Approved 3-11-85
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Senator Roy M. Ehrlich at
Chairperson

10:00 a.m./p.m. on March 8, 1985 in room 526-S of the Capitol.

All members were present except:

Committee staff present:

Conferees appearing before the committee:
Don Wilson, Kansas Hospital Association
Jerry Slaughter, Kansas Medical Society
Marlin Dauner, Blue Cross, Blue Shield
Secretary Barbara Sabol, Department of Health and Environment
William Barlow, Board Member, Health Systems Agency of Northeast Kansas
Secretary Robert E. Harder, Social and Rehabilitation Services
John Yulich, MD, Sabetha - written testimony
John Peterson, Charter Medical

Others Attending: See attached list

SB-296 - limiting construction, modification or establishment of hospitals prior to July 1, 1987.

Don Wilson, Kansas Hospital Association, testified and presented written testimony in support of SB-296. Mr. Wilson testified that health policy makers are in unanimous agreement that Kansas has more than enough in patient hospital beds to meet the need when the demand was at its peak. Attachment I

Jerry Slaughter, Kansas Medical Society, testified, and presented written testimony in support of SB-296. Mr. Slaughter testified that the medical Society feels a moratorium on expansion for a finite period of time is justified while the economic environment stabilizes. Attachment II

Marlin Dauner, Blue Cross, Blue Shield, testified in support of SB-296. Mr. Dauner testified that the available information and data shows a definite drop in the rate of hospital occupancy. There is concern that low risk specialities could siphon off low risk patients.

Secretary Barbara Sabol testified on SB-296. The Secretary pointed out issues she felt the committee needed to look at very closely. The Secretary called attention to:
1) the definition of hospital beds and placing a moratorium on them but will not include private psychiatric hospitals and kidney treatment centers and facilities
2) The Secretary felt that section 2 A should be changed to "licensed bed capacity"
3) Definition of "community"
4) Line 47 does not take into consideration Certificate of Needs under appeal at the time of sunset
5) consider date of service rather than limit construction regardless of date of certificate of need expiration
6) consider exempting state hospitals from the moratorium due to the possibility of other usages for state hospitals Attachment VI

William Barlow, member of the Board of Directors, Health Systems Agency of Northeast Kansas, testified and presented written testimony to raise concerns on SB-296. Attachment III

Secretary Robert Harder testified in support of SB-296. The Secretary asked that the exemptions requested by Secretary Sabol on state hospitals be considered.

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 526-S, Statehouse, at 10:00 a.m.~~p.m.~~ on March 8, 19 85.

Written testimony was presented by John Yulich, MD, from Sabetha, who was present on March 7 but was not able to return today to testify. Attachment IV

John Peterson, Charter Medical, testified and presented written testimony opposing SB-296. Mr. Peterson testified that other testimony supported Charter Medical's position that psychiatric care facilities and drug abuse centers are needed and should not be included in the moratorium. Mr. Peterson cited the Governor's budget providing for a center in Johnson County for treatment facilities for drug and alcohol abuse. Attachment V

Meeting adjourned.

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 3-8-1985

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Gary Robbins	Ks Optometric Assn
Bob Harris	Ks Dental Assoc.
Robt Harder	SRS
L. J. Sabol	KDH&E
Marilyn M. Johnson	K.S.A.N.E.I.R.
Harold E. Kiehm	KAAM
Crosby Vn Crosby	Physicians Resource Network Inc
Dick Hummel	KHCA
John Grace	KAHHA
Tom Bell	Ks. Hosp. Assn.
Bob West	Nat'l Electrical Contractors Assn.
HAROLD PITTS	TARTA
Ken Schatermeyer	KS Pharmacists Assoc.
Denny Burgess	Charter Med.
William R. Gibson	Charter Medical Corp.
John Peterson	
Dan Morgan	Assn. General Contractors of Ks.
Bill Bunten	HSDNEK
JERRY SLAUGHTER	KS MEDICAL SOCIETY
Marlon R. Dawner	Blue Cross & Blue Shield
Melissa Hungerford	KHA
Don Wilson	KHA
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS

① SB- 296 - 3-8-85 - Don Wilson

KANSAS HOSPITAL ASSOCIATION

TESTIMONY ON S.B. 296

March 8, 1985

The Kansas Hospital Association is here today to testify as a proponent of Senate Bill 296 which proposes to place a moratorium on the addition of new acute care beds by an EXISTING or a new hospital in Kansas. The proposed legislation limits ONLY the outlay of capital associated with expanding the system. That is, the limit is on INPATIENT ACUTE-CARE BEDS. This proposal is NOT intended to discourage competitive alternatives to inpatient care. It should also be noted that this proposal would sunset in two years.

Health policy makers are in unanimous agreement that Kansas HAD more than enough hospital beds to meet the need WHEN THE DEMAND WAS AT ITS PEAK...and demand has been decreasing rapidly and consistently since 1980. If you refer to Illustration A, B and C, you can see that no matter what group you look at, VOLUME IS DECREASING.

The key question to consider when discussing the concept of a moratorium is...WHAT ARE THE PUBLIC POLICY ISSUES OF LIMITING THE EXPANSION OF ACUTE CARE CAPACITY?

- Will new beds increase access to health care? Yes, in some instances increased capacity increases access; however, access is not an issue in Kansas. Kansans currently have excellent access to the 145 community hospitals in the state.

- Will new hospitals provide services at a lower cost? Yes, in some instances, new hospitals can provide "selected" services at a lower price. The key word here is "selected." We'll present to you an example of how expansion can directly impact...actually INCREASE...the cost of hospital care.

- Will a new hospital provide new jobs in a community? Utilization decreases would result in staff reductions in existing facilities, which like the volume would simply be transferred to the new facility.

3/8/85
Attachment I

- Will a moratorium interfere with competition? The moratorium is designed to PROMOTE COMPETITION for expanding markets such as outpatient care while at the same time avoid cost increases associated with capital investments in capacity for a decreasing volume of inpatient care. Remember, new hospitals or new beds don't influence more people to get sick.

- Would a new hospital provide services that are financially risky? We don't know the answer to that question. We do, however, believe that a new facility would structure itself to take advantage of the profitable components associated with inpatient care.

- Would a new hospital provide free services or services to people in welfare programs? Again, we don't know.

The moratorium proposal is a critical public policy issue. We can show that additional bed capacity can translate into additional cost to the community. We'll give you the actual financial implications using the Topeka area as an example. We believe that a new hospital would choose only the "bread and butter" services...those services that would not bring financial risks of exceeding the fixed price. A new hospital would attempt to attract the patients that represented a sure thing...for example a normal delivery, a healthy mother and a healthy newborn. A new hospital would not maintain the equipment or personnel to treat a baby with significant problems and would transfer the difficult case to another hospital. Simply attracting away the low risk cases would not close the original hospitals. This situation would, however, reduce the base from which to recoup fixed costs.

Now for a specific example.

Topeka. There are currently three hospitals in the community. In essence, there already is competition in the Topeka market. They take the private pay patients along with the charity, Medicare and Medicaid patients and provide access at a reasonable cost. If you'll look again at Illustration A, the graph at the bottom of the page shows the actual discharge history in Topeka. After looking at this illustration, you might ask...Why, if the volume is decreasing, would anyone want to enter the market? As we mentioned earlier, a new player in the marketplace

would most probably select those services and procedures which would allow them to attract primarily low risk procedures...the winners, so to speak, leaving the high risk patients to the original hospitals.

Refer now to Illustration D. The top graph is the actual service profile of the existing Topeka hospitals. They provide primary, secondary and tertiary medical and surgical services to all ages and types of patients along with pediatrics, nursery and a variety of other services (alcohol and substance abuse, psychiatric and other specialized services.) A total of 33,923 people used the three Topeka hospitals in 1983.

The bottom graph shows the service and volume most likely chosen by a new facility, let's call it New Community Hospital and let's put it in Southwest Topeka. Notice that the total volume did not increase. Rather selected patients were "skimmed" and, in effect, transferred to the new hospital. In this example, approximately 7,600 patients would now choose "New Community Hospital" leaving about 26,000 choosing the original Topeka hospitals.

Illustration E compares the remaining services of the Topeka hospitals to those that would most likely be transferred if New Community Hospital were built in Topeka. New Community would most likely choose services, such as primary level surgeries, pediatrics, obstetrics, etc., for patients who are generally privately insured.

The bottom graph simply illustrates what the new hospital's service profile and volume would look like. These 7,600 patients would give the new hospital 70 percent occupancy for a capacity of 100 beds. (We assume that no one would want to enter the market unless they could achieve a 70 percent occupancy.) Again, this does not represent new volume, rather TRANSFERRED VOLUME.

Now if you'll refer to Illustration F, we'll look at the financial implications of the transfer of volume. One point to remember as we're going through this example is that we assume that the volume will stay constant...when in actuality demand is decreasing which would make the implications even more pronounced. At the top of Illustration D are our assumptions. Again, there is no increase in volume, 70 percent occupancy and, most important, we are even assuming that the new hospital

will have lower prices in order to attract patients from other facilities...here we are assuming a 15 percent differential. This will be our conservative example. A more liberal example would assume equal prices.

The existing hospital volume is 33,923 discharges (1983). The new facility would attract away 7,696 patients, leaving 26,227 discharges in the three original hospitals.

According to a recent Kansas Employer Coalition on Health report, the average charge for the most frequent services (the services that were illustrated in our graphs) is $2,008 per discharge. Assuming a 15 percent differential, an average charge would be about $1,700. Following our conservative example, 7,696 discharges times an average charge of $1,700 yields a revenue of $13,083,200 transferred out of the original hospitals into the new hospital.

If 40 percent (again a conservative figure) represented the fixed costs of the existing facility, this would mean that $5,223,280 of the TRANSFERRED revenue would need to be recouped from the remaining patient load. Five million dollars of the costs would not go away.

What does this mean on a per patient basis? It means that anyone using the established hospitals would pay an additional $200. If more liberal figures are used, that amount could increase to $295. For an employer, this amount would be multiplied by the number of employees and family members who needed hospital services.

Before I conclude my comments, I'd like to give you some information about a specific issue which is being discussed within the context of the moratorium proposal.

JOHNSON COUNTY: The population in Johnson County is increasing. The Kansas Department of Health and Environment projects that the population will increase by about 15,000 (from 303,885 in 1985 to 316,329 in 1987) in the next two years. CURRENT average discharges per thousand population in Johnson County (and remember demand and usage IS going down) applied to the population increase yields a need

for approximately 25 beds total for all services. Current occupancy figures for the three acute-care hospitals in Johnson County indicate that there are at least 25 beds available.

Also in Johnson County, there are discussions concerning the addition of a specialty hospital, a psychiatric hospital. If you will refer to Illustration G, this graph displays the actual discharge trend in a Johnson County psych unit, at Shawnee Mission Medical Center. As with acute care, volume is decreasing. Using a similar method for determining costs, we would, according to real data, need to assume a much higher (almost 75 percent) fixed cost -- since psychiatric services are space and labor (rather than technology) intensive.

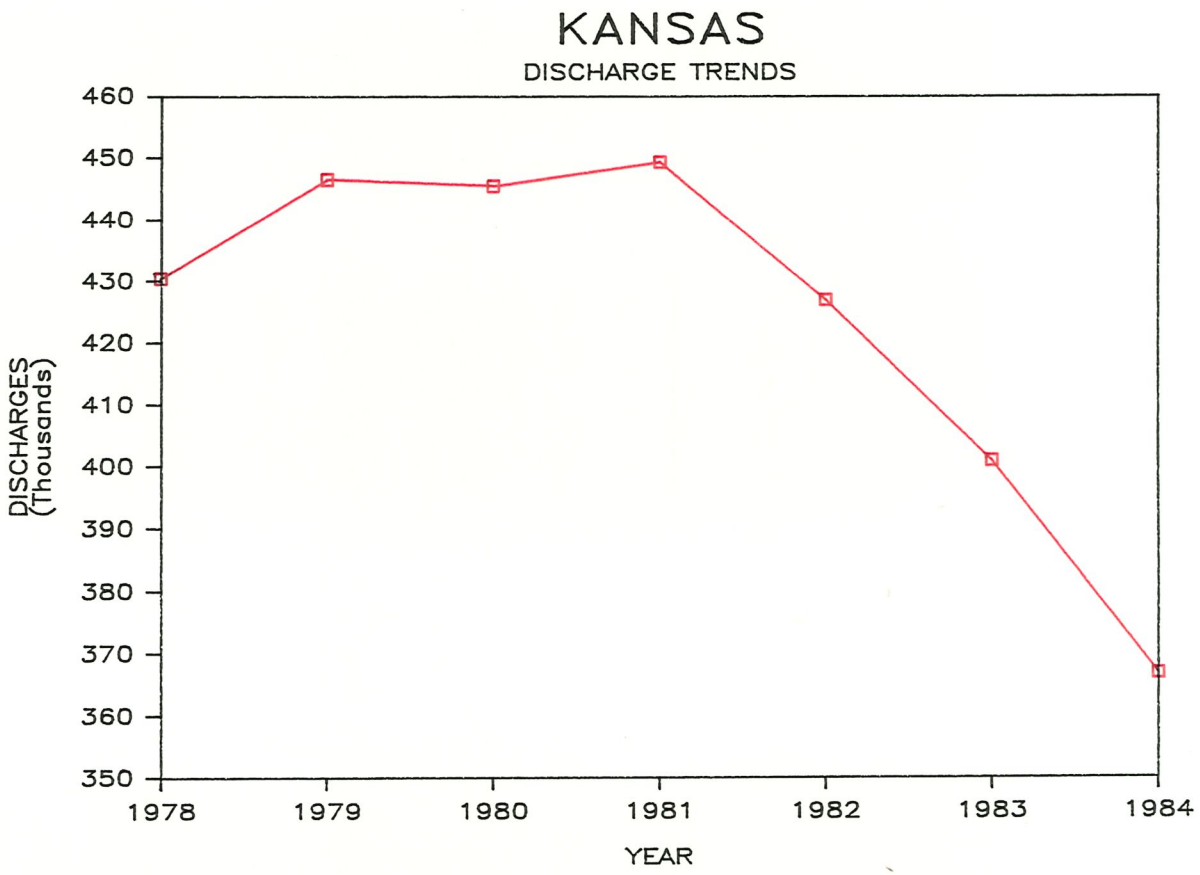
WHAT ARE THE PUBLIC POLICY ISSUES CONCERNING THE PROVISION OF ACUTE-INPATIENT CARE IN KANSAS COMMUNITIES? Consumers are demanding lower health care costs. As policymakers, your decision is critical. A moratorium on acute-care capacity would prevent the increase in costs associated with new acute-care beds. The Kansas Hospital Association urges you to recommend this bill...as it is now written...favorably.

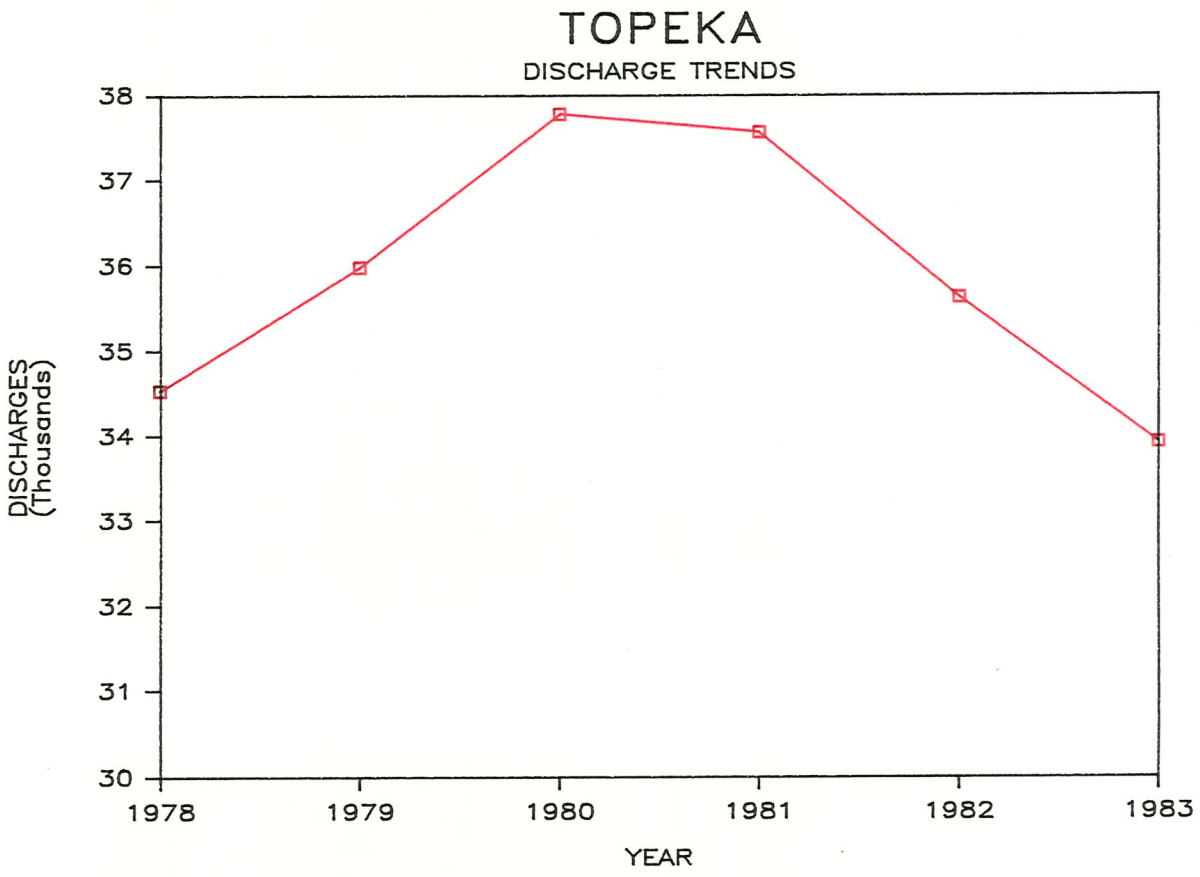
Kansas Hospital Association

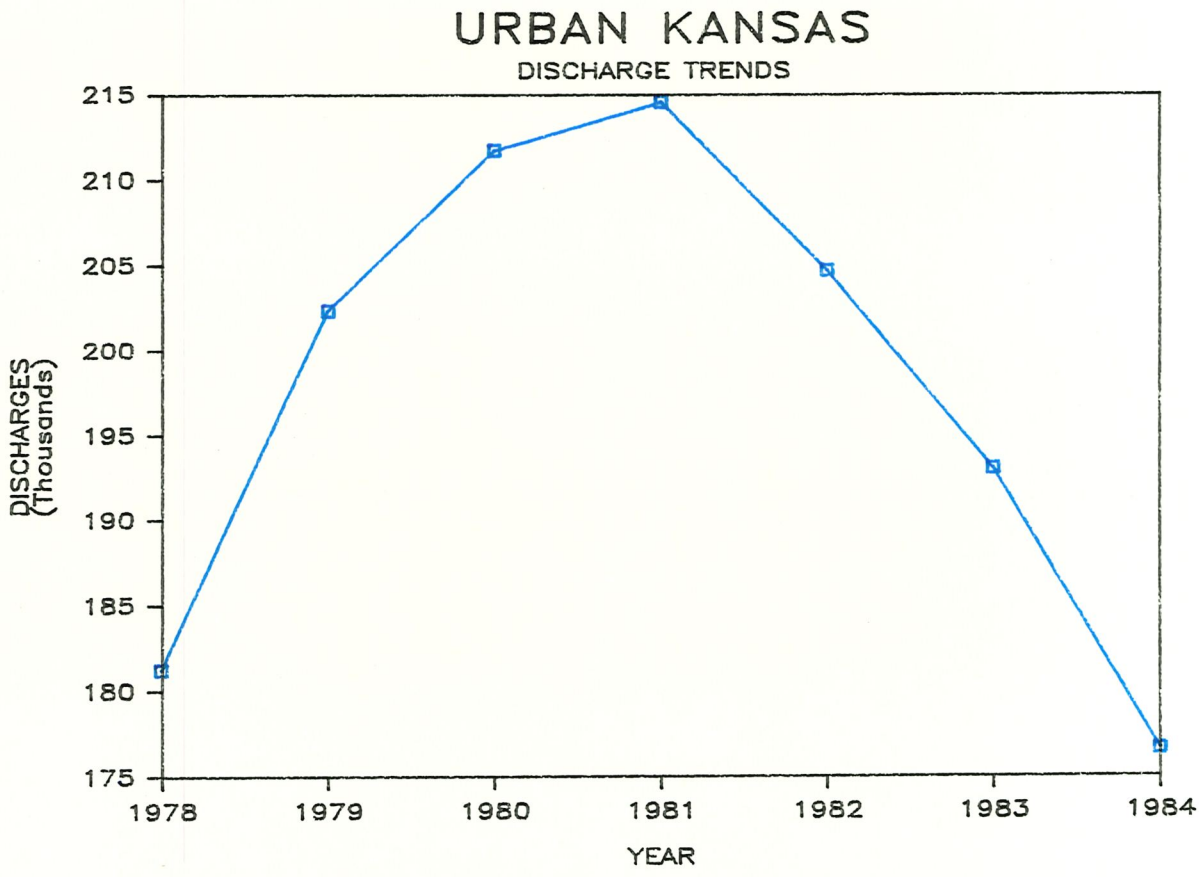
TESTIMONY ON S.B. 296

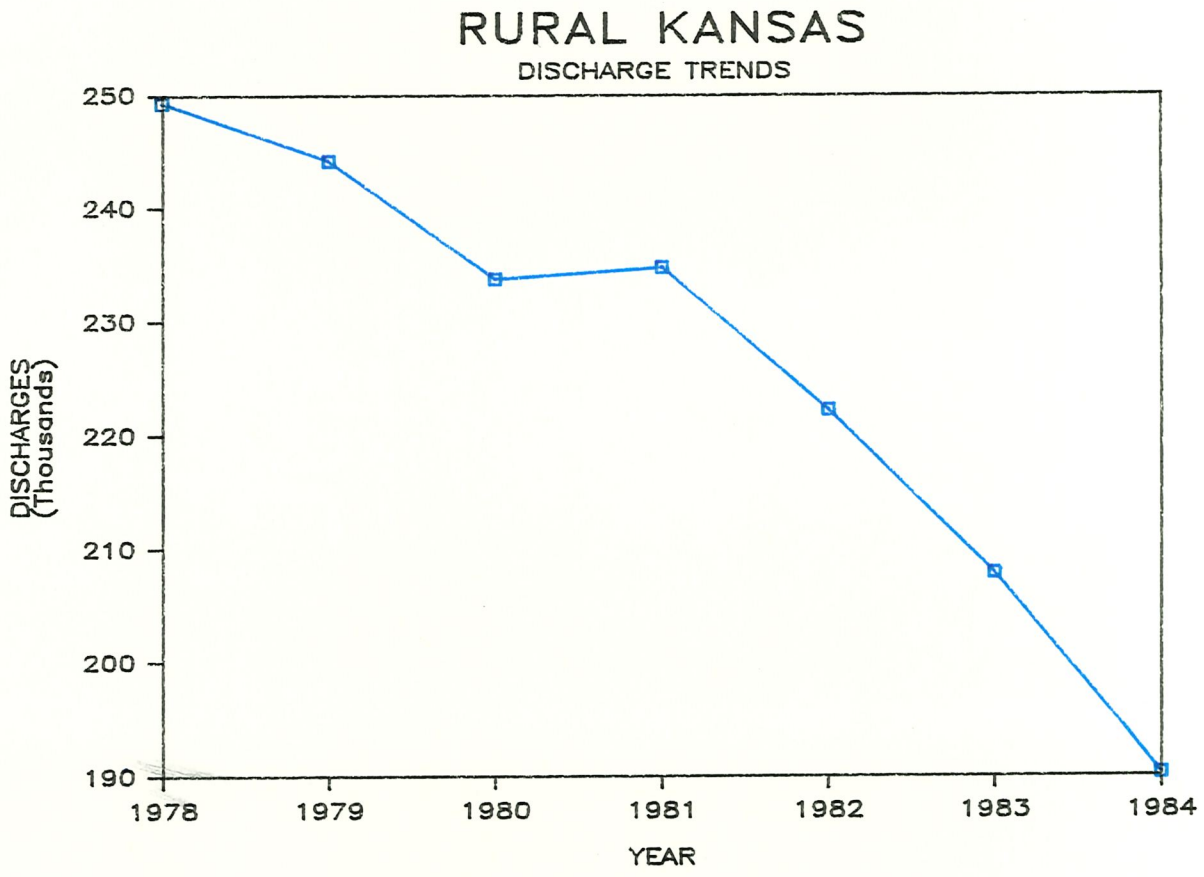
March 8, 1985

Attachment I


KANSAS
DISCHARGE TRENDS
460
450
440
430
420
410
400
390
380
370
360
350
DISCHARGES (Thousands)
1978
1979
1980
1981
1982
1983
1984
YEAR

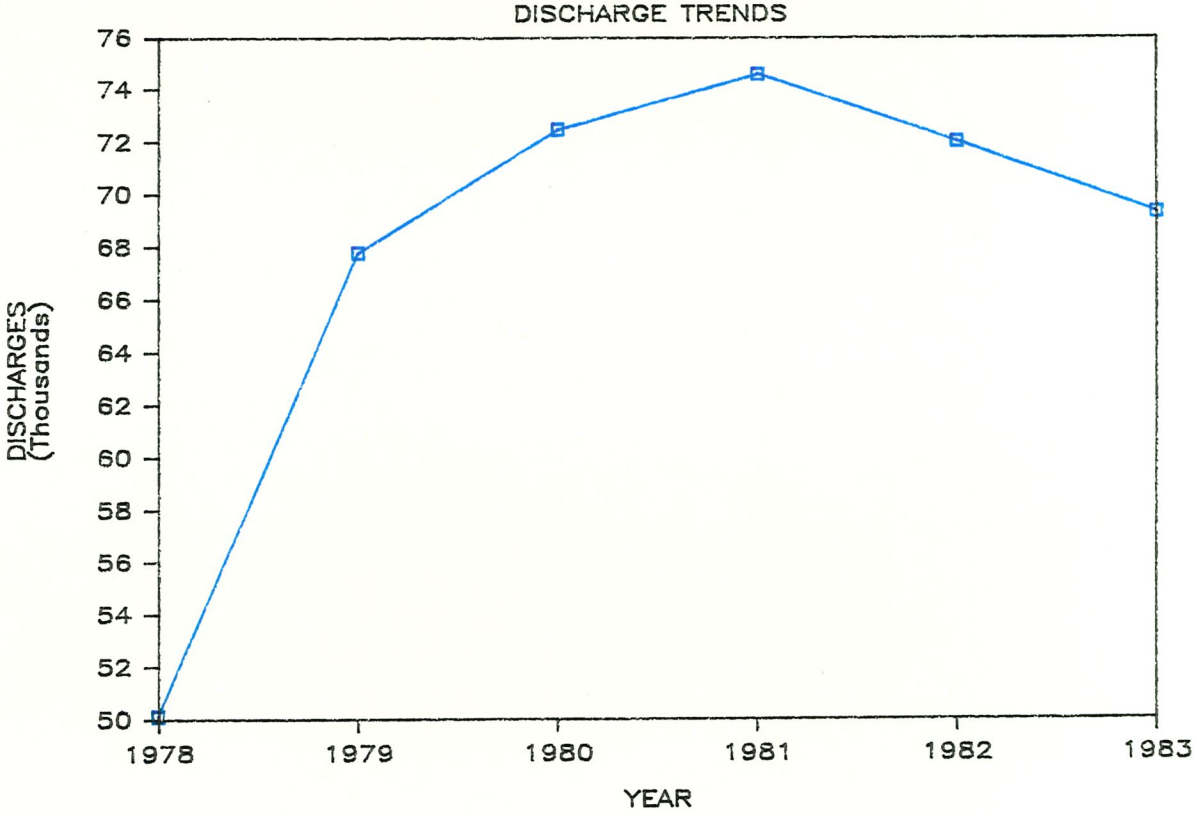

TOPEKA
DISCHARGE TRENDS
38
37
36
35
34
33
32
31
30
DISCHARGES (Thousands)
1978
1979
1980
1981
1982
1983
YEAR


URBAN KANSAS
DISCHARGE TRENDS
DISCHARGES (Thousands)
215
210
205
200
195
190
185
180
175
1978
1979
1980
1981
1982
1983
1984
YEAR


RURAL KANSAS
DISCHARGE TRENDS
DISCHARGES (Thousands)
250
240
230
220
210
200
190
1978
1979
1980
1981
1982
1983
1984
YEAR

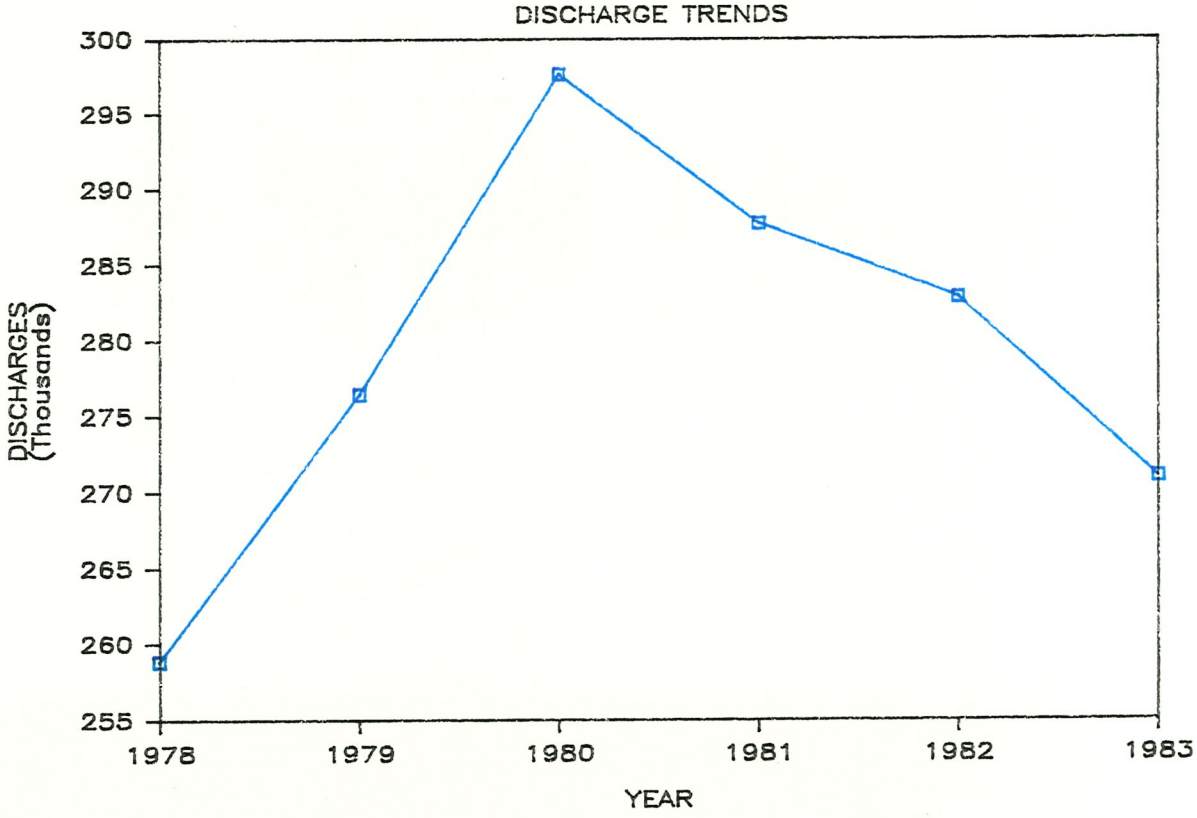
KANSAS CITY, KS

DISCHARGE TRENDS



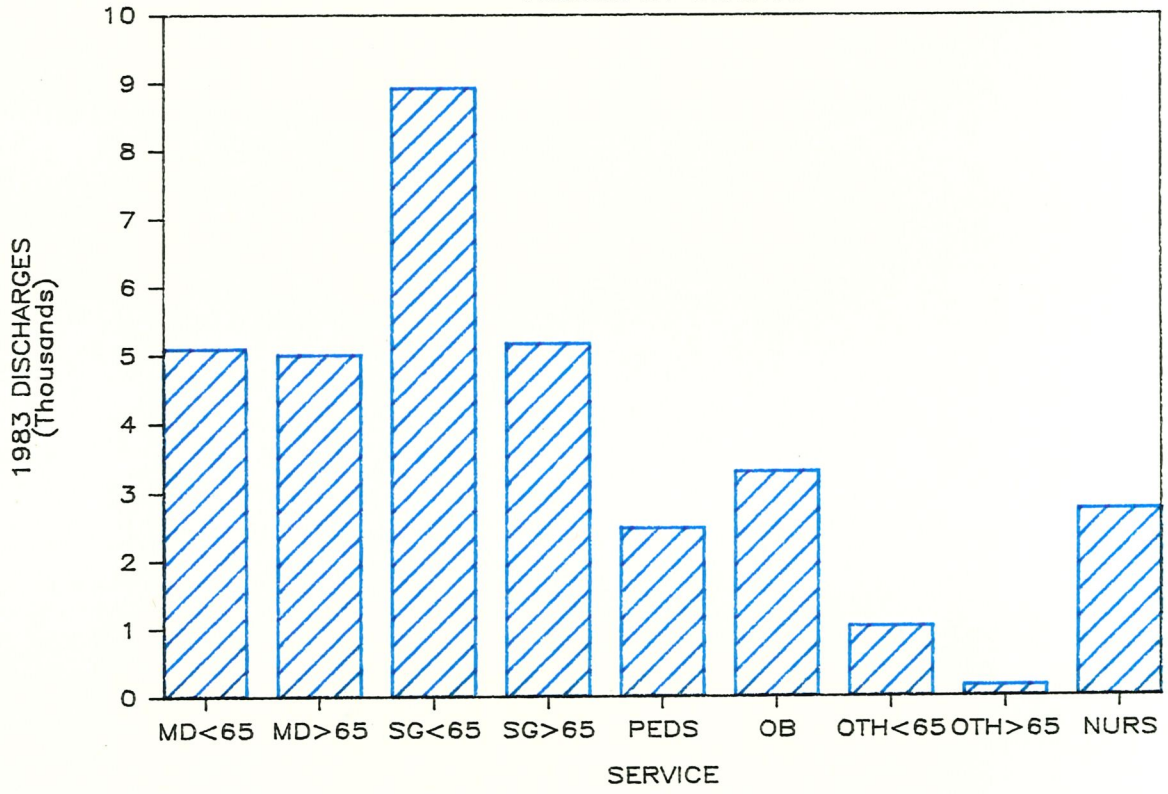
KANSAS CITY, METRO

DISCHARGE TRENDS



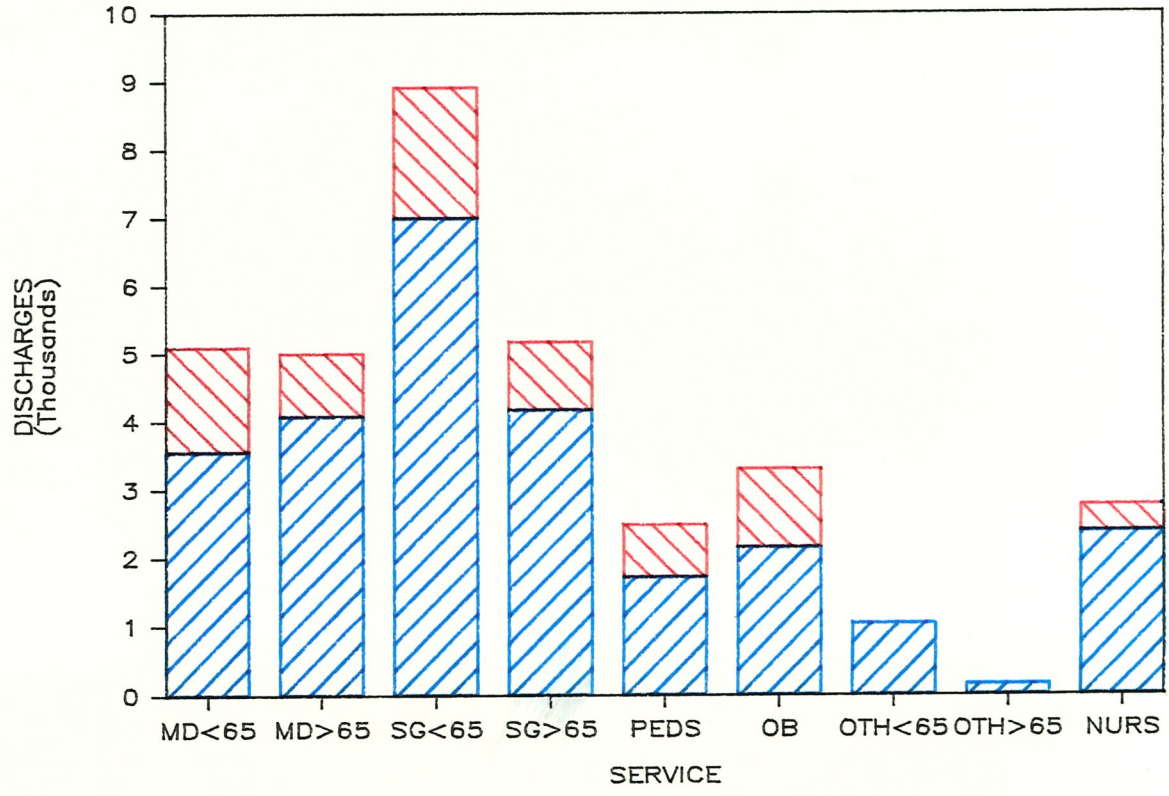
TOPEKA HOSPITAL SERVICE PROFILE

VOLUME BY SERVICE

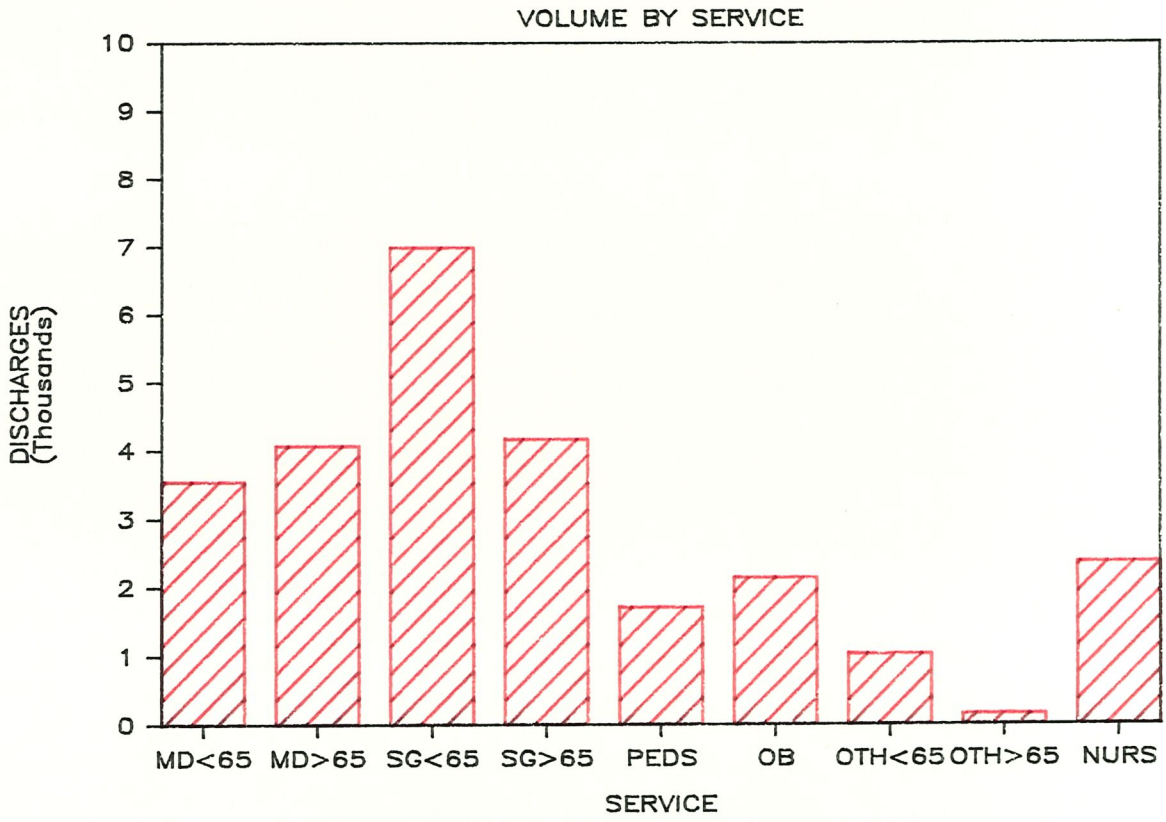


TRANSFERRED SERVICES

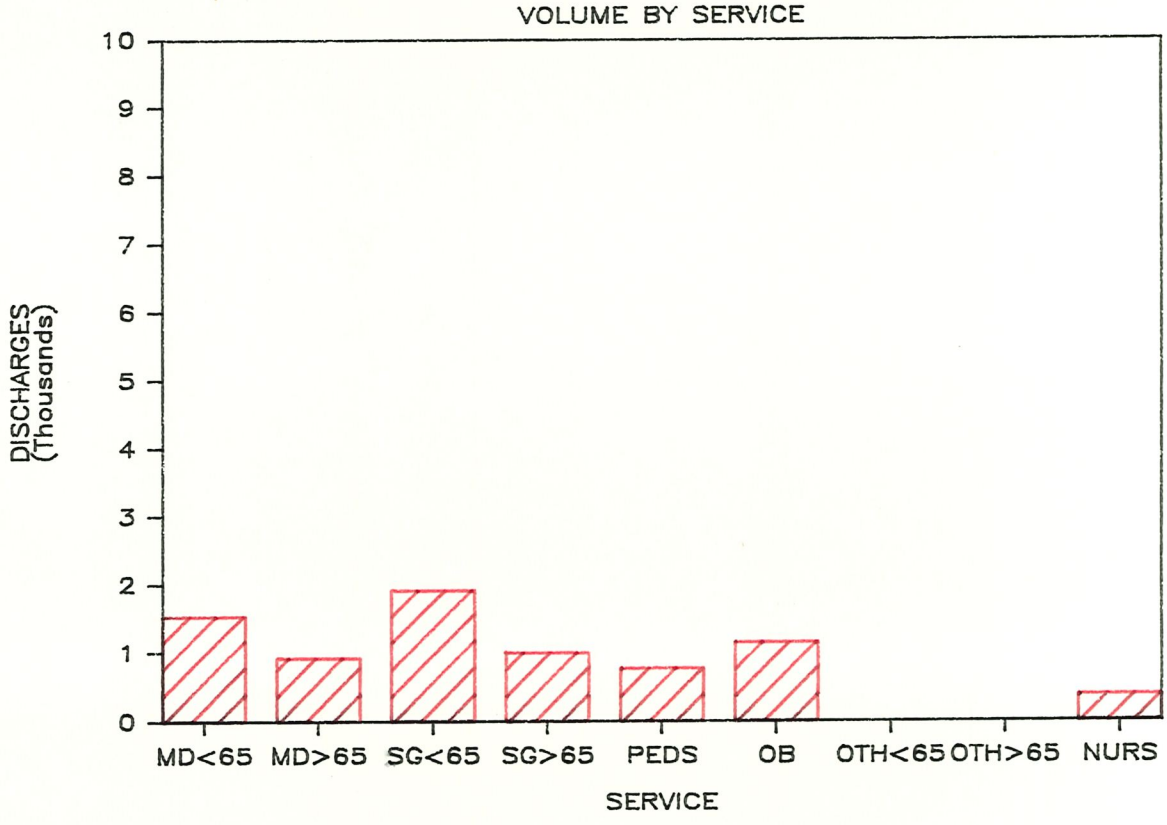
COMBINED VOLUME



REDUCED TOPEKA SERVICE PROFILE



NEW COMMUNITY HOSP. SERVICE PROFILE



FINANCIAL EXAMPLE

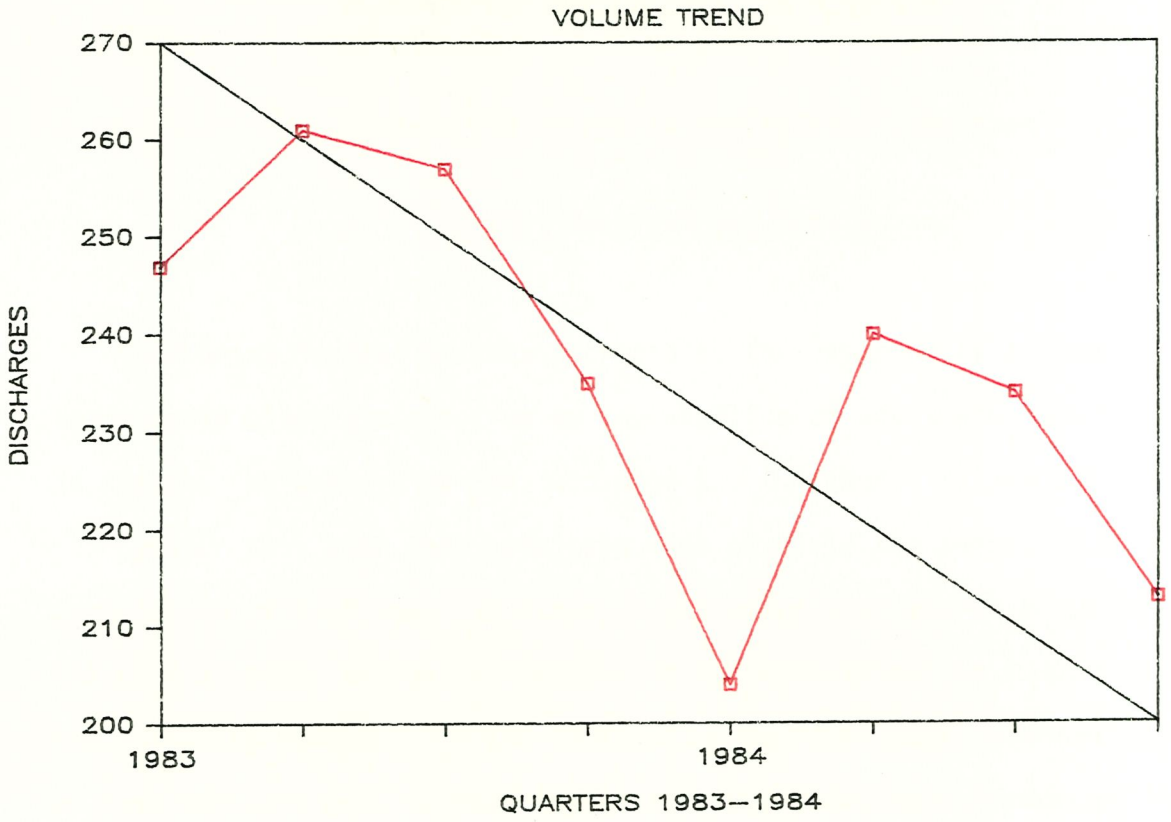
ASSUMPTIONS:
1) no increase or decrease in volume
2) 70 percent occupancy in New Community Hospital
3) price discounts to attract patients

CURRENT HOSPITAL DISCHARGES	33,923
NEW COMMUNITY HOSPITAL DISCHARGES:	7,696
DECREASED VOLUME AT CURRENT HOSPITALS:	26,227
KANSAS EMPLOYER COALITION ON HEALTH AVERAGE CHARGE FOR TOPEKA HOSPITALS' MOST FREQUENT SERVICES:	$2,008
15% DISCOUNT:	$1,700

	CONSERVATIVE	LIBERAL
TRANSFERRED REVENUE: (discharges x average charge)	$13,083,200	$15,453,568
FIXED COST PORTION OF REVENUE: (revenue x fixed cost %)	5,223,280	7,726,784
PER PATIENT COST INCREASE: (fixed cost / decreased discharges)	$200	$295

$200 TO $295 COST INCREASE TO EACH HOSPITAL STAY

SHAWNEE MISSION PSYCH UNIT



② SB-296- 3-8-85 Jerry Slaughter

KANSAS MEDICAL SOCIETY
1300 Topeka Avenue · Topeka, Kansas 66612 · (913) 235-2383

Senate Public Health and Welfare Committee
March 8, 1985

SB 296; Hospital Bed Moratorium

The Kansas Medical Society appreciates the opportunity to comment on SB 296, which would place a moratorium on the addition of new acute care hospital beds in Kansas. We support SB 296, and urge you to report it favorably.

Earlier this year this committee made possible the sunset of the state's Certificate of Need law. We strongly supported your action to sunset certificate of need, and do not believe it is inconsistent to support this bill for the following reasons. In the instance of hospital beds, everyone agrees that we have adequate beds to meet the demand, which has been decreasing for the last couple of years. The changing reimbursement incentives have played a key role in reversing demand for acute care beds, and we feel a moratorium on expansion for a finite period of time is justified while the economic environment stabilizes. With a tremendous capital investment already in place in the form of existing beds, many of which are empty, we believe it makes good sense to limit further expansion, at least until the new payment systems shake out in a couple of years. After that, the rapidly changing payment systems will probably be in place, and the moratorium can be lifted so that market forces can begin exerting influence on the need for expansion of acute care beds.

Thank you for this opportunity to offer these comments.

Jerry Slaughter
Executive Director

JS:ab

3/8/85
Attachment II

3-8-85- HASNER-

COMMITTEE OR PUBLIC HEALTH AND WELFARE

TESTIMONY PRESENTED ON

S.B. 296 BY THE HEALTH SYSTEMS AGENCY OF NORTHEAST KANSAS

My name is William Barlow, member of the Board of Directors of the Health Systems Agency of Northeast Kansas (HSANEK). I am here this morning representing the fifty members of the Board of Directors of the HSANEK, which serves the residents of twenty-five counties in Northeast Kansas.

I appreciate this opportunity to present the following testimony on S. B. 296. I am not here to be in any particular position as a proponent or opponent, but rather to encourage reflection on changes in what might be the legislators choice of law.

What is being proposed by the Committee is essentially a moratorium on construction of new hospital beds until July 1, 1987. We would like to raise the following concerns on S.B. 296:

o The moratorium is anti-competitive

The moratorium would essentially enfranchise existing providers, protecting them from new entrants into the market. A moratorium is the most extreme form of regulation, and provides no opportunity to address changes that might occur in the health care market during the two year period. It preserves all of the undesirable side-effects of CON without the counter - balacing opportunity for community input.

o Moratoriums are arbitrary

A moratorium treats all health facilities, and the consumers they serve, alike, and offers no opportunity for expansion of services in areas where there is need.

3/8/85
Attachment III

o Moratoriums deal only with cost containment

A moratorium necessarily ignores the non - cost containment related aspects of health planning and certificate of need concerns for access and quality of care issues.

o The moratorium doesn't deal with the real problem

The addition of new beds is not a primary source of growth in the hospital industry. The major source of health care cost increases today --purchases of new capital equipment, such as CT Scanners, MRI's (Magnetic Resonance Imaging),etc. isn't addressed by the moratorium. During the past fours years the hospitals in Northeast Kansas applied for Certificates of Need for $10,210,550 worth of capital equipment was approved. The amount of $840,400 was withdrawn. Most of the remainder of CON applications were for skilled or intermediate adult care beds. Unless some form of restriction, or review, is placed on the purchase of captial equipment, hospitals will continue to purchase capital, regardless of the cost, and regardless of whether the purchase is a duplication of services in the community. The present system of cost reimbursement, specifically Medicare, provides no incentive to control unnecessary purchase of equipment. The cost of equipment will be passed to you and I, health care consumers, in the form of increased health insurance premiums and higher out of pocket cost. It is unlikely, judging from past experience, that hospitals will voluntarily monitor the cost impact of their purchasing decisions on the community.

o The moratorium is essentially meaningless

Hospitals in Kansas are not going to undertake new construction or add beds, whether a moratorium is in place or not. Utilization is down; we

already have sufficient hospital capacity. In the past four years, the HSANEK has reviewed no projects for additional hospital bed capacity.

If this is so, why is this bill being proposed? At best, the moratorium is a smokescreen to divert attention from the probable impact of CON repeal; at worst, it's a fence to keep out-of-state competition away from Kansas hospitals.

HEALTH SYSTEMS AGENCY OF NORTHEAST KANSAS
CERTIFICATE OF NEED PROGRAM SUMMARY

Project #	Description	Sponsor	Project Cost	Current Status
2-DK-061	60 Bed ICF	Solomon Manor Estates, Inc.	$800,000	Withdrawn
2-SN-063	Full Body CT Scanner	Memorial Hospital	$683,550	Approved
2-SN-064	60 Bed ICF-MR	The Lodge, Inc.	$ 40,000	Approved
2-SN-065	Expansion of Hemodialysis	St. Francis Medical Center	$ -0-	Withdrawn
2-BR-066	11 Bed Addition	Oak Ridge Acres, Inc.	$143,000	Withdrawn
2-BR-067	60 Bed ICF	Westwood Development Co.	$775,000	Withdrawn
2-FR-068	12 Bed ICF	Ransom Memorial Hospital	$ -0-	Approved
2-BR-070	Addition to ICF & Renovation	Maple Heights, Inc.	$140,000	Withdrawn
2-OS-071	24 Bed Alcoholism	Osage Treatment Center, Inc.	$142,000	Withdrawn
2-SN-072	Addition of 35 ICF Beds	Rossville Valley Manor	$400,000	Denied
2-SN-073	Nuclear Medicine Service	Community Memorial Hospital	$115,000	Withdrawn
2-JA-074	Bed Conversion To Different Levels of Care	Holton	$ 5,000	Withdrawn
2-AN-075	Mobile Nuclear	Anderson County Hospital	$ -0-	Approved

Project #	Description	Sponsor	Project Cost	Current Status
2-JF-076	34 ICF Beds	Jefferson City Hospital	$200,000	Withdrawn
2-AT-077	Renov./Expan. of Alcoh./Drug Abuse Treatment Facility	Valley Hope Association	$278,100	Approved
2-SN-078	Education Building	Stormont-Vail	$4.7 Million	Approved
2-LY-079	CT Scanner	Newman Memorial (Emporia)	$840,400	Withdrawn
2-SN-080	Conversion of 34 of 100 ICF to SNF	United Methodist Homes for Aged	$ -0-	Not Required
2-SN-081	Conversion 50 ICF to 58 SNF	Aldersgate Village	$ 3,875	Approved
2-GE-082	Expansion of Med. Arts Building	Geary Community Hospital	$660,000	Approved
2-LY-083	CT Scanner	St. Mary's Hospital (Emporia)	$959,000	Approved
2-MS-084	Mobile Nuclear Medicine	Marysville Hospital	$ -0-	Approved
2-SN-086	Expansion/Renovation	Slagle Sch. Topeka State Hospital	$2,991,010	Not Required
2-BR-087	Const. of Medical Office Building	Hodon Foundation	$491,500	Approved
2-FR-088	Replacement of ICF Facility + New Beds	Cedar House (Ottawa)	$1,700,000	Withdrawn
2-SN-089	Purchase Digital Radiograph Equip.	Stormont-Vail Hospital	$335,000	Withdrawn
2-SN-090	Add 35 SNF Beds	Rossville Valley Manor	$500,000	Denied
2-PT-091	Renovation/Expansion	Onaga Community Hospital	$378,000	Approved

Project #	Description	Sponsor	Project Cost	Current Status
2-SN-092	Purchase of Digital Subtraction Angiography Equip.	St. Francis Hospital	$ 350,000	Withdrawn
2-SN-093	Add 10 ICF Beds	Briarcliff Care Center, Inc.	$ 92,000	Letter of Int.
2-RL-094	Establish Mobile CT Scanner Services	Mobilscan, Inc.	$ 1.1 Million	Approved
2-DG-095	Purchase Full Body CT Scanner	Lawrence Memorial Hospital	$ 968,000	Approved
2-SN-096	Purchase Full Body CT Scanner	Stormont-Vail Hospital	$ 1.3 Million	Approved
2-FR-097	Replace 113 ICF Add 7 ICF Beds	Ottawa Care Center	$1,223,488	Approved
2-JE-098	Add 60-80 Beds	Kaw Valley Care Home	$ 1. Million	Letter of Int.
2-MS-099	Build 50-60 ICF	Summerfield Care Center	$1,227,386	Denied
2-SN-100	60 Bed ICF	Aldersgate Village	$1.2 Million	Denied Pending State Decision
2-NM-101	New 31 Bed Hospital	Nemaha Valley Comm. Hosp.	$3.7 Million	Application Received
2-LY-102	60 Bed ICF/SNF	Retirement Living, Inc.	$2,141,464	Denied
2-SN-103	ICF Facility For Mentally Ill	Project Charlee	$ 90,000	Withdrawn
2-SN-104	NMR	Cooperative Planning Group	$ 3.9 Million	Letter of Intent
2-CY-105	Renovate/Expand ~~Residence~~ Reduce by 6 Beds	Clay County Hospital	$ 2.4 Million	Public Hearing 12/15/83
2-DG-106	Lease 100 Bed Nursing Home	Autumn Care Manor	$ 135,617	Letter of Intent

TESTIMONY - SENATE BILL 296

My name is John Yulich, I have been a medical doctor in Sabetha since 1981, moving there after almost twenty years of practice in Kansas City, Kansas. Because of my involvement in both metropolitan and small town health care delivery, I felt that I wanted to propose some word changes in Senate Bill 296.

I have a personal working knowledge of Certificate of Need and health planning having served on the Provider Advisory Board of the Kansas City Metropolitan Health Planning Agency. The C.O.N. concept was based entirely on the premise of stopping the rapid escalation of health care costs in a climate of absolutely a non-existant law of supply and demand. Certificate of Need is dead and may it rest in peace, having accomplished only a portion of that for which it was intended.

The entire fiscal concept of health care has changed with the birth of D.R.G.s (Diagnostic Related Groups) by first Medicare and then Blue Cross and Blue Shield. I am sure that you are all aware of this concept and how it functions. This is health care cost containment in possibly it's finest form and can be equalled only by an absolute moratorium, i.e., Senate Bill 296.

I would suggest to the committee that legislation should be clear, concise, definitive and definable. Section 3 of this bill contains a non-definable term "community". From a legal, and a judicial prospective, this term will be as bothersome as the "neighborhood school" concept which many boards of education and courts have debated. We do however, have geographically and legally defined divisions of land in our state called "counties".

The intent of Senate Bill 296 is solely cost containment. Yet the vague terminology of Section 3 does little to accomplish this. A moratorium should be a moratorium, but I believe that Subsection (d) has some of those tricky "loopholes" within it. Therefore the changes that are proposed in Senate Bill 296 are (1) Section 3, Subsection (a) line 0036 change the last word of the paragraph from "community" to "county", (2) Section 3, Subsection (d) change the paragraph to read, "an uncompleted project for which a hospital had an unsuspended Certificate of Need under KSA 65-4801 et seq. on June 30, 1985, if actual construction of the project had legally begun pursuant to

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a Certificate of Need by April 1, 1985".

A moratorium until June 1, 1987 is reasonable and gives the Department of Health & Environment and the Legislature time to establish proper rules and guidelines.

Thank you for your consideration.

TESTIMONY

Senate Committee on Public Health and Welfare
John C. Peterson, Charter Medical Corporation
March 8, 1985

Mr. Chairman, members of the Senate Public Health and Welfare Committee, my name is John Peterson and I am appearing on behalf of Charter Medical Corporation. Charter Medical currently operates or has under development 44 hospitals throughout the United States--thirty are psychiatric hospitals and 14 are general acute care hospitals. They include a 200 bed general hospital in St. Louis, a 118 bed general hospital in Des Moines and the 88 bed Center for Psychiatry in Columbus, Missouri. These facilities total 4,839 beds, all of which are fully licensed and accredited by the Joint Commission for the Accreditation of Hospitals.

Charter Medical has filed a certificate of need to construct and build a 52 bed psychiatric facility primarily for the in-patient treatment of children and adolescents. In addition it will serve on an out-patient basis an additional 40 clients per day. That facility is to be located on approximately 19 acres in Johnson County, Kansas. Its construction will cost 6.28 million dollars funded entirely from non-tax revenues--no Hill Burton funds, federal or state funds, or even industrial revenue bonds.

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We did not participate or take a position during your deliberations concerning the extension of the certificate of need program. If certificate of need had been extended Charter Medical was comfortable in their ability to document and prove the need for such a facility in that area. If not extended they are comfortable enough with their needs analysis to be willing to invest such substantial resources in the state of Kansas.

As I read Senate Bill 296 I was first struck by its incompleteness. This Bill would place an absolute ban on new hospitals or new hospital beds, but it would allow existing hospitals the complete and unfettered freedom to undertake all of the capital expenditures previously requiring a certificate of need. I am sure that must have been an oversight of the proponents of this Bill. If we are going to place a statewide moratorium in order to allow "the dust to settle" after certificate of need is no longer required, then certainly this Bill should be amended in line 31 to add a new subsection (c) to section 2 stating that the act prohibits:

> (c) the expenditure, acquisition or other act or activity which would have required a certificate of need pursuant to K.S.A. 1984 Supp. 65-4805 immediately prior to the effective date of this act.

The certificate of need application contains an independent analysis of the need for such a facility to serve

Johnson County as well as patients that would be attracted from Missouri to such a facility. Population projections from the Kansas Department of Health and Environment show the Johnson County population in 1985 to be 303,885 and a projected population in 1990 of 334,994. The State Health Plan recommends a bed ratio of .6 psychiatric beds per 1,000 population, or a total need of 201 beds. Of the four general hospitals in Johnson County, only one has a psychiatric ward which, together with an existing free standing facility in Olathe, account for a total of only 97 licensed psychiatric beds in Johnson County. In addition, hospitals in Johnson County, given their proximity to the greater Kansas City area, have 25 to 35 percent of their admission from non-Johnson County residents.

I provide you this information as general background. But I really believe that this specific data begs the issue. The issue is not limited to this one project and the issue is not limited to whether or not a need can be proven. Obviously no business would invest 6.8 million dollars in construction and create 78 new jobs with a 4 million dollar annual budget if it was not satisfied that there was an un-met need that it could fill in a community. But the issue that Senate Bill 296 raises goes far beyond those questions. The fundamental issue that it presents is whether our free marketplace is going to determine

supply and demand need for services and facilities or whether you will make that determination by passing an absolute ban. In our free society, what interest does the state have in saying: "no, you shall not compete?" It's one thing for the state to make a determination to no longer expend tax revenue in a particular area. It's one thing for the state to determine, for example, that we have enough veterinarian and to decide not to spend as much money, or not to spend any money in their training or education. It's quite another thing if their association were to come to you and say we have enough veterinarians in Kansas, here is data that proves it, they have invested substantial capital and equipment, staff, salaries and to allow more might place that in jeopardy, so please pass a law saying no new veterinarians can be licensed in the state. I have a strong suspicion of what your reaction would be to that and yet that is exactly what you are being asked to do today in regard to hospitals.

As you have listened to the testimony of the proponents I hope that you have thought about how many other industries and how many other businesses could make that same kind of argument. And once you start down that road, the road where state laws make economic decisions about competition instead of our free market-place making those determinations, that road will be long and

wide and will include numerous industries who will have rationales as to why the state should mandate that they should not have to face new competition.

Let me discuss very briefly the "cream of the crop" argument. Again, I would note that in Johnson County only one out of four general hospitals even offers psychiatric facilities, so the other three have certainly not regarded psychiatric treatment as any portion of their "crop". Secondly, is there anything inherent in hospital licensing, standards, or regulations which prohibits them from equally competing for the "cream"? If you feel that there is, then turn on the television tonight and see how long it takes before an ad comes on promoting an existing hospital's new "alcoholism", "substance abuse" or "mental health" program or unit. They can and do have the ability and capability of competing equally well.

Several years ago federal law relating to certificate of need was re-written to encourage competition in the health care field. They specifically included as one of the goals "preserving and improving . . . competition". This legislature last year enacted 1984 House Bill 2648 which amended the certificate of need program to specifically require that the criteria for approval be designed to encourage appropriate competition.

This summer Interim Committee in Public Health and Welfare studied a wide range of health care issues including the certificate of need program. Marlon Dauner, Sr. Vice President for Blue Cross/Blue Shield of Kansas testified before that committee that:

> The certificate of need process has historically been of value but not to the extent experienced by those interested in radically slowing down the escalating health care costs of the past ten years. The new market forces will likely do in a few months what the certificate of need was unable to do over a period of years.

The Legislative Research Department Memorandum of November 7, 1984, reviewed activities of several states. The Iowa experience was referred to in their final report. The memorandum notes that:

> The Iowa legislature responded to a big push by business, insurers and the health care industry to control costs that began in the early 1980's by creating a commission to outline a state-wide strategy to control escalating health costs. This first commission concluded that the best approach was to use market forces of competitors and incentives rather than regulating to influence the cost of health care.

At the October 29th hearing the Health System Agency of Northeast Kansas, noted in regard to the alternative of eliminating the certificate of need program that:

> For-profit hospitals have demonstrated throughout the nation that efficiently operated facilities can be profitable and at the same time provide savings to the tax payers by providing the necessary mix of medical and health care services. . . . It is important to note that these corporations will not only bring competition into the Kansas health care system but also much needed

> investment and jobs. This alternative should foster competition . . . .

It was only about three weeks ago that this Committee defeated Senate Bill 18, which would have extended the certificate of need program. All of us should remember the rationale for reporting Senate Bill 18 unfavorably. The proponents of killing certificate of need were clear in their philosophical basis. The Medical Society testified on January 24:

> The mood in this country is to discard artificial, regulatory controls, and encourage competition. Any truly competitive delivery system combines free market entry of providers and services, and a wide degree of patient choice. Certificate of need limits market entry, and in effect, creates exclusive franchises for some facilities and services. It is simply out of step with the emerging forces which are changing our health care delivery system.

The Kansas Hospital Association also urged you to kill the certificate of need program, a position which they took for the first time in their testimony on January 24. They told you that the certificate of need law was not appropriate in the new health care environment. "Certificate of Need prevents hospitals from participating on a level playing field with other health care providers." And now they come back to you and say, thank you for placing hospitals on a level playing field with other health care providers. But just one more thing, would you please

enact a law that says that nobody else can buy a football. We want to play on that level playing field, we want to buy new equipment and grow and compete with other health care providers in this new competitive environment, but please use the force of Kansas law to assure that we won't have to face any new competition.

How much money does the state spend every year to try to bring economic growth and development to Kansas? KDED representatives have been to Georgia. They have met with Charter Medical and visited its facilities. They have told them about our state and about its people.

And now that Charter Medical has the land, the plans and the willingness to invest in our state, the proponents of this bill would have you pass a law that would say to them, stop right there at state line; don't you dare presume to put that 6 million dollar building on the Kansas side; you put it down if you want over in Missouri (which has certificate of need requirements but no moratorium); you create those 78 new jobs and an annual payroll of 2 million dollars and all the taxes that that generates over there; but don't you dare try to bring it into Kansas. And if your facility is a good high-quality one, you can compete in the marketplace, you can draw our Kansas residents over there for services and have them spend their Kansas dollars

in that state, but don't you dare try to build it in Kansas and be part of the Kansas property tax base and bring Missouri residents to your facility in Kansas.

The Hospital Association came to you and urged you to kill certificate of need, and now they come back and say gosh we have a problem. You should ban all new beds because they are not needed--after they have killed the state program that evaluated whether or not in fact they are needed. They killed that program and they should live with the results.

We would urge the committee to table Senate Bill 296. That would give this Committee and our State a period of six months to see what does occur in the state by way of innovation and new facilities, and to come back in January 1986 after a six month period, to analyze and deal with legitimate health care planning at that time.

Thank you for your time and consideration.

PP030450-15/20

Charter Medical Corporation, an international health care concern with its corporate offices in Macon, Georgia, proposes to construct and operate a specialized, free-standing psychiatric hospital in Johnson County, Kansas. The facilities will include a fifty-two (52) bed inpatient hospital and a day (partial) hospital capable of serving forty (40) clients per day. The total project cost will be approximately $6,500,000 and is planned to be completed in mid 1986.

The main objective of the inpatient and day (partial) hospital programs is to provide psychiatric treatment services in the most appropriate and least restrictive setting. In the inpatient hospital, special programs will be designated for the treatment of children (ages 5-11 years), adolescents (ages 12-17 years) and adults.

The day or partial hospital facility, located on the same campus as the inpatient hospital, will provide similar programs as the inpatient hospital in a less restrictive environment. Specific, distinct programs will be offered for children, adolescents, and adults. It is expected that a total of 40 patients will be treated per day at capacity.

The partial programs are unique in that they allow the patient to experience several hours of intensive, personalized therapy daily for five to six days per week while maintaining a normal daily lifestyle. For patients with a reasonably stable home life, these programs are ideal because the family can reinforce and support the progress the patient has achieved at the hospital. In addition, these programs will complement the inpatient program and ease the transition from inpatient hospitalization to return to daily living.

The outpatient program completes the continuum. These programs include family involvement in the inpatient or partial hospital patient's treatment; follow-up care to inpatients on a routine, scheduled basis; crisis intervention and counseling; alumni support groups and other adjunct services to the inpatient and partial programs.

The facilities will be designed and furnished to meet patient needs and create a comfortable, home-like atmosphere. By eliminating the custodial and institutional design that has been customary for psychiatric facilities and by emphasizing openness and accessibility, the Charter hospital will be better able to integrate patients into an effective, therapeutic milieu and increase the patient's ability to recover.

The Charter hospital and partial hospital will initially employ approximately 70 people with an annual payroll in excess of 2 million dollars. The hospital will pay federal, state and local taxes and will be fully accredited by the Joint Commission on Accreditation of Hospitals and licensed by the Kansas Department of Social and Rehabilitative Services.

For further information, contact Bill Gibson at Charter Medical Corporation, 577 Mulberry Street, Macon, Georgia, 31298; (912) 742-1161.

Attachment U

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

TESTIMONY ON SB 296

PRESENTED TO Senate Public Health and Welfare Committee

BACKGROUND INFORMATION:

On January 29, 1985 the Public Health and Welfare Committee adversely reported on the recommendation to continue the Certificate of Need Program. With the sunsetting of the Certificate of Need Program, testimony was presented voicing concern that without controls health facility construction would dramatically increase, and thereby increase health care costs. SB 296 establishes a two year moratorium on the erection, building, alteration, reconstruction, modernization, improvement, extension, leasing or other acquisition by or on behalf of a hospital which increases the bed capacity of a hospital or relocates hospital beds from one physical facility or site to another. This bill prohibits the establishment of a new hospital, but specifically allows total replacement of an existing hospital's beds within the same community if there is no other hospital in the community and consolidation of two or more hospitals whose maximum bed capacity after consolidation is at a level to accommodate a 70% occupancy rate based on aggregate average daily census of the consolidating hospitals during the previous fiscal year of each hospital. SB 296 excludes federally owned hospitals. The bill gives the Secretary waiver authority in cases of natural disasters, the authority to adopt rules and regulations and the power to enjoin in alleged violations of the act.

To gain a perspective on what effect(s) sunsetting of the Certificate of Need Program and enactment of a hospital moratorium would have on health care services and cost containment, the Department of Health and Environment contacted the Regional Office of the Department of Health and Human Services and other states who have deregulated hospital construction.

When staff of the Department of Health and Human Services was contacted they indicated that are currently two proposals before Congress related to cost containment and Medicare/Medicaid reimbursement. The bills would:

1. Reimburse facilities for capital expenditures under Medicare/Medicaid at a certain percentage level through a "capital pass through" or

2. Make the 1122 program mandatory for all states as of October, 1986.

   (1122 is an agreement between a State and HHS. State reviews proposed hospital capital expenditures. Hospitals proceeding with disallowed projects are denied under Medicare, Medicaid and the Maternal and Child Health Programs. If an 1122 program is not implemented, State risks losing all Medicare/Medicaid reimbursement, as well as other public health monies.)

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Due to the deficit reduction attitude of Congress, HHS staff has indicated that a mandatory 1122 program may be the more likely of the two pieces of legislation to be enacted.

Contact was made with health planning staff in Minnesota, New Mexico and Utah, three states which have allowed Certificate of Need to sunset.

The State of Minnesota sunsetted Certificate of Need on June 30, 1984. At that time, three moratoriums were put into effect for three years. They covered:

1. Nursing home beds

2. Hospital beds

3. CAP on the <u>total</u> number of ICF/MR beds allowed in the state.

Minnesota had an 1122 program operating simultaneously with Certificate of Need. The State retained the 1122 program and is using it as a monitoring device for health planning.

The moratoriums in Minnesota have generally been well received, no new beds have been allowed in the state, and the state has been given time to take a fresh look at its health care regulatory policies.

New Mexico allowed Certificate of Need to sunset in June, 1983. That state also has chosen to retain the 1122 program. New Mexico moved toward "strengthening it state health plan" to include desired occupancy rates and beds per 1,000 elderly criteria. (Kansas already has taken this action.) Health planning staff in New Mexico indicated that the 1122 program "seems to work about as well as Certificate of Need" in the cost containment area. New Mexico staff also indicated that a moratorium would "buy time" until a decision is made about what kind of program to have in place.

The State of Utah appears to be the only state which has sunsetted Certificate of Need without implementing the 1122 program or imposing any type of moratorium.

Certificate of Need sunsetted in Utah on December 31, 1984. At that time the state had 5,000 nursing home beds (a surplus of 500). Since January 1, 1985 the licensing division of the state agency received plans for the addition of 2,400 nursing home beds in Utah. Additionally, architectural plans were submitted for the construction of three hospitals in Salt Lake City, a city which is already considered over-bedded by health planners.

The experiences of these three states yield the lesson that if the goal of the Legislature is to promote a competitve health care marketplace, a moratorium will hinder the implementation of that policy.

If, however, the goal of the Legislature is to prevent an increase in hospital beds a moratorium is an option. However, there are several policy issues which must be addressed:

SB 296 would place a moratorium on hospitals defined in K.S.A. 65-425 which are general hospitals and special hospitals. The moratorium would not cover psychiatric hospitals, kidney treatment centers, including centers not located in a medical facility or federal hospitals. In addition, the bill does not address the purchase of new equipment or the introduction of new services in health care facilities. Under SB 296, it would be possible to expend large amounts of capital to "redistribute" beds as long as the total bed capacity did not change.

Additionally, current licensure regulations allow facilities to request licensure for less than the full number of beds the facility as constructed could serve. If the definition of bed capacity is defined to mean constructed capacity a facility could possibly expand bed number without construction and without violation of the moratorium. Therefore, the Department recommends defining bed capacity as licensed bed capacity.

The 1984 Plan for the Health of Kansans identifies an apparent surplus of 1,351 to 1,702 acute care hospital beds. It would seem doubtful that a great deal of construction of new hospital beds would occur with a moratorium. However, as the bill is written (simply listing what hospitals can not undertake) it would not cover the following: expenditures for capital resources on expensive new diagnostic and treatment equipment, and capital projects for the development of new services or redistribution of beds from one type of service to another. Section 2 allows the redistribution of beds as long as the total bed capacity of the facility remains unchanged. With no Certificate of Need programs in place, large capital expenditures could be made for new units as long as the total beds were not increased. For example, millions of dollars could be spent to shift medical/surgical beds to pediatric, alcohol-chemical dependence, in-patient beds, etc. without benefit of a need analysis. A statement on how some other states address major medical equipment is attached.

Section 3 of the bill grandfathers hospitals which have been issued a Certificate of Need. Currently, 11 hospitals have been issued certificates of need which would not be affected by the moratorium. The request would not affect beds but would cover approximately $23,451,624.00 in renovation, new services and purchase of major medical equipment. The bill will not address certificate of need denials which have been appealed to court and which may be overturned after the certificate of need statutes have expired. There is currently one certificate of need being appealed by a hospital requesting approval to completely replace a 24-bed facility at a cost of $3,943,000.00. The Department recommends that the language be changed to require hospitals to commence construction of projects prior to the expiration date of the certificate of need.

Section 4 of the bill gives the Secretary of KDHE, in cases of natural disasters, the authority to waive provisions of the act if adequate health care facilities are not available for the people who previously used the applicant hospital's facility. Inadequate definition of what constitutes adequate health care facilities could result in a variety of legal actions being initiated against the Department, brought by those dissatisfied with what the Secretary defines as adequate resources and acceptable access to those facilities.

Section 5 grants the Secretary of KDHE or a hospital the right to bring action to enjoin any alleged violation of this action but does not establish a procedure for review of such actions to determine if they are appropriate or illegal under the act.

In addition in Section 3 there is no definition of "community." Under the Certificate of Need provisions there were standards that did define "community." The bill could create confusion as a result of no definition of "community."

The Secretary of the Department of Health and Environment licenses state hospitals under the special hospital provisions. I would recommend that if this bill is passed it be amended to include an exemption for state hospitals.

It is also important to note that there is no provision for the adoption of rules and regulations except under Section 4.

Presented by: Barbara J. Sabol, Secretary
Kansas Department of Health
and Environment

STATE CERTIFICATE OF NEED LAWS COVERING ACQUISITION OF MAJOR MEDICAL EQUIPMENT NOT TO BE USED FOR HOSPITAL INPATIENT SERVICES*

STATE	EQUIPMENT THRESHOLD ($ x 000)	CON LAW	CON REGULATIONS	COVERAGE PROVISION
Colorado	1,000	25-3-5, CR.S., 1973 (as amended April 30, 1982)	Colorado CON Rules, December 1, 1982, pp. iii-iv.	A capital expenditure of $1,000,000 or more by any person for major medical equipment to provide "health services."
Connecticut	400	Sections 19a-155(b), C.G.S., as amended by P.A. 83-215, May 26, 1983	Sections 19-73a-1 through 19-73a-91.	"Any person" proposing to acquire or lease "imaging equipment" costing $400,000 or more must obtain a certificate of need.
District of Columbia	400	D.C. Code Sec. 32-301 et seq.	22 DCMR 100	Major medical equipment acquired by any person, by or on behalf of physicians, dentists, etc.
Hawaii	250 new 400 replacement	HRS Sec. 323D (1982 Supp.)	Administrative Rules, 11-185 and 11-187 (January 9, 1981); 11-186 (June 19, 1982)	"Offices of physicians, dentists, or other practitioners of the healing arts in private practice as distinguished from organized, ambulatory health care facilities" are exempted from CON coverage except for purchase or acquisition of equipment costing more than the expenditure minimum.
Iowa	400	Iowa Code Ann., Sec. 135.61(19)(g)(1983 Supp.)	IAC (470) Ch. 202	By or on behalf of an individual health care provider or a group of health care providers... in a private office or clinic.
Montana	500	Mont. Rev. Code Ann., Sec. 50-5-301(d) (1983 Supp.)	Rule 16.32.10[illegible] (Administrative Rules of Montana, June 30, 1983	The "acquisition by any person of major medical equipment, provided that such acquisition would have required a certificate of need ... if it had been made by or on behalf of a health care facility."
New Hampshire	400	RSA 151-C:4(1)(c)	He-C 300	Covers diagnostic and therapeutic equipment acquired by ambulatory care facilities, but exempts physicians' private offices and private clinics.
Rhode Island	150	23-15-2(k)	R23-15-CON	"Medical equipment ... proposed to be utilized by a health care provider" (physician, dentist, nurse, etc.).
Virginia	400	Sec. 32.1-102.1, 6e, Code of Virginia (1950)	Va. Medical Care Facilities Certificate of Public Need Rules and Regulations, July 1, 1982	Equipment generally and customarily associated with the provision of health services in an inpatient setting, by or on behalf of a physician's office.
Wisconsin	600	1983 Sen. Bill 83, Sec. 1565w amending Wisc.Stat.Ann 150.61(3) (1982 Supp.)	HSS 123.02	Includes independent practitioners, partnerships, unincorporated medical groups, and service corporations.

* The federal requirement is that state certificate of need laws cover acquisitions, by anyone, of major medical equipment that will be used to provide services to hospital inpatients. This listing is of those state laws that provide greater coverage than that minimum requirement.

Alpha Center
October 1984

ATTACHMENT I

MORATORIUMS ESTABLISHED IN OTHER STATES

Expire

Hospitals

1-1-85 Missouri-Yes

1-85 Arizona-Yes

2-28-85 Alabama - All CON Projects.

Louisiana - No CON Program in place.
1122 Program in affect.
Moratorium on all 1122 Projects.

Minnesota - Moratorium on new beds and construction, but not part of CON Program.

Nursing Homes

Maine-Yes

New Hampshire-Yes

Kentucky-Expired recently. Do not know if extended.

2-28-85 Alabama-All CON Projects.

8-85 Mississippi-Yes

South Carolina-Believe they have a moratorium, but not found in statutes.

Minnesota-Medicaid Certification Nursing Home Moratorium only.

7-1-87 Missouri-Yes

Lousiana-No CON Program in place.
1122 Program in affect.
Moratorium on all 1122 Projects.

Arkansas-Believe it has expired, date unknown.