Approved 3-5-91
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./pxmx on February 26, 1991 in room 526-S of the Capitol.

All members were present except:

Committee staff present:

Emalene Correll, Legislative Research
Norman Furse, Revisor's Office
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:

Senator Doug Walker
Al Tikwart, Jr., President, American Lithographers, Inc., KC,Mo.
Thomas Kirker - Diagnostic Imaging Center, K.C., Mo.
John L. Kiefhaber, Kansas Health Care Association
Paul Klotz, Executive Director, Community Mental Health Centers
Donald A. Wilson, President, Kansas Hospital Association
Robert J. O'Brien, St. Joseph Health Corporation, Wichita
Chip Wheelen, Kansas Medical Society

Chairman Ehrlich called the meeting to order at 10:00 a.m. and announced the minutes for February 19, 20 and 21, 1991, were distributed to the committee for review.

Hearing on:

SB 184 - Certificate of need required for health facility projects and services.

Senator Walker, sponsor of SB 184 submitted written testimony and appeared in support of his bill stating SB 184 would require all health facilities to obtain a permit before purchasing new equipment that would cost more than $400,000, or adding new service or construction in excess of $600.000. The bill would also establish a Health Facilities Review Board that would review, approve or deny permits. Senator Walker also stated the bill would not solve the health care cost crisis, but would be a useful tool in helping bring those costs under control. (Attachment 1)

Al Tikwart, President of American Lithographers, Inc., presented written testimony and spoke in support of SB 184. He also stated if the check and balances, as suggested in this bill, are not implemented, and if the state continues to condone the medical arms race, Kansans could be in the position he was in 17 years ago when medical expenses took almost all of his family income and savings. (Attachment 2).

Thomas Kirker appeared next in support of SB 184 reading a letter to the committee from Edwin M. Hermann, M.D., Diagnostic Imaging Center, of Kansas City, Missouri. Dr. Hermann's letter indicated some provisions and criteria are needed to control the development of additional and new health care services, and that increasing health care costs are directly related to such development. Dr. Hermann stated in his letter that the diagnostic imaging facilities in Johnson County make the need for additional providers unnecessary, since the facilities are spread through the county, making patient access readily available. (Attachment 3) Question was asked by Senator Hayden as to the chronological order of diagnostic centers in Johnson County.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

CONTINUATION SHEET

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 526-S, Statehouse, at 10:00 a.m./~~p.m.~~ on February 26, 1991

John L. Kiefhaber, Executive Vice President, Kansas Health Care Association, presented his written testimony and appeared in support of SB 184. He stated the association supports the bill because its members support the idea of health care planning and control. He also pointed out that low occupancy rates in nursing homes can burden Title XIX Medicaid programs, because fixed costs such as building maintenance, utilities, and staff labor do not decrease as occupancy drops. The Medicaid program can pay out more in service reimbursement per resident without getting more long term care services per resident when those occupancy rates drop. (Attachment 4)

Paul Klotz, Executive Director, Association of Community Health Centers of Kansas, submitted written testimony and stated the association is generally favorable toward SB 184, but has some concern with language on page 3, Section 5, (3), of the bill regarding mental health care services that would require a health facility permit be undertaken each time such a service is added or substantially expanded. He questioned if such a requirement would delay or interfere with the progress of mental health reform. (Attachment 5) Staff Correll called attention to the fact there was nothing in the mental health reform bill that was enacted last year that would keep community mental health centers from contracting with existing services. Clarification of expansion of mental health facilities and language in Section 8 - 11 of the bill were also discussed.

Presenting written testimony and appearing in opposition to SB 184 was Donald Wilson, President, Kansas Hospital Association, who stated that the passage of a certificate of need bill this session would not help solve any of the state's health care problems. He felt an independent study of what factors are causing health care costs should be made, and urged that SB 184 be held in committee so that the entire topic of health planning can be a part of the larger discussion. (Attachment 6)

Speaking in opposition of SB 184 and presenting written testimony to the committee was Robert J. O'Brien, Executive Vice President and CEO of the St. Joseph Health Corporation of Wichita. He also encouraged the committee to hold the bill until an independent study could be undertaken which would address all of the complexities and issues which contribute to the high cost of health care. (Attachment 7)

Submitting written testimony and appearing in opposition to SB 184 was Chip Wheelen, Kansas Medical Society, indicated states that still have certificate of need laws have not subdued the cost of health care by comparison to those states that do not have certificate of need laws. He also stated a need to study the bill further, possibly in a joint committee. (Attachment 8)

An information - briefing of SB 184 was presented by Richard J. Morrissey, Deputy Director, Division of Health, Department of Health and Environment. Mr. Morrissey stated the department has had considerable experience with a program similar to this type of proposed legislation that was in effect from the late 1970's to July, 1985. He stated that the chief aim of programs such as certificate of need and the one proposed by SB 184 is to reduce health care costs through the restraint of capital expenditures. The regulatory model in which capital expenditure control was originally proposed also included control on prices and utilization, though most states, including Kansas, implemented only the capital expenditure program. He further emphasized there is no evidence that capital expenditure regulation by itself has been effective in restraining increases in health care costs. (Attachment 9)

The chairman announced continued hearing on SB 184 would be held following adjournment of the Senate session today. The meeting was adjourned at 11:05 a.m.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE 2-26-91

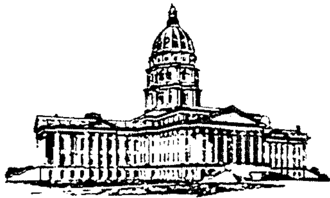
(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
LISA Getz	WICHITA Hospitals
ROBERT J. O'BRIEN	ST. JOSEPH HEALTH CORP.
Don Snodgrass	& ATS Topeka Ks
Mary Ellen Conlee	Wichita Hospitals
JOHN KIEFHABER	Ks HEALTH CARE ASSN.
F C Eaton	" " " "
GARY Robbins	Ks Opt Assn
David Hanzlick	KS Dental Ass'n
HARRY SPRING	HUMANA PRIME HEALTH
Jeannine Harmon	Behavioral Sciences Regulatory Board
Tom Hitchcock	Bd Pharmacy
JOE FURJANIC	KCA
Marilyn Bradt	KINH
Kelley Kultala	NOW
W. H. Crockett	AARP
Richard Morrissey	KDHE
Tom Gress	KMA
Joseph F Kroll	KDHE
Kevin McFarland	Ks. Homes for the Aging

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE 2-26-91
10:00 a.m

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Glenda Freeman	K.A.H.A
Pat Johnson	Board of Nursing
Diane Oxford	KCI
Melissa Hungerford	KHA
Richard H. Hanson	Bd of Healing Arts
John Grace	KAHA
Harold Riehm	KAOM
Tom Bell	KHA
Don Wilson	KHA
Jerry Slaughter	KMS
Chip Wheelen	KMS
Charles Konigsberg	KDHE
Jim Schwartz	KECH
Paul M. Klotz	Assoc. of CMHCs of KS, Inc.
R. Rein	KPhA
Carl Schmitthenner	Kansas Dental Assoc.
John C. Peterson	
Bob Williams	Ks. Pharmacists Assoc
Nancy Zogleman	BC/BS of Ks

DOUG WALKER
SENATOR, 12TH DISTRICT
MIAMI, BOURBON, LINN,
ANDERSON, ALLEN AND
NEOSHO COUNTIES
212 FIRST
OSAWATOMIE, KANSAS 66064
(913) 755-4192 (HOME)
(913) 296-7380 (STATE CAPITOL)

STATE OF KANSAS



TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNM.

MEMBER: CONFIRMATIONS
EDUCATION
ENERGY AND NATURAL RESOURCES
FEDERAL AND STATE AFFAIRS
PUBLIC HEALTH AND WELFARE

TESTIMONY FAVORING PASSAGE OF SB 184

Senate Bill 184 would require all health facilities to obtain a permit before purchasing new equipment which costs more than $400,000, or adding a new service or new construction which costs in excess of $600,000.

This bill establishes a Health Facilities Review Board to review, and approve or deny permits.

Currently, 39 states have legislation that requires "reviews and permits" for medical equipment and facilities. It has proven to be one effective tool to help control health care costs. Last year health care costs rose about 19%.

In health care, the competitive free market system works to cause health care costs to rise. To be competitive in today's market, each hospital feels it must have the latest, most expensive, most technologically-advanced equipment. To cover these costs, hospitals increase prices and spend considerable sums of money advertising to attract more patients to help pay for this equipment. The determination to purchase new equipment frequently comes down to convenience and marketing rather than medical necessity for the area served.

Let me give you a few specific examples why we need the

process outlined in SB 184 in Kansas.

In Iowa, Kansas, Minnesota, Missouri, Nebraska, North and South Dakota, there was an increase of 12 psychiatric hospitals between 1978 and 1988. Six of these hospitals were built in Kansas.

All new facilities need to be justified in light of the fact that Kansas hospitals occupancy rate is only 56.6%

Canada has 12 MRI scanners in the entire country; Wichita has 6 (possibly 7).

SRS Task force recommendations on long term care also called for a moratorium on reimbursement for any nursing facility bed built or created through conversion. This bill will help accomplish that end.

I have enclosed a couple of newspaper articles which illustrate the problem with unregulated medical expenditures. The first article illustrates the burden too many mammography machines place on our health care system, driving costs up without improving access. The second article points out that doctors who invest in or own medical equipment are more likely to order tests than doctors who do not own such equipment. This indicates that there may be economic incentives, rather than medical need, for many tests.

This bill will not solve our health care cost crisis but it will be one useful tool, in concert with other efforts, in helping us bring those costs under control.

X-ray use: Motivated by money?

Doctors with their own equipment take more images, study reveals.

The Associated Press

BOSTON — Doctors take four times as many X-rays when they own X-ray machines and make money on them, according to a study that provides new evidence of how profits may influence the way physicians practice medicine.

Doctors make a profit on every picture they take with their own equipment. But they earn nothing when they send patients to other specialists for X-rays.

In recent years, many doctors have purchased X-ray and ultrasound machines so they can take diagnostic images in their offices. Although they argue that this is convenient for them and their patients, critics suspect that the chance to make more money is also a big incentive to buy and operate these machines.

The new study provides circumstantial evidence that doctors who own their own imaging machines may overuse the equipment in order to collect fees. Compared with those who send their patients to radiologists, those who own X-ray and ultrasound machines take four times as many diagnostic images for such common complaints as colds and backaches, according to the study published today in the *New England Journal of Medicine.*

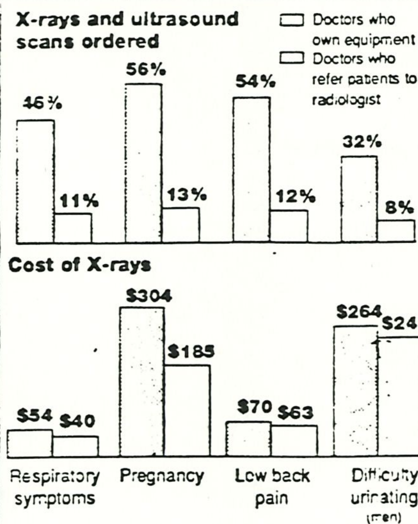
Dr. Bruce J. Hillman of the University of Arizona, who directed the study, cautioned that it could not determine whether the extra X-rays were needed.

Among other findings:

- Doctors with ultrasound machines ordered scans at each visit to check the fetuses of 56 percent of pregnant women, while those without machines ordered this test for 13 percent of patients.
- Doctors with their own ultrasound machines charged $304 for each scan, while outside radiologists' fees averaged $185 for the same work.

Cost and frequency of patient X-rays

Compares [frequ]ency of X-rays ordered and patient cost by doctors who have [their own] X-ray equipment with those of doctors who send their pati[ents to a ra]diologist.



Based on a study of 65,517 doctor visits by privately insured patients treated for colds, pregnancy, low back pain and men having difficulty urinating.

AP

Mammography units exceed need

The Associated Press

PHILADELPHIA — The United States has nearly four times the number of mammography machines it needs, contributing to the high cost of breast cancer detection, federal researchers said.

Researchers from the National Institutes of Health and the Food and Drug Administration reported in Monday's *Annals of Internal Medicine* that the excessive equipment and high cost of the test may hinder increased use of mammography machines, which detect breast cancer.

"Despite an increasing trend in usage that we project, we found that the supply of dedicated mammography machines is outrunning the need," said lead author Martin L. Brown of the National Cancer Institute.

An editorial accompanying the report warned that the abundant supply may not improve health care.

"The oversupply of mammography units may ultimately lead to a situation in which more care does not mean better care, and it certainly is unlikely to mean more cost-effective care," said Dr. Alvin Mushlin of the University of Rochester Medical Center.

Researchers estimate that each year, 150,000 American women develop breast cancer and about 44,000 die from the disease. Breast cancer rates could be lowered about 30 percent if women received mammograms as recommended by the National Cancer Institute, according to several earlier studies.

Although about 10,000 mammography machines were installed in U.S. medical facilities by 1990, only about 2,600 are really needed, the study said.

Brown said the study's estimate was based on accepted recommendations for screening mammograms, nationwide figures on the number of machines and an average cost of about $100 per test.

"Even with some follow-up diagnostic tests, we can't come close to accounting for all those machines," Brown said.

The high number of machines reduces the number of clients per machine, keeping costs high.

If the cost of the test was lowered from $100 to $50 by using fewer machines, the country could save $763 million a year in health costs, he said.

Al Tikwart, Jr.
109 W. 49th
Westwood Hills, Kansas .05
Office: 816-561-5443
Home: 913-432-0304

SPEAKING FOR SENATE BILL 184

26 February 1991
10:00 AM
526 South, Statehouse

For over 20 years, health care costs have been two to three times as high as the average inflation rate. The Kansas rate of health cost inflation is no different. Never in the 129-year history of our state have we had one issue that could bankrupt our state.

The process of solving challenges in our lives is information, study, and then action.

Since the first Health Care Cost Commission in 1977, of which I was a member, to the present day, volumes of information have been gathered.

This information has been studied by many people from many different backgrounds, from the seven members in 1977 to the 46-member "1990 Governor's Commission on Health Care." I, like many, subscribe to the "If it ain't broke, don't fix it" management style. But to say that 7 - 18% inflation rate of health care costs over the last 20 years is not "broke" would be a joke.

We have the information. We have done many studies. The time for action is now.

This Health Facility Permit bill is an important action item which is again needed in Kansas.

This bill provides the right action step since it has no exemptions to any particular group so as to have a level playing field for everyone. Some of the other positive benefits include the following:

*It has the provisions for self-funding.

*As an independent agency, it would take some of the heat off of current state agencies by having fresh input into the health cost challenge.

Senate P H&W
Attachment #2
2-26-91

*Citizens and health care providers would have to work together and thus have a better chance of solving the Kansas health care crisis.

I understand that the Kansas Medical Society will oppose this bill saying that this legislation is not needed. The question back in the Medical Society's court would be, "How would they stop unnecessary duplication of facilities and equipment?" And don't let them tell us the solution is lowering medical malpractice rates.

If checks and balances like this bill are not implemented, and if the state continues to condone the medical arms race, Kansas could be in the position that I was in 17 years ago when medical expenses took almost all of our family's current income and savings.

DIAGNOSTIC IMAGING CENTER

RADIOLOGISTS, INC.

(COLLEGE OFFICE)

RODGER W. LAMBIE, M.D.
EDWIN M. HERMAN, M.D.
MORDECAI KOPPERMAN, M.D.
JENNIFER H. CRAWLEY, M.D.
ANGELA M. NOTO, M.D.
NEAL K. LURZ, M.D.

February 25, 1991

Senator Doug Walker
State of Kansas - Senate Chamber
Senator-12th District
Topeka, Kansas
Fax #(913)296-0103

Dear Senator Walker:

Increasing health care costs are a constant concern to all of us in the medical field, as well as to the public in general. We appreciate the interest you have in trying to control such costs while trying to preserve the quality of medical care.

There should be some provisions and criteria to control the development of additional and new health care services. Increasing health care costs are directly related to such development.

My expertise is in the field of Diagnostic Radiology. Let me give you some examples and facts related to this field. These factors can be similarily utilized in other fields of medicine.

The diagnostic imaging facilities available in Johnson County, make the need for additional providers unnecessary. The facilities are spread through the county, making patient access quite readily available. The quality factor is excellent. There is no delay in scheduling. The cost factors are fair and are far below the local hospital charges, as well as far below the national average.

Senate P H&W
Attachment #3
2-26-91

6724 TROOST, SUITE 900 • KANSAS CITY, MO 64131 • 816-333-8420
5500-5520 COLLEGE BLVD. • OVERLAND PARK, KS 66211 • 913-491-9299

DIAGNOSTIC IMAGING CENTER

RADIOLOGISTS, INC.

(COLLEGE OFFICE)

RODGER W. LAMBIE, M.D.
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JENNIFER H. CRAWLEY, M.D.
ANGELA M. NOTO, M.D.
NEAL K. LURZ, M.D.

Additional imaging units in the Johnson County area are not necessary at this time. No one unit is operating at full capacity. The equipment in all centers is current and state of the art. The professional support is excellent. New imaging centers would serve merely to increase cost. These units would actively attract patients through self referrals, over utilization, and unnecessary examination.

New and additional services should have to present their facts and figures to a regulatory body. They need to justify the necessity for such services. Arbitrary addition of such services without regard to the need of the community, and only for economic gain is not necessary. Every hospital and every doctor, does not need to have every piece of equipment or does not need to provide every service. There needs to be cooperation and sharing of services, which in turn will assist in keeping cost factors down.

I appreciate the opportunity to convey some of my thoughts to you. I appreciate the fact that you are attempting to control health care costs. The establishment of a Certificate of Need (CON) in Kansas would only be one step in attempting such control. I am available in the future to help study such additional mechanisms of controlling cost with you and your associates.

Sincerely yours,

Edwin M. Herman MD

Edwin M. Herman, M.D.

6724 TROOST, SUITE 900 • KANSAS CITY, MO 64131 • 816-333-8420
5500-5520 COLLEGE BLVD. • OVERLAND PARK, KS 66211 • 913-491-9299

KHCA

Member of ahca

Kansas Health Care Association
221 SOUTHWEST 33rd STREET
TOPEKA, KANSAS 66611 • 913-267-6003

Testimony before the

Senate Public Health and Welfare Committee

by

John L. Kiefhaber
Executive Vice President
Kansas Health Care Association

Senate Bill No. 184

"An Act requiring a health facility permit..."

Chairman Ehrlich and Committee Members:

The Kansas Health Care Association appreciates the opportunity to speak in support of Senate Bill 184 to require a health facility permit for certain health facility projects and services. The Association supports the bill because its members support the idea of health care planning and control. The State has limited resources with which to address the health care needs of its citizens and we believe that maximizing the use of those resources requires planning.

The long term care industry does not work on a simply market mechanism. In many communities in Kansas supply can increase over demand. At other times demand grows ahead of supply. Therefore, total system resources should be controlled to allow a balance to be found from county to county.

Let me give a quick example of the problem we face in Kansas at this time. In the following counties where this bill's sponsors reside. The latest nursing home occupancy rates range from a high of 92% to a low of 74%.

County	%	County	%
Miami	85	Smith	87
Douglas	89	Lyon	74
Shawnee	87	Butler	92
Wyandotte	89	Barton	87
Cowley	92	Cloud	92
Riley	75	Labette	84
Crawford	90	Sedgwick	88

Kansas Average - 87%

Senate P H&W
Attachment #4
2-26-91

4

The State has great disparities in availability of services and we believe health facility permits can help accomplish a balance in these resources. Without facility permitting we can have a greatly disportionate share of new construction in one area or another.

In conclusion, we would like to point out a problem that low occupancy rates can burden our Title XIX Medicaid program with. Because fixed costs such as building maintenance, utilities, and staff labor do not decrease as occupancy drops, the Medicaid program can pay out more in service reimbursement per resident without getting more long term care services per resident when those occupancy rates drop.

We appreciate the opportunity to support this step in the direction of planned health care resource investment.

Association of Community Mental Health Centers of Kansas, Inc.
835 SW Topeka Avenue, Suite B, Topeka, KS 66612
Telephone (913) 234-4773 Fax (913) 234-3189

Testimony
Senate Bill 184
Senate Public Health & Welfare Committee
Honorable Roy Ehrlich, Chair
February 26, 1991

John G. Randolph
President
Emporia

Eunice Ruttinger
President Elect
Topeka

Ronald G. Denney
Vice President
Independence

Donald J. Fort
Secretary
Garden City

Don Schreiner
Treasurer
Manhattan

Dan Watkins
Member at Large
Lawrence

Kermit George
Past President
Hays

Paul M. Klotz
Executive Director
Topeka

Thank you for the opportunity to comment.

The Association is generally favorable toward S.B. 184. We certainly understand the need to contain the rising costs of health care.

In 1990, the state passed major legislation into law commonly called "mental health reform". This law, among many other things, is expected to develop and implement a great variety of services, at the community level, to care and treat the mentally ill at the local level - as an alternative to state hospital care and treatment. This means that new and/or expanded services will be added where none now exist. Yet S.B. 184, on page 3, section 5, subsection 3 seems to require that such services will require a "health facility permit" be undertaken each time such a service is added or substantially expanded. Other subsections of section 5 might also apply. Will such a requirement delay or interfere with the progress of mental health reform?

Thank you!!

Senate P H&W
Attachmetn #5
2-26-91

Memorandum

Donald A. Wilson
President

February 26, 1991

TO: Senate Public Health and Welfare Committee

FROM: Kansas Hospital Association

RE: SENATE BILL 184

There is little disagreement about the issues that are the basis for today's hearing. Our health care system is currently facing many serious problems. First, health care costs continue to rise at a rate that most people find unacceptable. Second, health insurance premiums are rising at an even more alarming rate. The result is that hundreds of thousands of people in our own state find themselves without any health insurance. Everyone agrees that in one way or another, our system is broken. The question is -- what do we do about it?

Senate Bill 184 is an attempt to do something about one aspect of the problem. It would essentially reinstate the old certificate of need process for all health care providers. The theory behind CON has traditionally been that such a process would eliminate unnecessary or duplicative health care services and thereby act to contain health care costs. For numerous reasons, we don't think that passage of a CON bill this session will help to solve any of the state's health care problems.

History of CON

In 1974, Congress enacted the National Health Planning and Resources Development Act, designed to create a nationwide health planning structure with the capability of developing and implementing policy. This Act required states to enact and administer CON statutes. It also provided

Senate P H&W
Attachment #6
2-26-91

1263 Topeka Avenue • P.O. Box 2308 • Topeka, Kansas 66601 • (913) 233-7436 • FAX (913) 233-6955

assistance and funding to states for health planning activities. The federal law was amended several times to broaden its application.

CON was a multi-layered procedure. Localized health systems agencies and state health planning and development agencies each had a role to play in the planning and review process. Initial review would be performed by the HSA, which would then send its findings along to the state agency for final determination.

Over the years, the focus of public policy gradually shifted from the regulatory model to a more "competitive" model. The federal government's role in the CON issue ended when President Reagan signed the Omnibus Budget Reconciliation Act of 1986. Since that time, CON programs have been left up to the states.

The CON Experience

The reason that the federal government and many states abandoned CON is simple -- it did not work to contain health care costs. Evidence of this fact is abundant. A 1987 report from the Federal Trade Commission found that certificate of need requirements seem to have led to higher prices of between 4 and 5 percent. The study also found that hospitals in states with CON requirements had higher operating margins.

A comparison of per capita hospital expenses from states in this region seems to support the conclusions of the FTC study. The attached charts show the Kansas experience as compared to other states in the Midwest. All states in this region have CON processes except for Kansas, South Dakota and Minnesota. While some may argue this comparison does not conclusively show that CON leads to higher costs, at the very least it does show CON had no effect in containing costs.

Further, a 1988 report in the **New England Journal of Medicine** titled "The Effects of Regulation, Competition, and Ownership on Mortality Rates Among Hospital Inpatients" reported that hospitals in states with the most stringent CON procedures had ratios of actual to predicted death

rates that were 6-10 percent higher than those of hospitals in less regulated states.

Clearly, the evidence is simply not there to show that CON has helped to contain health care costs. The question that remains is whether CON has any promise of showing better performance in the future.

We think it is fair to say that CON could potentially be even less effective at controlling costs in the future. Ever since Medicare began its prospective payment system, hospital reimbursement has focused more on the degree of risk faced by the hospital. In today's environment, hospitals must negotiate with HMOs, PPOs or insurers. These negotiations are driven by many factors, including whether the hospital has adequate resources to finance the service. As such, new services are considered carefully before being offered. In addition, the Medicare prospective payment system continues to discourage capital expenditures by hospitals. In fact, the federal government issued regulations this past Friday that would cause capital expenditures to be reimbursed through the Medicare DRG system, thereby drastically reducing incentives for such expenditures. This trend is supported by statistics showing that capital expenditures are actually increasing at a slower rate than they were during the mid 1980s.

Working Toward Solutions

We are not saying that health planning doesn't deserve to be discussed. All aspects of the problem should be thoroughly considered. What we are saying, however, is that before intelligent decisions can be made on how to control health care costs, there needs to be some consensus on what is driving those costs. For example, what is the impact of the severe personnel shortage? What role does our aging population play? What effect does "cost shifting" have? What is the impact of duplication of services? What role does increasing technology play? Obviously, everyone has their own ideas, but there should be a conscious effort to look at all the factors and then work on solutions that deal with the biggest problem areas.

We also think it is very important to talk about health planning in a broad perspective. In addition to facilities and services, this concept should

include state goals and plans concerning prenatal care, immunizations, the role of local health departments, and substance abuse issues among others.

KHA Recommendations

First, we think it is extremely important to conduct an independent study of what factors are causing health care costs to increase. Such a study would not only be very educational for all concerned, but it could also be used to form the basis for any long-term solutions in this area.

Second, we think it is just as important for the state to begin focusing on this problem in a comprehensive manner. Different parts of the health care system do not operate in a vacuum. They are all entirely interrelated. Any one particular solution must take into account the effect on the system as a whole. Senate Bill 205, to be discussed tomorrow, is a starting point for such a discussion. We urge that Senate Bill 184 be held in this committee for the 1991 session so that the entire topic of health planning can be a part of the larger discussion.

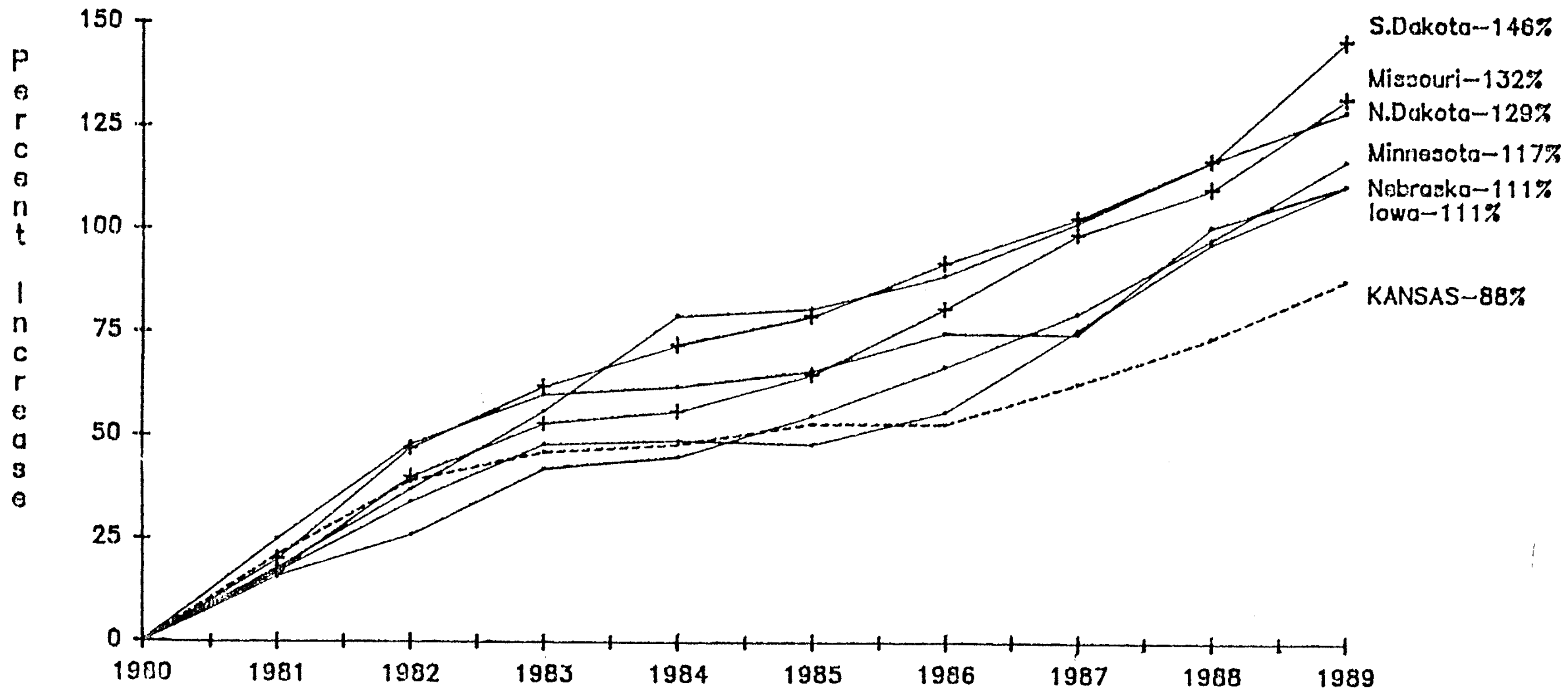
Thank you for your consideration of our comments.

TLB / pj

Attachments

Hospital Expenses by State

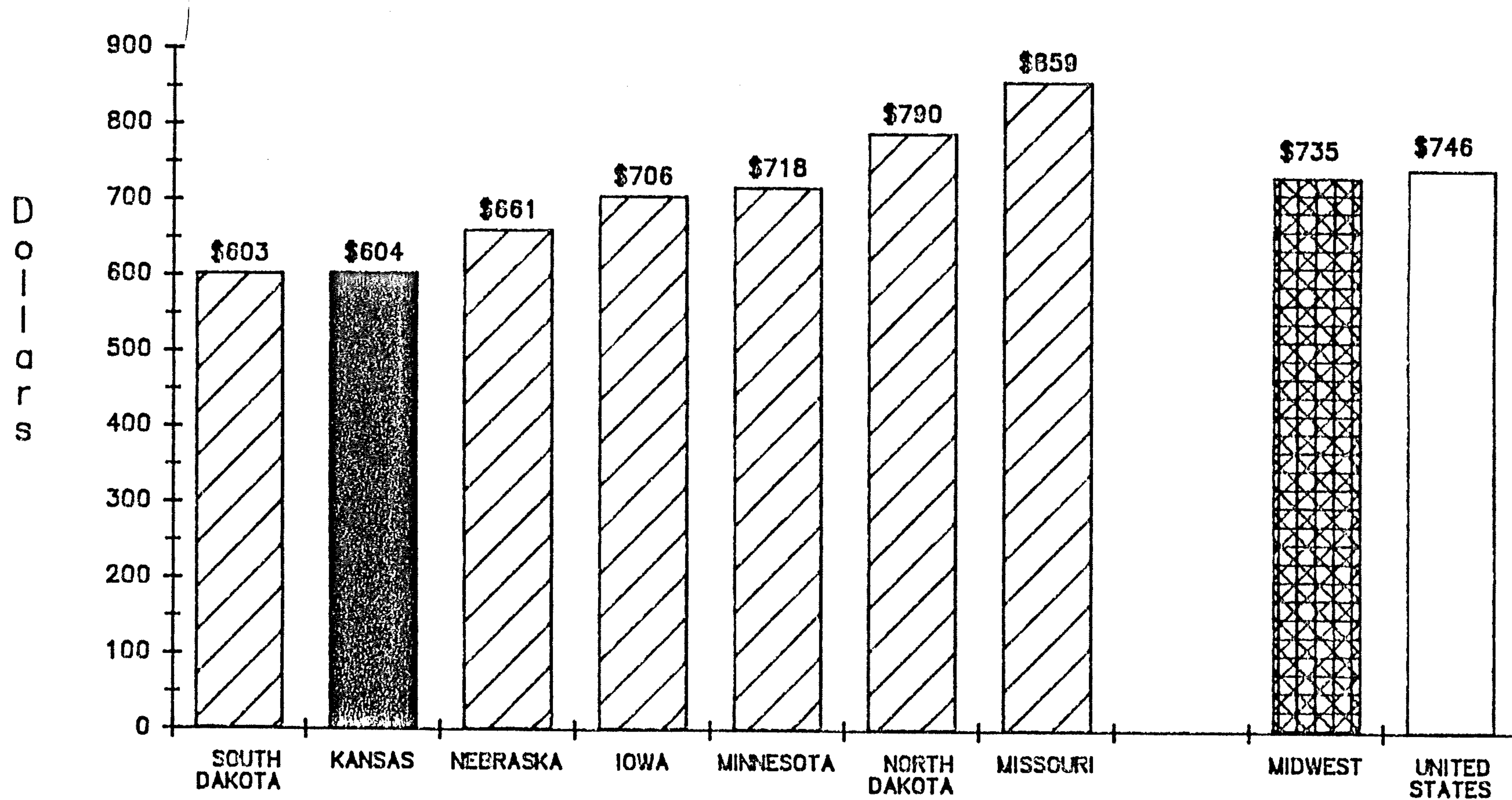
Cummulative Percent Increase 1980 - 1989



Source: AHA Annual Survey

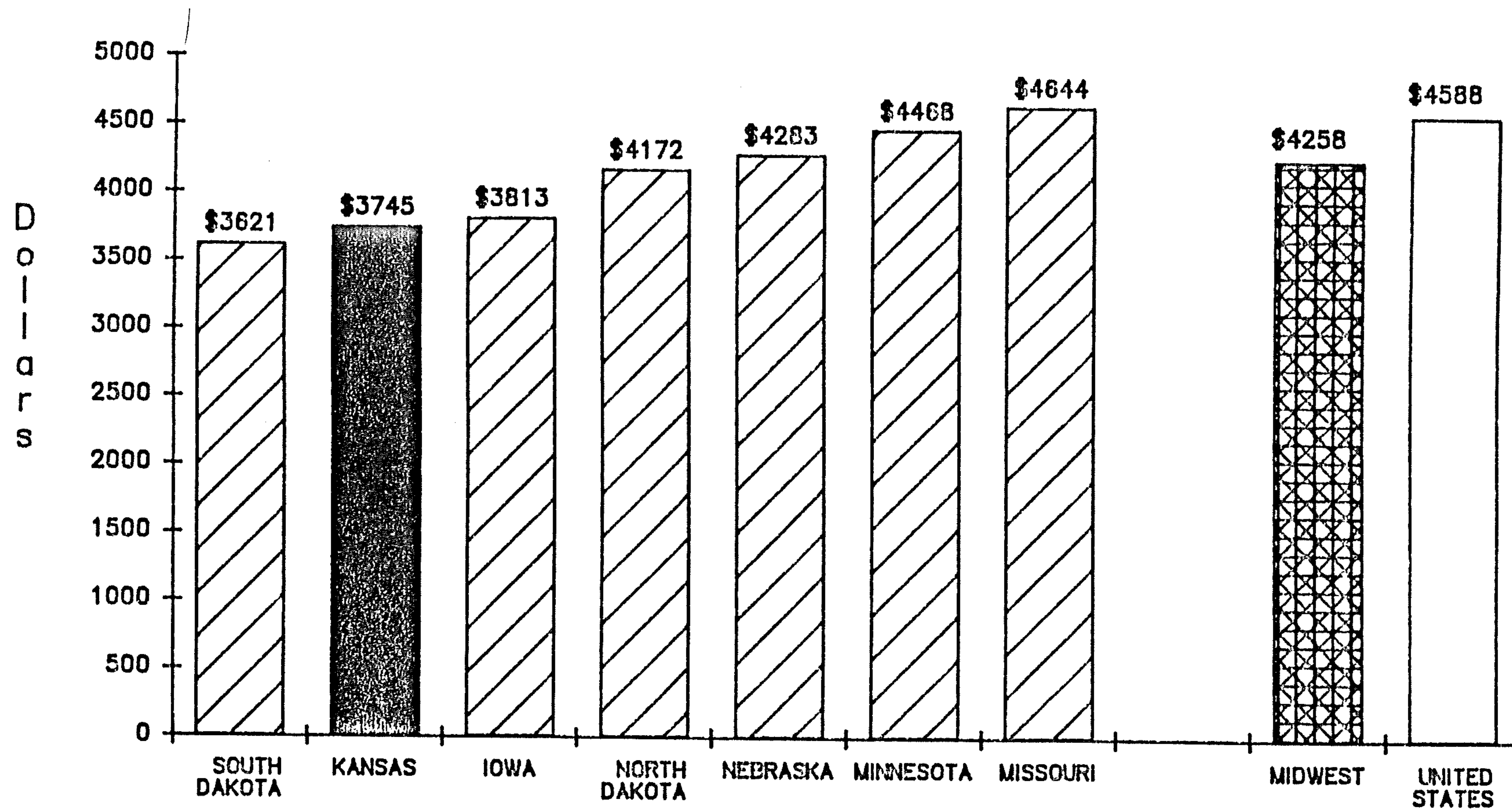
6-5

Hospital Per Capita Costs
1989



SOURCE: AHA ANNUAL SURVEY, "Statistical Abstract of the United States 1990"

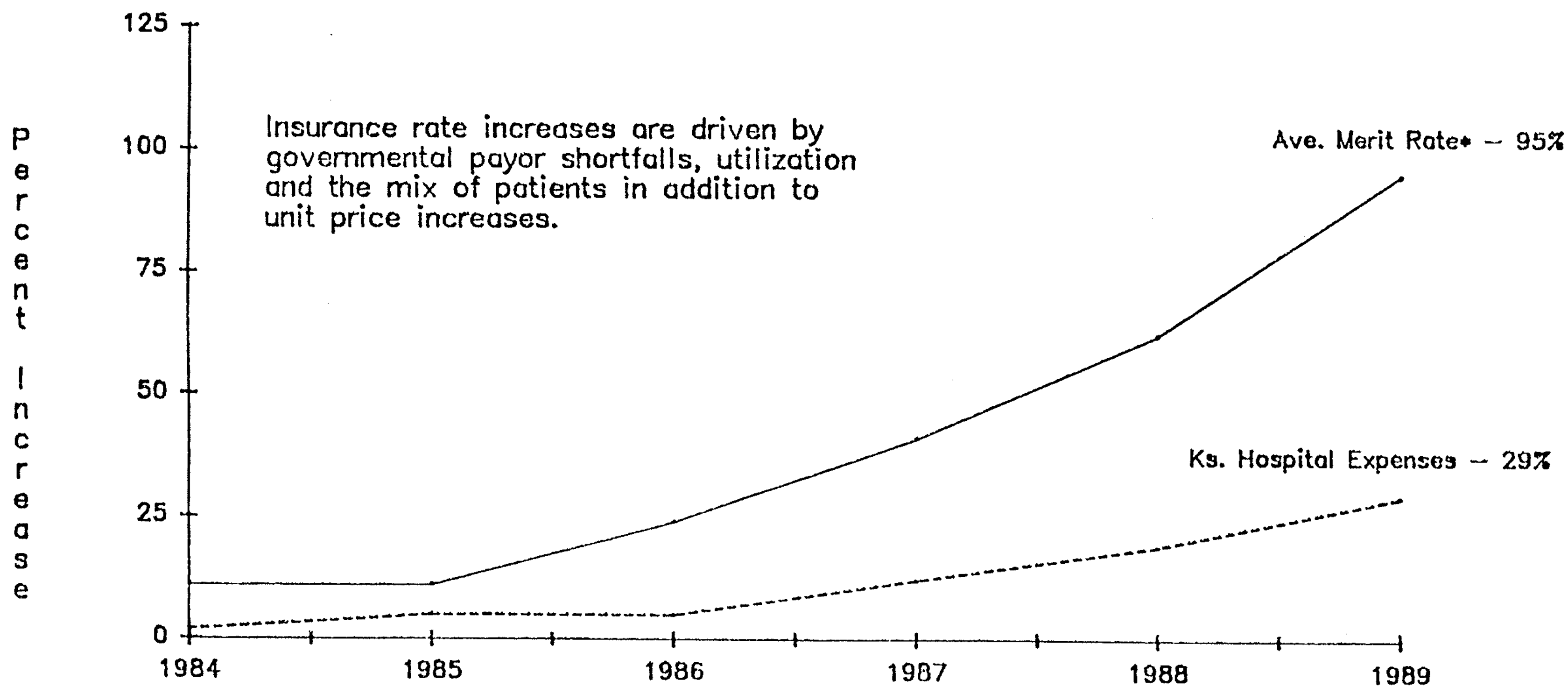
Hospital Cost Per Admission
1989



SOURCE: AHA ANNUAL SURVEY

Insurance Rates and Hospital Expenses

Cummulative Percent Increase 1984 – 1989



*Includes health coverage only. Does not include the free standing dental or drug portions of the contracts.

Source: AHA Annual Survey, Blue Cross and Blue Shield of Kansas

St. Joseph Health Corporation
1100 South Clifton • Suite C • Wichita, Kansas 67218 • (316) 682-9010

M E M O

February 26, 1991

TO: Senate Public Health and Welfare Committee

FROM: Robert J. O'Brien, FACHE
Executive Vice President and COO

RE: Senate Bill 184

Mr. Chairperson --- Members of the Public Health and Welfare Committee --- my name is Robert J. O'Brien. I am the Executive Vice President and Chief Operating Officer of St. Joseph Health Corporation in Wichita, Kansas.

I appreciate having this opportunity to appear before the Committee this morning, as a conferee speaking in opposition to Senate Bill 184. My testimony is also on behalf of the four Wichita hospitals --- HCA/Wesley Medical Center, Riverside Hospital, St. Francis Regional Medical Center, and St. Joseph Medical Center.

By way of background, I have been a health care administrator in the state of Kansas for the past twenty-six years. During that time, I have had the opportunity of serving on the Board of Directors of the Health Planning Council of South Central Kansas, and its successor, the Health Systems Agency of Southeast Kansas, prior to the elimination of Certificate-of-Need legislation here in Kansas in 1985.

I believe it is important to point out that Certificate-of-Need was a regulatory mechanism which was conceived during the era of cost-based reimbursement and was intended to curb excess health facility spending on capital expenditures, including new and expanded facilities, technology and new services.

With the advent of the prospective pricing system and DRGs under the Medicare and Medicaid programs, which have subsequently been adopted by most third-party payors, providers were moved into the new health care era of "competition."

Coupled with the efforts on the Federal level to include capital costs in the basic Medicare DRG allowances, rather than as a separate pass-through reimbursement allowance, health care providers now find themselves in a precarious situation where all capital expenditures have to be prioritized as to their impact on reimbursement levels in line with patient care and patient outcome. Only very prudent decisions will result in continued financial viability in the competitive environment.

In no way am I trying to indicate that the issue attempting to be addressed by this proposal is not important.

Rather, I am suggesting that it is only a single factor in the ailments that face the health care delivery system and the associated costs of health care.

Coupled with other components, such as inflation, government regulatory and reimbursement policies which cause providers to shift payment shortfalls to the private sector, the ever-increasing number of uninsured persons and accessibility to appropriate levels of care, we cannot afford to have a myopic and fragmented view on each of the individual components. It's like using baling wire and bubble gum. It just won't hold together very long.

We need to address all of these issues in a responsible and comprehensive manner in order to achieve a shaping of state and national health policy which will direct the re-creation of our delivery system.

In line with these thoughts, I would encourage the Committee to hold this bill in abeyance while an appropriate state-wide, independent study is undertaken which would address all of the complexities and issues which are contributing to our mutual dilemma of providing quality, and affordable, health care.

Thank you for your consideration.

KANSAS MEDICAL SOCIETY
1300 Topeka Avenue • Topeka, Kansas 66612 • (913) 235-2383
Kansas WATS 800-332-0156 FAX 913-235-5114

February 26, 1991

TO: Senate Public Health and Welfare Committee

FROM: Kansas Medical Society *Chip Wheelen*

SUBJECT: Senate Bill 184; Health Facility Permits

Thank you for this opportunity to express our reservations about SB 184. The Kansas Medical Society questions whether further regulation of expenditures by hospitals, medical practices, and other health care facilities would actually achieve any beneficial result. The experience in the past with the certificate of need law was educational but otherwise nonproductive. Furthermore, the available evidence indicates that those states that still have certificate of need laws have not subdued the cost of health care by comparison to those states that do not have certificate of need laws.

The premise of SB 184 and similar laws throughout the country is that health care costs are driven in major part by amortization of the cost of capital improvements or equipment acquisitions. It is assumed hypothetically that if government makes it more difficult for health care facilities to construct additional space or acquire new equipment, that the cost of health care will not increase as rapidly. The statistical evidence indicates that this hypothesis is false. It is based on an assumption that administrators of health care facilities and physicians in private practice do not employ prudent business administration in their decisions regarding capital expenditures. We respectfully suggest to you that this is not the case. Those who administer hospitals and other such facilities are held accountable by boards of directors or trustees and therefore, do not inadvisedly build facilities nor acquire expensive equipment that is not in sufficient demand to be utilized in an efficient manner.

The Kansas Medical Society agrees with the Kansas Hospital Association that there is a need for objective analysis of those factors which are driving the cost of health care in Kansas. Thus far, various organizations including public entities have studied health care issues and have attempted to grapple with solutions. Most have agreed that the principal cause of increased health care costs is increased utilization of services. Yet, we still attempt to deal with the other factors that are perhaps marginal in effect. It is for this reason that we agree with the KHA that we should expend the funds necessary to acquire an independent, objective, economic analysis of our health care system. The Kansas Medical Society is willing to pledge itself to the effort of raising funds for such a study.

Thank you for considering our comments. We respectfully request that you report SB 184 not recommended for passage.

Senate P H&W
Attachment #8
2-26-91

State of Kansas

Joan Finney, Governor

Department of Health and Environment

Division of Health

Acting
Stanley C. Grant, Ph.D., Secretary

Landon State Office Bldg., Topeka, KS 66612-1290

Reply to: ________

FAX (913) 296-6231

Testimony presented to the

Senate Public Health and Welfare Committee

by

The Kansas Department of Health and Environment

Senate Bill 184

Background

I am pleased to appear before the Committee today to present testimony on Senate Bill 184. As many of you realize, the Kansas Department of Health and Environment has had considerable experience with a program very similar to the type proposed in this bill. From the late 1970s until its legislative sunset in July, 1985, KDHE was responsible for implementation of the state's Certificate of Need program authorized by K.S.A. 65-4801 through K.S.A. 65-4821. Although similar, there are some notable differences between the programs which would affect implementation of SB 184. These include:

1. The previous CON program was developed in response to federal legislation (Health Planning and Resource Development Act of 1974). That federal legislation provided funding and staff to the state for health planning activity in addition to administration of the Certificate of Need program. Federal sanctions against the state (Medicare/Medicaid payments) could be levied if a CON program was not in place. In 1985, when it was obvious federal sanctions would not be imposed, the state eliminated its CON program for various reasons. Further federal cutbacks to other health planning activities continued. Without state funding to replace those federal monies, KDHE was forced to eliminate positions and has been without designated health planning staff since that time.

2. SB 184 defines the state agency as the health facilities review board rather than the Secretary of KDHE.

3. A permit would be required for the acquisition of "major medical equipment" costing over $400,000 regardless of purchaser. Clinical laboratories and physician offices were ultimately excluded from the previous program.

Senate P H&W
Attachment #9
2-26-91

Charles Konigsberg, Jr., M.D., M.P.H.
Director of Health
(913) 296-1343

Director of Environment
(913) 296-1535

Lorne Phillips, Ph.D.
Director of Information Systems
(913) 296-1415

Roger Carlson, Ph.D.
Director of the Kansas Health and Environment Laboratory
(913) 296-1619

4. On page 5, line 26, a technical error appears. Reference is made to a "health systems agency." No other references are made to health systems agencies. Under the earlier health planning program, such agencies were federally funded and provided preliminary project application review and staff analysis for approximately half the state. Since these agencies no longer exist, the fiscal impact for the state in providing similar staff resources would be significantly increased.

It seems apparent that this bill in large part is intended to address concerns over the cost of nursing home care by controlling bed availability.

Controlling and limiting the construction of new nursing home beds ended when the Certificate of Need program expired July 1, 1985. That decision was made after significant debate over several sessions of the legislature. As might be expected, many of the arguments to reinstate control on nursing home bed construction are not different than those arguments rejected several years ago.

Attachment one is a bar graph showing the number of new adult care home beds applied for in Kansas from 1985 through February 21, 1991. These are beds for which a formal licensure application has been filed. The beds are displayed in terms of those added to existing facilities and those proposed in new facilities.

Attachment number two shows the state-wide adult care home occupancy rate, by quarter, for 1985, 1986, 1987, 1988, 1989 and the first three quarters of 1990. Please note that the difference in occupancy from the second quarter 1985 when Certificate of Need ended, to the third quarter of 1990, is 2.68%.

Attachment number three shows the number of newly licensed beds each fiscal year since 1985. Nursing home beds (excluding personal care and beds for the mentally retarded) have increased by a net of 2,439 beds, or a 9.5% increase in the five and one half years since Certificate of Need ended. 86.9% of this increase is for skilled beds, indicative of the need to meet the demands of a growing, more frail, nursing home population. Yet occupancy is within 2.68% of where it was with Certificate of Need.

Some question must be raised whether the establishment of the program proposed in SB 184 is justified by this modest decrease in occupancy, particularly when consideration is given to the fact so many new beds, in accordance with state of the art design, were made available to the consumer.

Is the construction of new beds likely to continue? We believe that Attachment I shows interest in construction of new beds has waned. In 1990, no applications were submitted for new facilities, and only 46 beds were added as part of facility additions. To date in 1991, no applications have been received.

Does the state-wide occupancy rate which is 2.68% less than in existence July 1, 1985 increase Medicaid costs? The Medicaid program has a control to avoid paying excess costs generated by low occupancy. If the primary policy concern is the effect of new beds on Medicaid costs, we suggest that the Medicaid program be looked to maintain control to prevent paying inappropriately for low occupancy.

Does competition in the market have an impact on the quality of care? When the market for nursing home beds is tightly constricted and new construction is controlled, existing operators are rewarded with relatively high occupancy and protection from new competition. In this situation the incentives to compete for customers by offering new or higher quality services is severely limited. Conversely, the market situation where operators are forced to compete to fill their beds, maximizes the incentives to offer new and higher quality services. We hear about the health care market not being competitive, but this observation must be tempered with respect to the adult care home market. It is accurate that price competition is limited because the Medicaid program dominates pricing in the market. However, there is the potential for price competition in the private pay market and there is the potential for significantly increased competition among facilities to fill beds.

Does the nursing home industry need protection from low occupancy rates? There is some evidence that the newest homes in the market have the lowest occupancy, which seems to be appropriate.

Impact on KDHE

Senate Bill 184 would have a major impact upon the Kansas Department of Health and Environment. As previously indicated, considerable data compilation and analysis is required for the successful implementation of such a program. Section 4 requires the state agency (review board) to "establish criteria to be applied in granting and denying health facility permit applications. The criteria shall include cost containment, quality of care, community need and access." The earlier Certificate of Need program was directly linked to other planning activity. Health care resources were identified locally and on the state level. Optimum utilization goals and recommendations were studied and referenced in a yearly published State Health Plan. The last such document was published in 1984 and no specific, formal health facility service analysis has been completed since that time. Considerable "groundwork" and data analysis would need to occur by review board staff, requiring considerable input from several KDHE bureaus, other agencies, and providers.

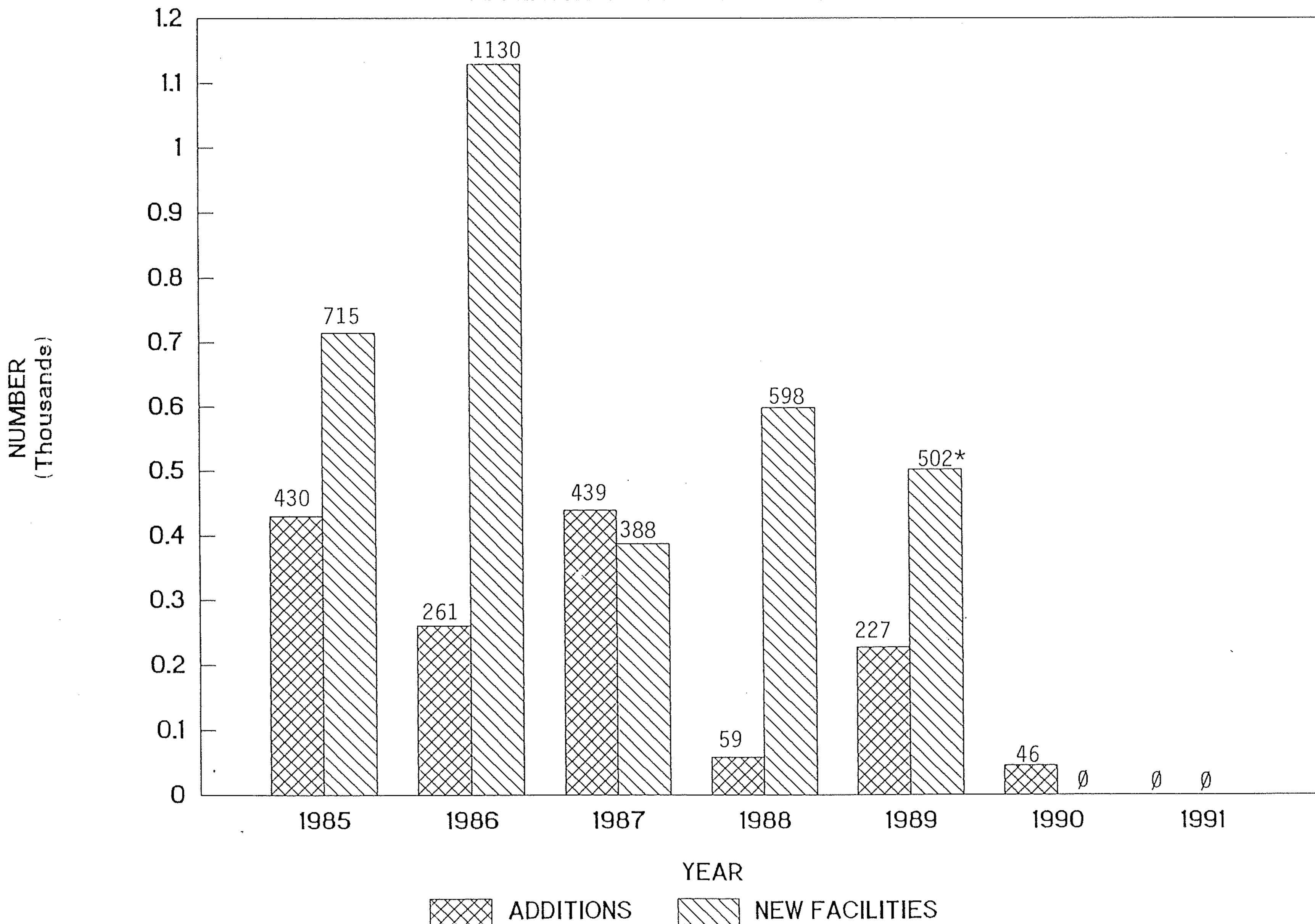
Conclusion

The chief aim of programs such Certificate of Need and the one proposed by SB 184 is to reduce health care costs through the restraint of capital expenditures. The regulatory model in which capital expenditure control was originally proposed also included controls on prices and utilization, though most states, including Kansas, implemented only the capital expenditure program. There is no evidence that capital expenditure regulation by itself has been effective in restraining increases in health care costs.

Nursing home bed construction has peaked and hospitals are struggling to convert to a service mix that is not exclusively inpatient. Health care costs continue to rise but access to care and quality of care are also priority concerns. A new attempt at capital expenditure control in health care does not appear to be supported by our experience or the present status of capital expenditure growth in the industry.

Testimony Presented by: Richard J. Morrissey, Deputy Director
Division of Health
Kansas Department of Health Environment
February 26, 1991

Attachment I



* Of the applications for 502 beds in new homes 267 were skilled or intermediate and 235 beds were personal care or mental retardation beds.

Attachment II

ADULT CARE HOME

OCCUPANCY REPORT

by Percent

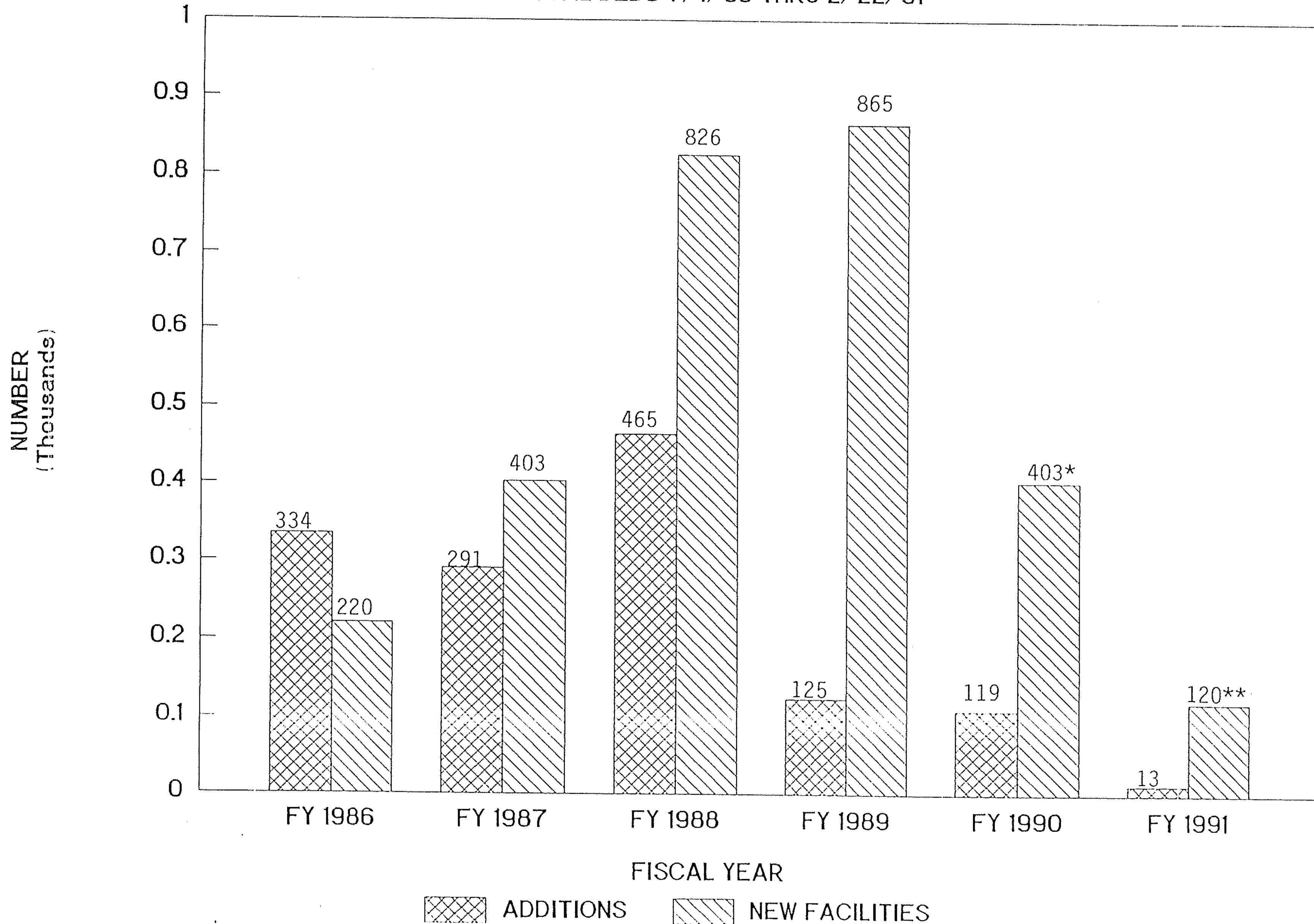
	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Annual
1985	90.01	90.02	90.33*	90.59	90.17
1986	90.60	90.48	89.92	89.08	90.22
1987	89.41	90.06	89.91	89.20	89.64
1988	87.80	87.11	87.64	87.32	87.46
1989	87.34	88.13	88:45	88.24	88.04
1990	86.68	86.09	87.34		

Source: Adult Care Home
Quarterly Report
Bureau of Adult and Child Care
Kansas Department of Health and Environment

February 1991

* First quarter post Certificate of Need

Attachment III



* 269 of the 403 beds were licensed skilled or intermediate

** 60 of the 120 beds were licensed skilled or intermediate