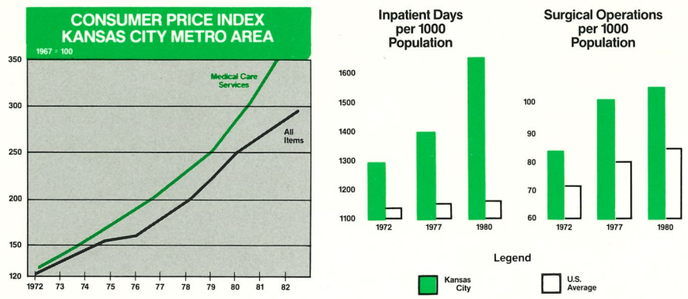
As a business executive and employer, you know that excessive health care costs affect your profitability and your employees' welfare…

NATIONALLY

Employee health care costs have risen almost 183% since 1975. The national cost of medical care has doubled in the past 20 years. In 1965 the cost of medical care represented 5.9% of the Gross National Product, and in 1982 it rose to 10.5% of the GNP, a total of $321 **billion** spent for that year on medical care. Nationally, in 1982, medical costs increased by 11.6% over 1981, compared to a 6.1% increase for all other items.

IN THE KANSAS CITY AREA

There is strong evidence that health care costs are growing faster in Kansas City than they are nationally. Health costs here have risen dramatically in comparison to the Consumer Price Index. The number of surgical operations and hospital in-patient days in the Kansas City area far exceeds the national average.



WHY?

Part of the problem is that employer health benefit plans have yet to provide incentives for cost effective care. The Mid-America Coalition on Health Care received data from 94 employers and 15 insurance companies in the greater Kansas City area who described prevalent health care practices. The firms responding are highly aware of health care cost problems, and **many are beginning to manage their health costs.** Some effective management techniques have included higher deductibles, greater premium sharing, increased coinsurance, health promotion activities, and employee assistance programs. These techniques, combined with revised coverage and reimbursement provisions, as well as employee communications and education regarding health care, have shown significant savings for the employer and acceptance by the employee, not just here in Kansas City but in other cities as well. The Coalition has taken these survey findings into consideration in forming a model health care plan for Kansas City. The Model Plan can help you manage your health costs.

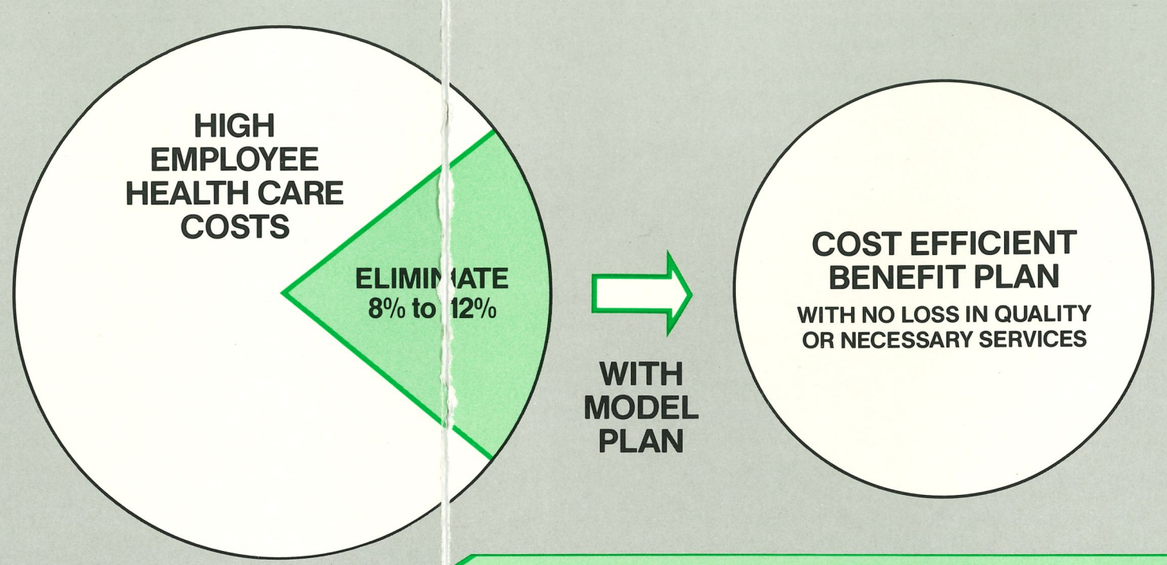
PLAN:

A MODEL PLAN

To address high health costs, a panel of benefits experts have designed a model health plan that incorporates the survey findings as well as data and experience of other successful programs around the country. **The Model Plan represents an 8% to 12% estimated annual savings for employers,** without sacrificing the quality or accessibility of necessary medical treatment for your employees or associates.

CUT YOUR HEALTH COST PIE AND KEEP IT WHOLE

Slice out unnecessary expenses but provide all the necessary coverages.



INCLUDES:

- Coverage only for medically necessary procedures and services.
- Employer/employee sharing of premium costs.
- A $200 annual deductible per enrolled individual (i.e. for each employee and each enrolled dependent).
- Employee payment of 20% of the first $5,000 of covered expenses for each enrolled individual, after the deductible has been met.
- Coverage for medical/surgical procedures only in an appropriate place of service.
  - ☐ Outpatient: Physicians' groups have identified 520 procedures normally treated on an outpatient basis, avoiding hospitalization.
  - ☐ Physician's office: Physicians' groups have identified 200 procedures normally treated in a physician's office, avoiding both hospitalization or outpatient surgery fees.
- Coverage of home care services for individuals who need skilled nursing care, avoiding hospitalization.
- Coverage of extended care facilities for individuals who need post-hospitalization nursing care, avoiding hospitalization.
- Use of Midlands Medical Review Plan, during hospitalization, to determine the necessity for continued hospital care.
- Pre-admission laboratory testing to decrease the length of hospital confinement.
- No weekend admissions unless medically necessary.
- Coverage for individuals requiring treatment for mental illness, alcoholism or drug abuse in an out-patient setting or a specialized institution, rather than in a hospital.
- Hospice care for the terminally ill patient and his family during the final stages of the illness.
- Coverage for the cost of a second opinion from another qualified physician when elective surgery is recommended.

SOLUTION:

IMPLEMENTING THE MODEL PLAN

To manage a cost-effective medical benefit plan and to provide a quality health plan for your employees, take the following steps.

• MAKE THE DECISION

Tell your broker or insurer that you have decided to change from your current program to the Model Plan. Set a timetable to implement the Model Plan.

Implement an educational program for your employees, explaining the purpose of a cost-effective health care program stressing the benefits under such a program. With proper communication, they will respond favorably to your efforts to reduce the high cost of medical care.

• TALK TO US

Call us for more information **(816)531-6550.** We will be happy to explain the information in this brochure in further detail. We'll also discuss the impact you can have on decreasing the high cost of medical care by taking an active role in the Mid-America Coalition on Health Care, a non-profit organization.

• GET THE WHOLE STORY

Get our book, *Managing Health Care Costs: The Kansas City Model Plan.* This detailed, readable manual gives you the information you need to understand the advantages of the Model Plan, to plan your health care wisely, to deal with your insurer, and to communicate with your employees about this important subject.

For your copy send $15 to:
Mid-America Coalition on Health Care
4118 Broadway
Suite 204
Kansas City, Missouri 64111

IN RERS WILLING TO OFFER THE MODEL PLAN

To help local employers implement the Model Plan, the Coalition found 24 health insurers in Kansas City who would offer the Model Plan (subject to normal underwriting practice). Insurers that are willing to offer the Model Plan partially or completely are shown below:

INSURERS	Employer Size (number of employees) 10-25	26-50	51-100	101-250	251-500	501+
American United Life Insurance Co.	●	●	●	●	●	●
The Bankers Life of Iowa	●	●	●	●	●	●
Business Men's Assurance Co. of America	●	●	●	●	●	●
Connecticut General Life Insurance Co.	●	●	●	●	●	●
General American Life Insurance Co.	●	●	●	●	●	●
The Prudential Insurance Co. of America	○	○	●	●	●	●
New England Mutual Life Insurance Co.	○	○	○	●	●	●
Nationwide Life Insurance Co.	○	○	○	○	○	○
New York Life Insurance Co.	○	○	○	○	○	○
Pacific Mutual Life Insurance Co.	○	○	○	○	○	○
Washington National Insurance Co.	○	○	○	○	○	○
Benefit Trust Life Insurance Co.		●	●	●	●	●
Republic National Life Insurance Co.		●	●	●	●	●
Provident Life & Accident Insurance Co.		○	○	●	●	●
Home Life Insurance Co.		○	○	●	●	●
Mutual of Omaha Life Insurance Co.			○	●	●	●
The Mutual Life Insurance Co. of New York			○	○	●	●
Pilot Life Insurance Co.			○	○	○	○
The Equitible Life Assurance Society of the United States				●	●	●
CNA Insurance Companies				●	●	●
Blue Cross and Blue Shield of Kansas City				○	○	○
John Hancock Mutual Life Insurance Co.				○	○	○
Northwestern National Life Insurance Co.				○	○	○
Metropolitan Insurance Companies						●

● insurer will offer Model Plan in its entirety

○ insurer will offer Model Plan but with exceptions

MID-AMERICA COALITION (HEALTH CARE

John H. Kreamer, President
Dr. Robert C. Bonhag, Executive Director

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Sutherland Midwest Lumber Company, Inc.

Committee Staff:
William J. McKeel
Laurie D. Larson

Kansas Hospital Association

Points of Testimony

S.B. 827

Submitted by Howard M. Chase
Chief Executive Officer
Stormont-Vail Regional Medical Center
Topeka, Kansas

1. Hospitals in general have supported the extension of CON to all medical equipment regardless of setting or provider type. We feel strongly that the piecemeal dismantling of CON is not good policy.

2. The criticism of CON for the high percentage of approved applications is inaccurate. As with any regulatory process, those involved learn to work within the system. Hospitals will not enter into a costly application process if the prospects for approval are not good.

3. These deterred projects should be included in the savings quoted by KDH&E since they have prevented additional expenditures.

4. It should be noted that duplication, i.e., adding facilities like those exempted in S.B. 827, will not increase the number of surgeries performed. Instead, the same number of surgeries will be divided among more facilities. With fewer surgeries per facility, each surgery charge will necessarily carry a larger burden of fixed costs.

5. Historically, the legislature has opposed exemptions such as those in S.B. 827 because of the compliance issue and the potential federal withholding of public health funds.

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