Approved: 1-30-97
Date

MINUTES OF THE HOUSE COMMITTEE ON APPROPRIATIONS.

The meeting was called to order by Chairperson Phil Kline at 1:34 p.m. on January 29, 1997, in Room 514-S of the Capitol.

All members were present except:

Committee staff present: Alan Conroy, Russell Mills, Stuart Little, Legislative Research Department; Jim Wilson, Mike Corrigan, Revisor of Statutes Office; Marcia Ayres, Appropriations Secretary; Helen Abramson, Administrative Aide

Conferees appearing before the committee: Phyllis Nolan, Chair, Kansas Board of Regents
Dr. Donald Hagen, Executive Vice Chancellor, KUMC Campus
Wayne Lerner, Vice President, The Lash Group
Irene Cumming, Chief Executive Officer, KU Hospital

Others attending: See attached list

Minutes of the January 28 meeting were distributed for review. Chairperson Kline recognized Phyllis Nolan, Chair of the Kansas Board of Regents, to report on proposed changes in KU Hospital governance in response to the rapidly changing health care market. The impetus for the proposal came from the 1994 Arthur Anderson Consulting Study requested by the legislature, and now The Lash Group has outlined options for the University of Kansas to maintain its mission of providing high quality medical care and training future Kansas medical professionals. (Attachment 1) Ms. Nolan introduced Dr. Donald Hagen, executive vice chancellor of the medical center campus.

Dr. Hagen stressed these changes have to do strictly with the KU Hospital which is an academic teaching hospital and should not be confused with the function of the medical center as a whole. His job is to represent the mission of the hospital and medical center, and he discussed that mission with the committee. Although the hospital is located in northeast Kansas, its mission is state wide. Dr. Hagen reviewed the accomplishments that have taken place since the Arthur Anderson Study such as the uniting of physician groups so there is a single voice in managed care and the acquisition of land in Shawnee to develop an ambulatory care center to be able to teach in the ambulatory care environment. In order to improve the fiscal integrity and financial future of the hospital, they chose The Lash Group of Washington, D.C. as one of the nation's top consulting groups who work with academic health centers in these times of change. The Lash Group presented their report to the hospital who in turn presented it to the Board of Regents. After the consultant explains his findings to the committee today, the Board and Hospital plan to craft legislation specifically for Kansas to enable the changes in hospital governance. Dr. Hagen then turned the presentation over to Dr. Wayne Lerner, vice president of The Lash Group.

Dr. Lerner briefed the committee on his principal findings and recommendations which addressed the following two questions (1) what issues must be addressed or barriers removed to ensure KU Hospital's ability to sustain and enhance its mission effectiveness in service, education, and research in a market increasingly characterized by managed care and heightened levels of competition; and (2) what ownership/governance structure best enables KUMC to serve the health related education and research needs and interests of the citizens of Kansas and maintain an economically viable clinical enterprise? He detailed the handout entitled *Report to the Board of Regents, The Need for Ownership/Governance Change at KU Hospital* dated January 22, 1997. (Attachment 2)

Irene Cumming, C.E.O. of the KU Hospital, discussed the importance of having a consultant from the outside develop the framework for success and confirm that the obstacles and vulnerabilities confronting the hospital are, in fact, real. Because the market is changing so dramatically, the major issue is time which is difficult within a regulatory setting. She gave examples of the cumbersome procedures that restrict them in creative tasks and duties that other hospitals employ to become more efficient. Ms. Cumming is convinced that the KU Hospital can be turned around into a viable system positioned for success in the future, and that is very

important for the mission of education at KUMC and for the state of Kansas. She emphasized that it can be done, it's essential, but there isn't much time because of the tight market.

Committee members questioned the consultant and those present including Dr. Steve Jordan, executive director of the Kansas Board of Regents and Dr. John Hiebert, Regent.

Chairperson Kline thanked the presenters and also those members who stayed for the entire presentation.

A motion was made by Representative Dean, seconded by Representative Minor, to approve the minutes of January 28. The motion carried.

The meeting adjourned at 3:30 p.m.

The next meeting is scheduled for January 30, 1997.

APPROPRIATIONS COMMITTEE GUEST LIST

DATE: January 29, 1997

NAME	REPRESENTING
Jon Josserand	KU
Victoria Jones	KU
Bob Meitzler	SRS Medical
Adam Holmes	DOB
[illegible]	KBOR
Aaron Bauch	~~FB~~ B. Feuerborn
Marilyn Peine	B. Feuerborn
Elsie Burns	Rep. Bill Feuerborn
Jon Jackson	KU
Irene Cumming	KU
Don Wagner	KU
Chuck Nolan	Board of Regents
W. LERNER	KU
Stephen Jordan	KBOR
Marvin Burris	KBOR
Marlin Rees	KU
Rick Guthrie	Health Midwest
Karilyn Ewing	Intern for Rep. John Edmonds

Remarks by Phyllis Nolan, Chairman, Kansas Board of Regents
Re: Proposed Changes in KU Hospital Governance
January 29, 1997

Good morning/afternoon, I am Phyllis Nolan, Chairman of the Kansas Board of Regents. Regent John Hiebert and I are here with representatives of the University of Kansas and the Lash Group consultants to discuss with the Committee the need to change the ownership/governance structure of the University of Kansas Hospital to respond to the rapidly changing health care market. Much of the impetus for the proposal you will hear comes from the 1994 Arthur Andersen Consulting study of the Hospital, which was requested by the Legislature and commissioned by the Board of Regents. Andersen's recommendations were clear and specific. The Hospital needed to take specific steps to remain viable in the evolving medical environment. When Chancellor Bob Hemenway was hired two years ago, he was given three charges, one of which was to determine how to position the Hospital to fulfill its mission of providing high quality medical care and training future Kansas medical professionals. The Board asked him to study the issue and come back with recommendations. On January 22, 1997, the Board heard a compelling presentation from the University and the Lash Group, which outlined options for the University of Kansas to maintain its mission.

Appropriations
1-29-97
Attachment 1

Following considerable discussion, the Board unanimously passed the following motion:

> "That the Board of Regents authorize the Chancellor of the University of Kansas to proceed with the development of legislation to establish a public authority to operate the University of Kansas Hospital, such legislation to include the attributes set forth in the "Report to the Board of Regents, The Need for Ownership/Governance Change at KU Hospital," dated January 22, 1997 and presented to the Board during its meeting [of that date], including alternatives regarding frequency of meetings and method of appointments of [public authority] Board members, and further that the Chancellor provide the proposed legislation to the Board for final approval prior to introduction to the legislature."

The Board is united in its position that the Hospital governance structure must be changed to allow the Hospital to deliver on its mission. The public authority governance structure proposed by the University of Kansas will provide the Hospital the management flexibility to achieve this goal, while continuing to make the Hospital accountable to the State and its citizens.

Because the health care environment is changing so rapidly, the Board and the University believe that enabling legislation should be enacted during this Session. This puts the legislation on a fast track, but it is essential that the Legislature have the opportunity to fully comprehend and carefully consider the proposal in order to make informed decisions on the way the KU Hospital will do business in the future. It is the Board's desire that members of the Legislature hear from the University and the Lash Group as soon as possible and that these presentations serve to initiate dialogue between members of the Legislature and the Board and the University. This will assist the Board and the University in developing the legislation it will propose, pursuant to the Board's action of January 22.

Now I will turn the presentation over to Executive Vice Chancellor Don Hagen.

Appropriations
1-29-97
Attachment 2

Report to the Board of Regents

The Need for Ownership/Governance Change at KU Hospital

January 22, 1997

Lash Group

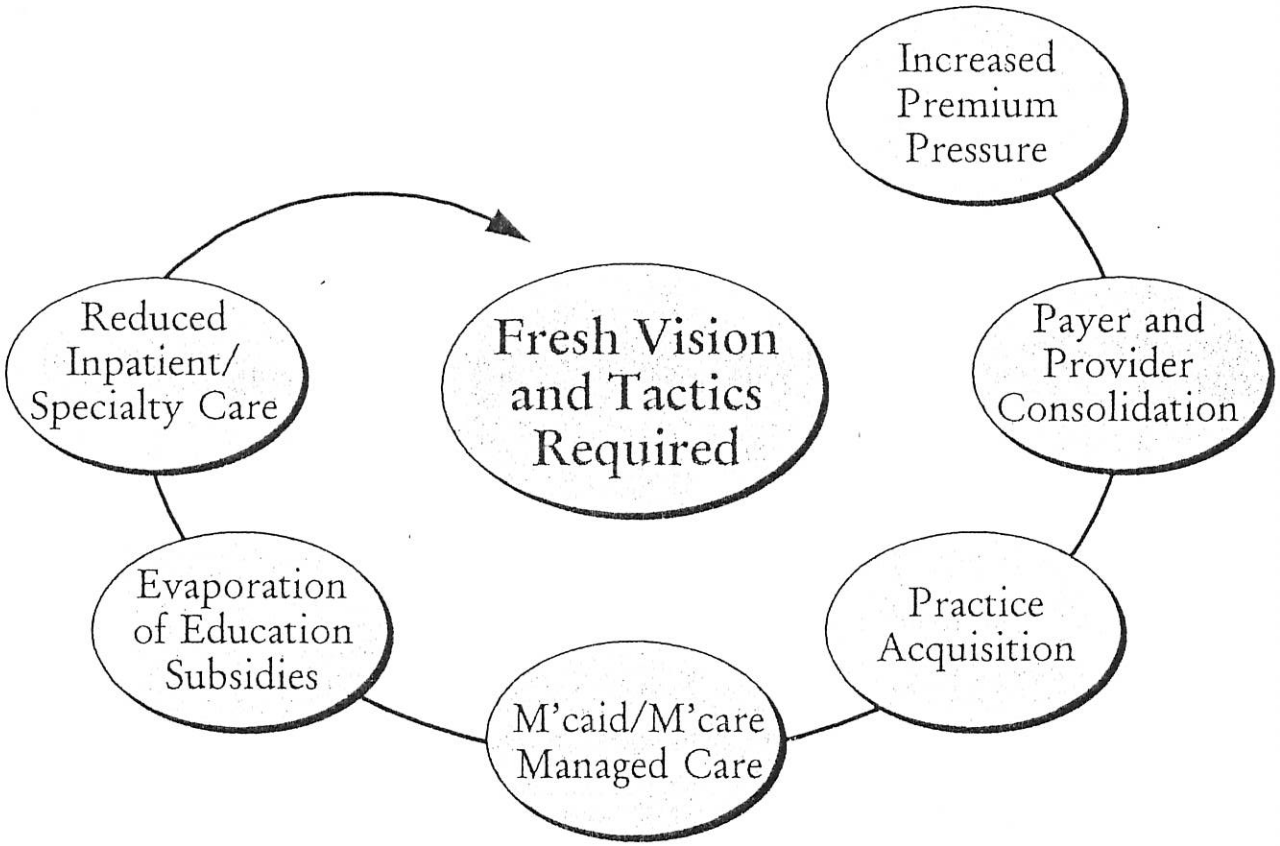
The following report details findings and recommendations from a study conducted by Lash Group and KUMC to address two questions.

- What issues must be addressed or barriers removed to ensure KU Hospital's ability to sustain and enhance its mission effectiveness in service, education, and research in a market increasingly characterized by managed care and heightened levels of competition?

- What ownership/governance structure best enables KUMC to serve the health related education and research needs and interests of the citizens of Kansas and maintain an economically viable clinical enterprise?

Health care continues its transformation to a market driven industry.

2-3



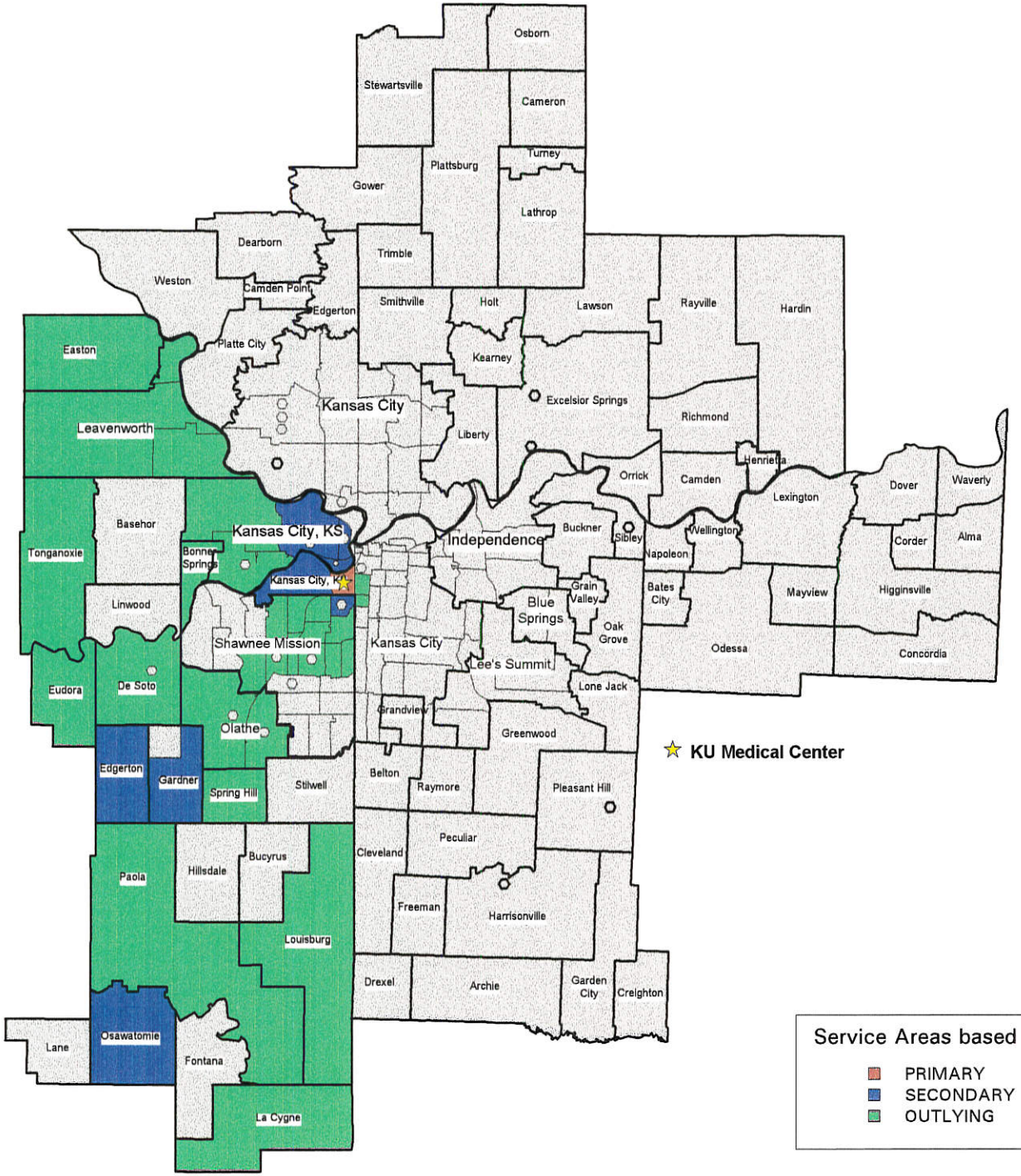
Source: University HealthSystem Consortium

Using UHC's staging model, Kansas City has evolved into an early Stage III managed care market.

Stages	Stage I	Stage II	Stage III	Stage IV
	Unstructured	Loose Framework	Consolidation	Managed Competition
Characteristics	Independent hospitals, physicians, employers, and HMOs	Lead HMOs or PPOs emerge, loose provider networks and weak hospital affiliations form Excess inpatient capacity develops Hospital discounts widen	Lead HMOs or PPOs achieve critical mass, begin to consolidate; hospital systems form; all aggressively recruit/compete for primary care group practices Selective contracting by major purchasers Development of large multi-specialty, primary care, and IPA groups Specialist practices under-utilized; discounts increase Beds close, hospital profits increase	Purchasers contract with integrated hospital/physician systems to provide comprehensive services to their beneficiaries Financial risk shifts to primary medical groups/provider networks Beneficiaries have strong incentives to use contract network (extensive channeling) Capitation model becomes prevalent
Pricing	Fee for service (FFS)	Discount, per diem	Per diem, per case, physician capitation	Stage III plus capitation
Basis for Healthcare Purchasing	Encounter, cost of claim Volume	Encounter, cost of claim	Cost per covered life per health plan	Beneficiary health status, total healthcare costs

Source: *University HealthSystem Consortium (UHC); Future stages still in development.*

KU Medical Center Service Area



Service Areas based on Market Share by Zip

PRIMARY	30% or more	(1)
SECONDARY	15% to 29.9%	(9)
OUTLYING	5% to 14.9%	(30)

Lack of provider linkages and modest geographic coverage pose serious threats to KU Hospital and KUMC physicians.

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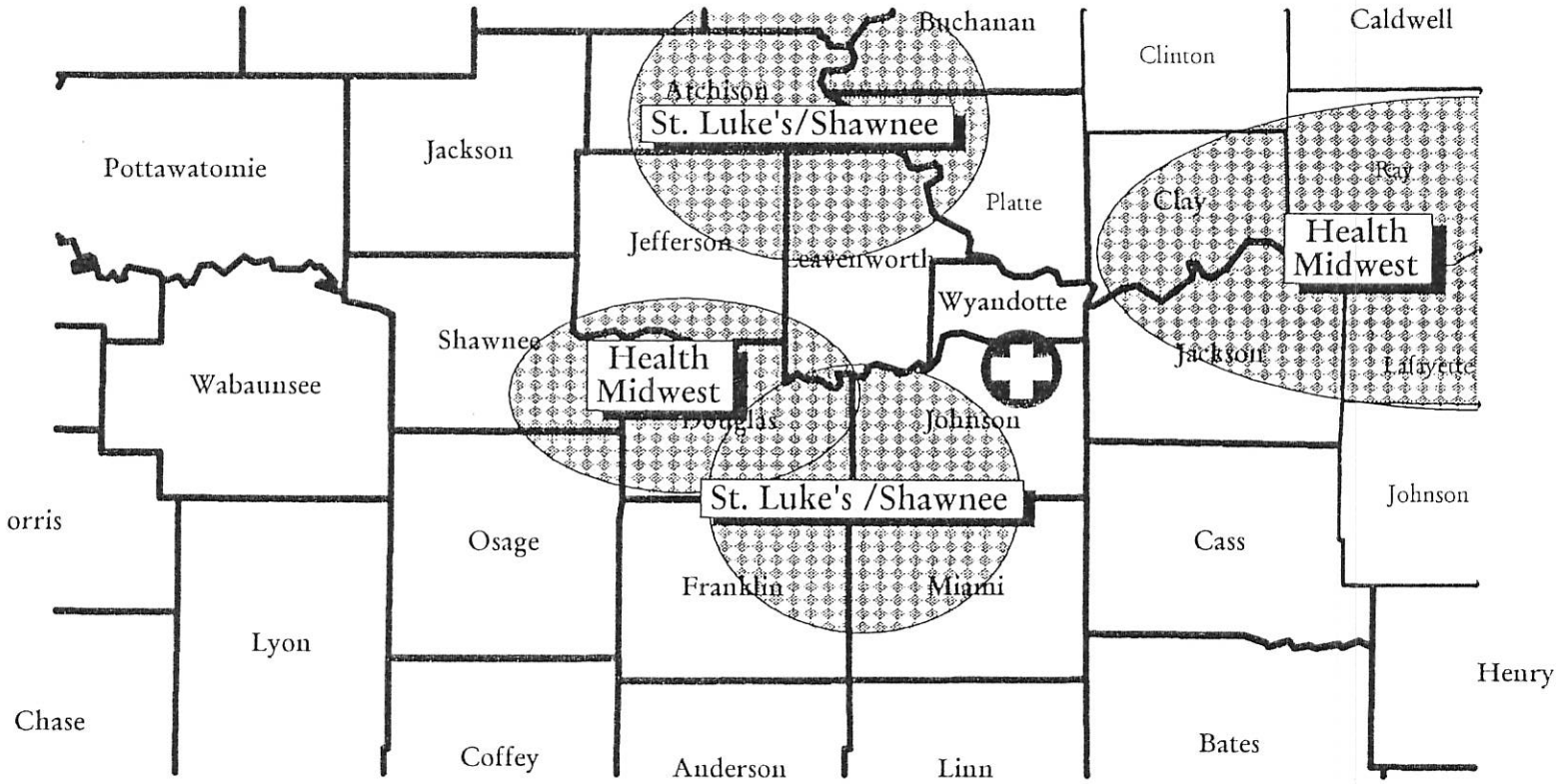
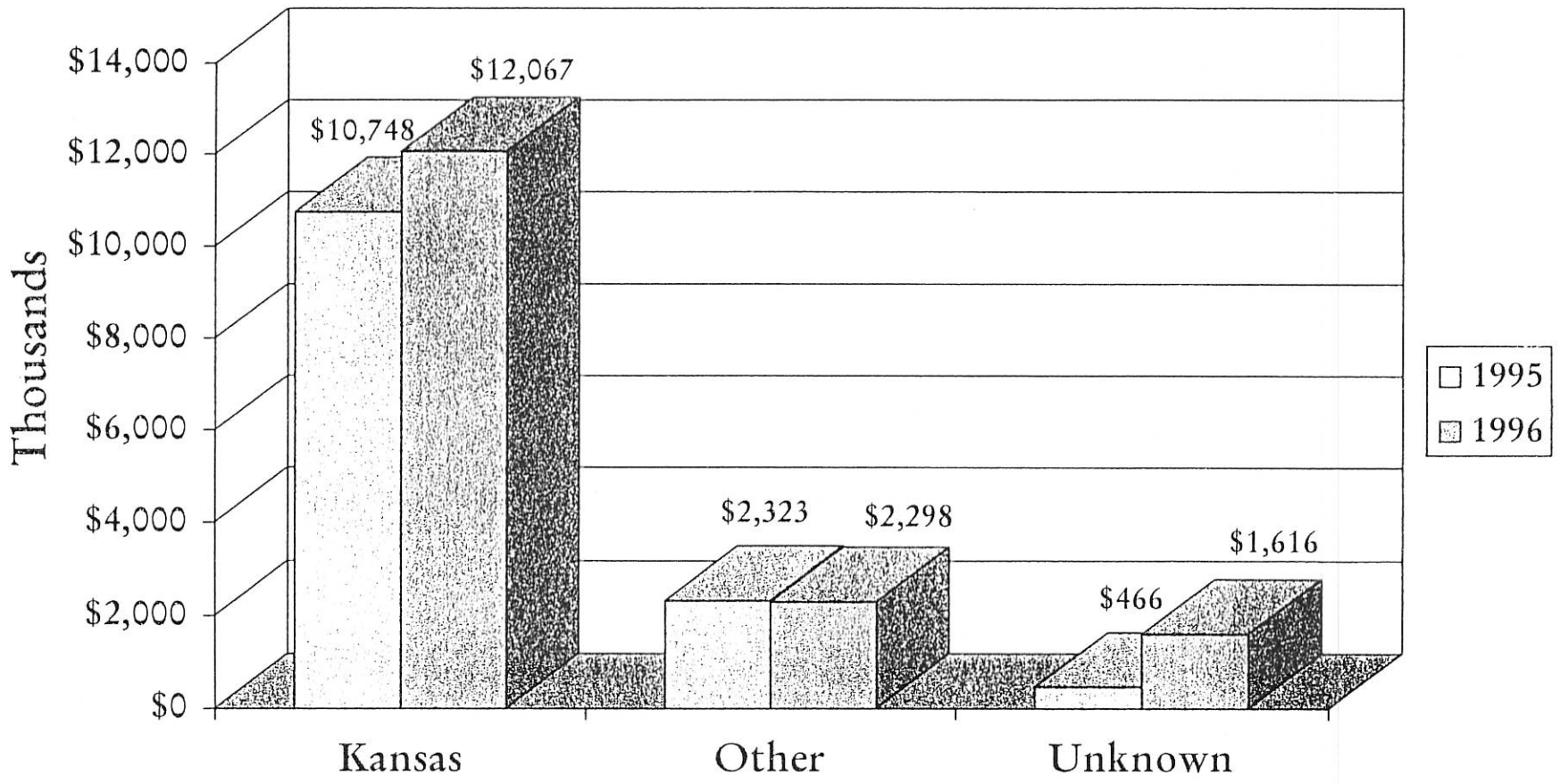


KUMC

Over the past two years, KU Hospital had a total of 2,221 uninsured inpatient cases from 46 counties in Kansas, with write-offs totaling $22.7 million.*

2-7



* Based on gross charges. KU Hospital's overall cost-to-charge ratio approximates 60%.

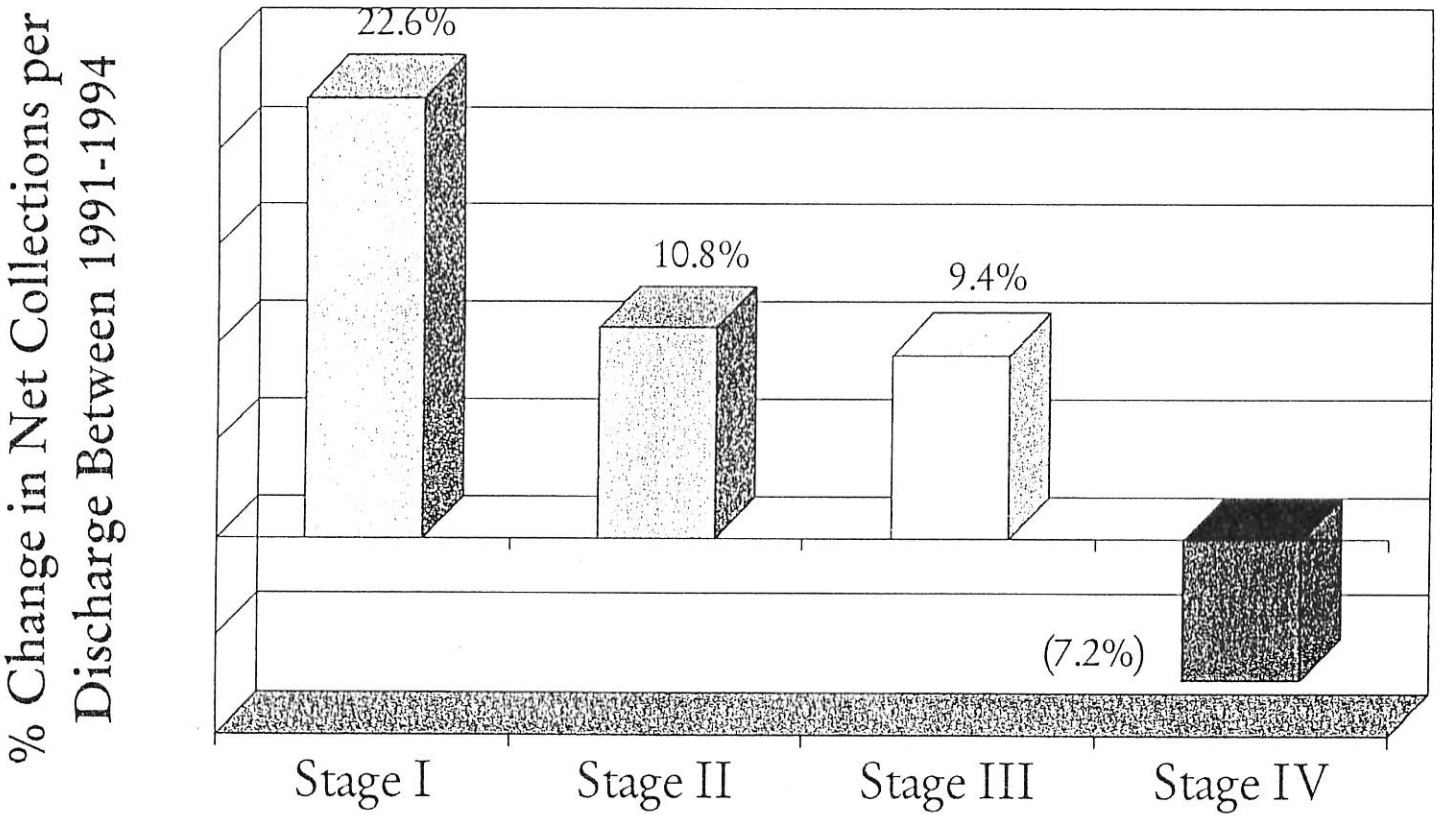
As managed care penetration increases, pressure to reduce inpatient utilization will intensify.

Comparison of Selected Market Characteristics by Stage

Location	Market Stage[1]	Hospital Days/ 1000 Population[2]	Beds/ 1000 Population[3]
Little Rock	II	1258.2	5.4
Indianapolis	III	992.5	3.8
Kansas City	III	818.0	3.9
Denver	IV	545.7	2.4
Tucson	IV	583.9	2.5
Minneapolis	IV	597.9	2.5
Portland	IV	469.4	1.9

Source: [1] *UHC*
[2] *The Competitive Edge, Part III: Regional Market Analysis*
[3] *1995/96 Hospital Stat: Emerging Trends in Hospitals*

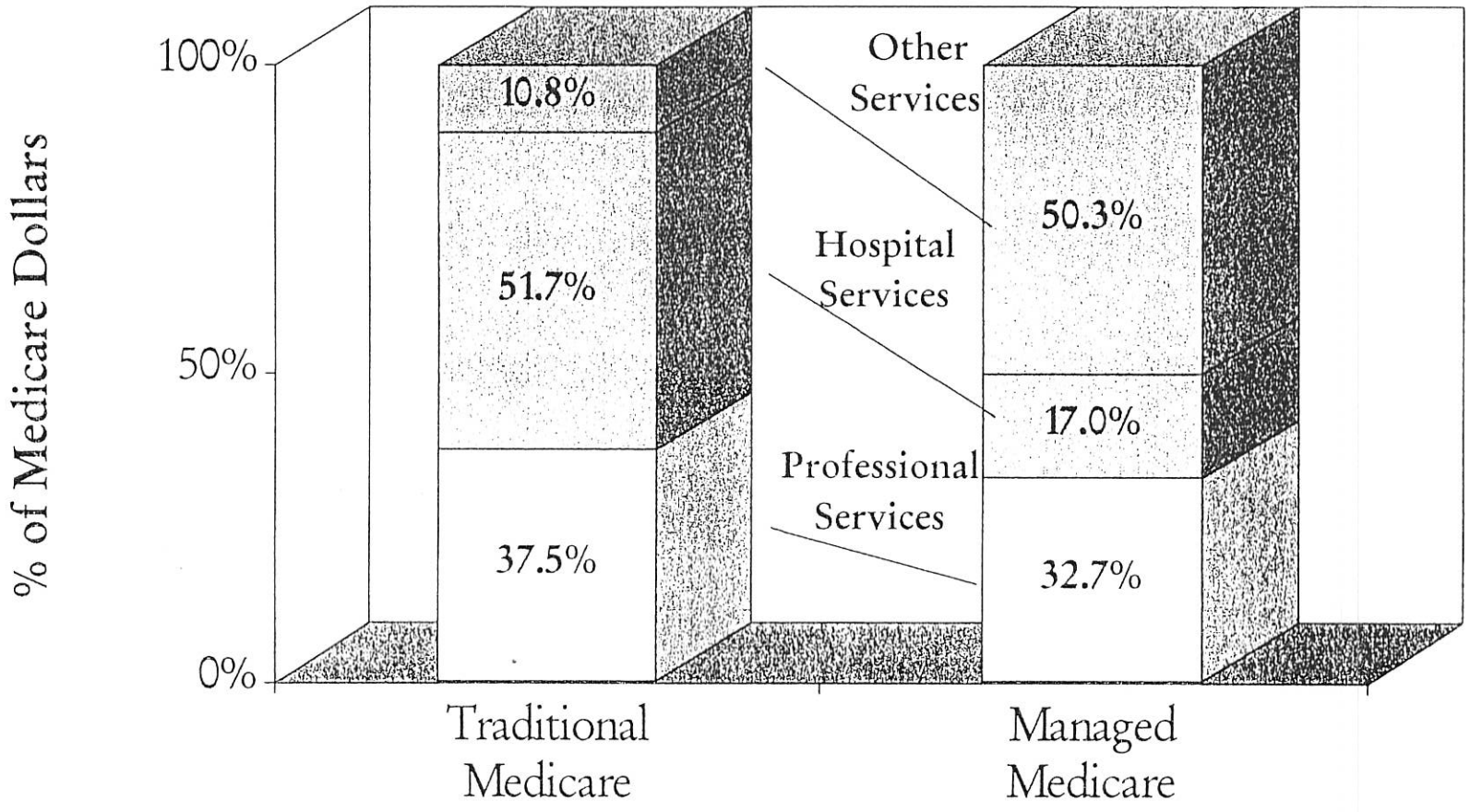
Declining inpatient use and deep price discounts have a significant impact on revenue potential in late stage markets.



Note: Does not reflect future changes in funding for government programs

Source: HCIA, UHC Financial Database

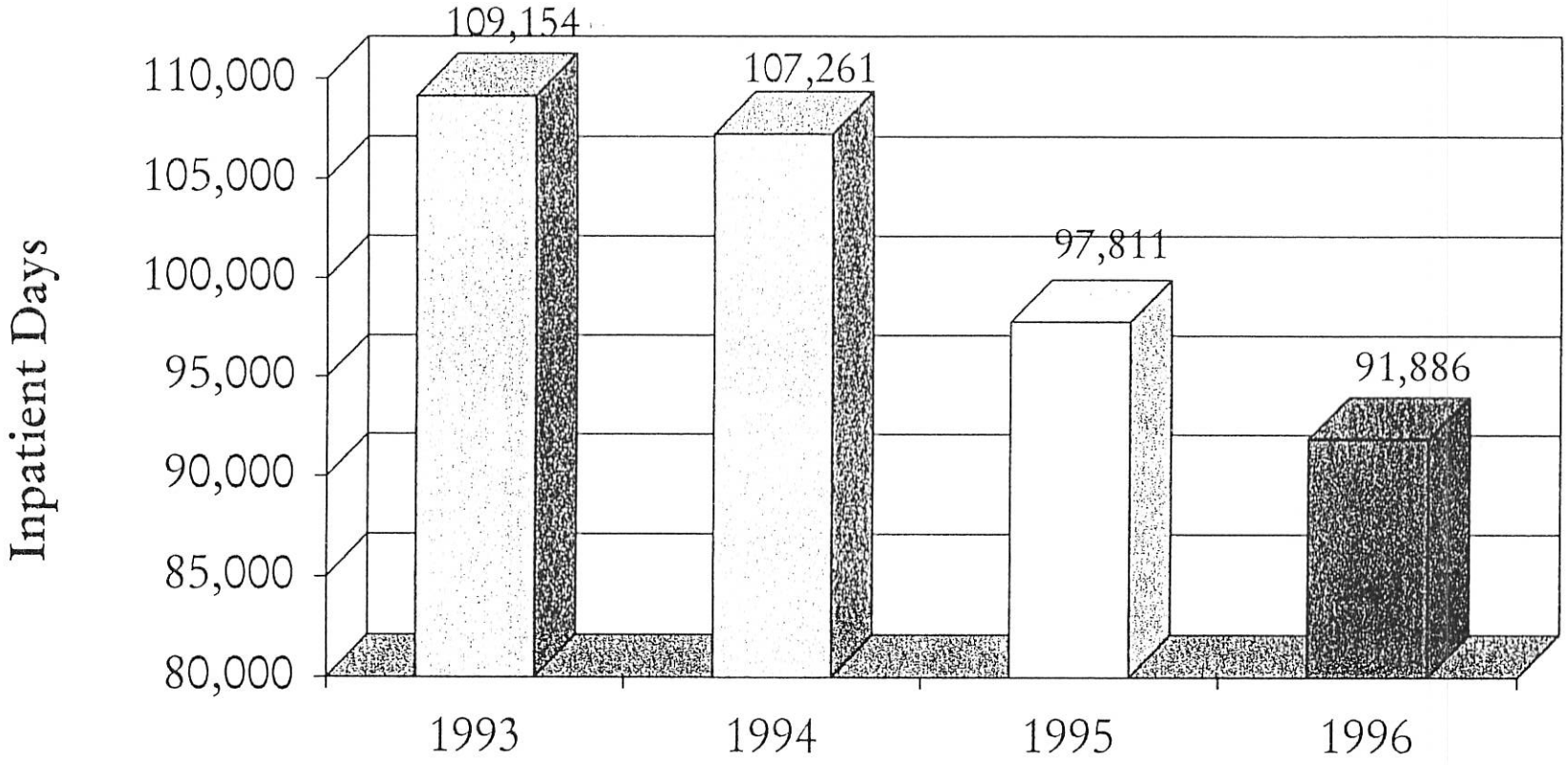
npatient revenue will be further constrained as Medicare and other government payers shift to risk contracting.



Whole dollar expenditures are greater with traditional Medicare.

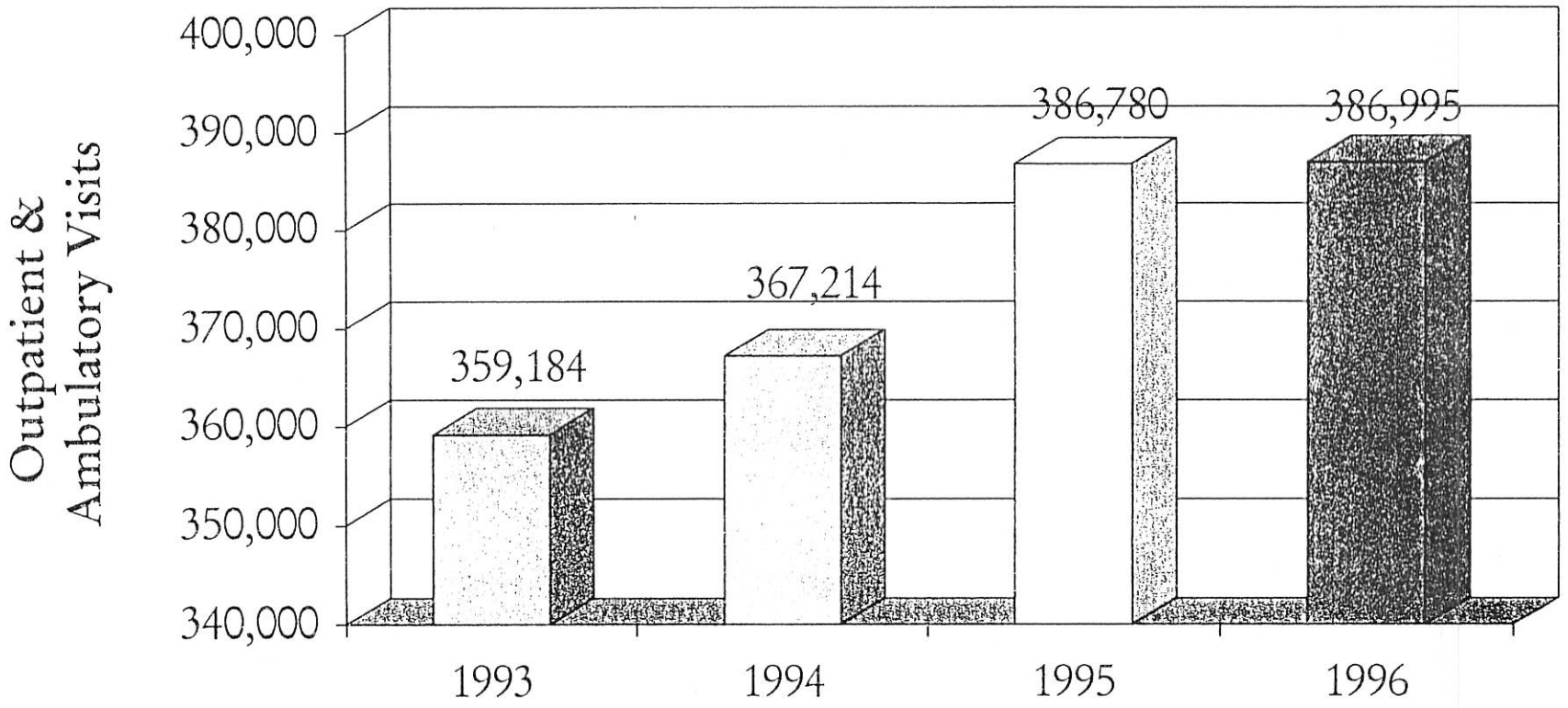
Source: Stanford Health Services Model, UHC

Declining admissions and length of stay have combined to significantly reduce KU Hospital's inpatient utilization.



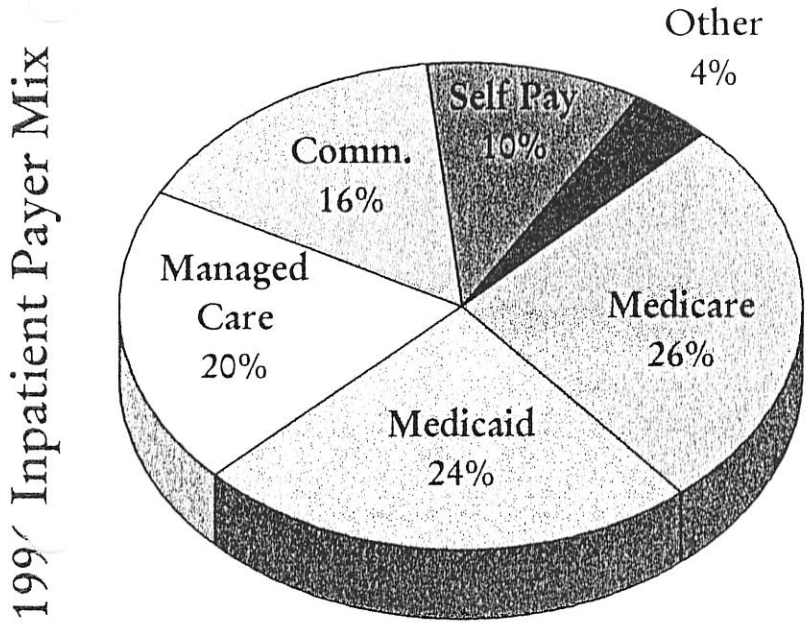
Source: Hospital Statistics, 1993-1996 fiscal year

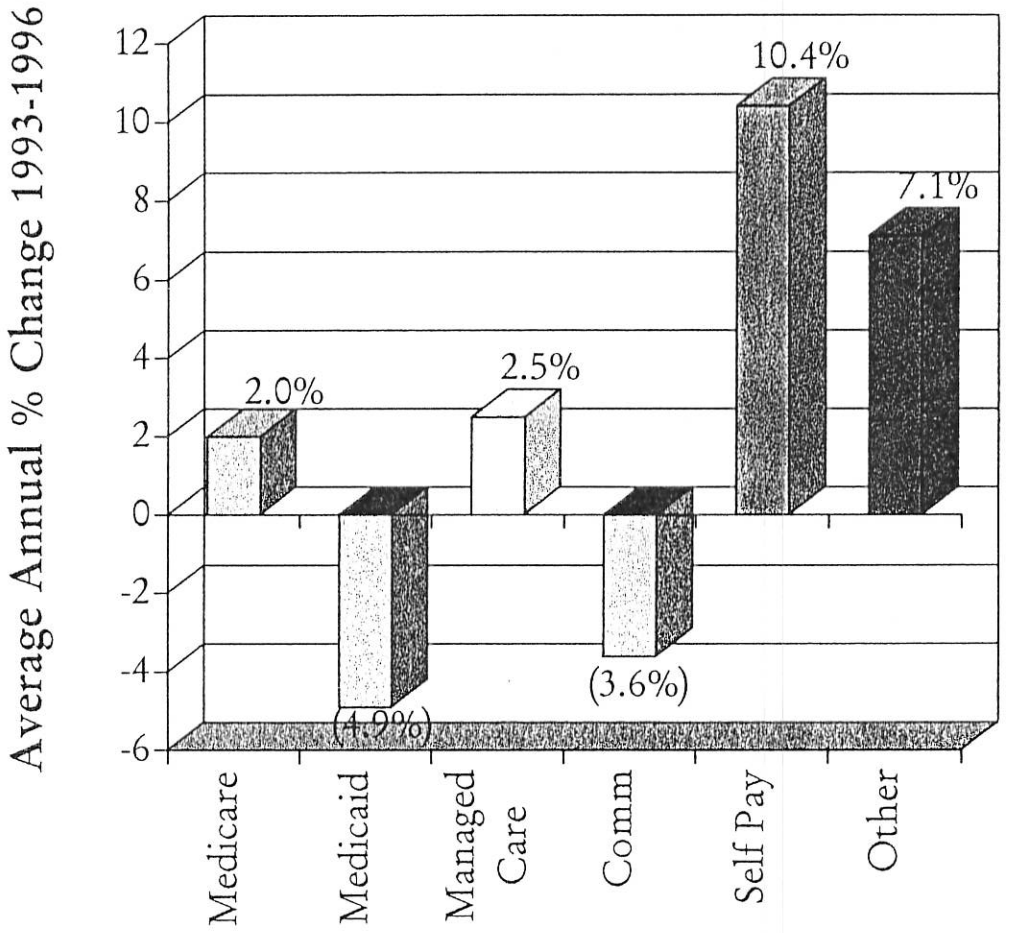
KU Hospital's outpatient utilization has grown, but has not off-set revenue losses from reduced inpatient activity.



Source: Hospital Statistics, 1993-1996 fiscal year

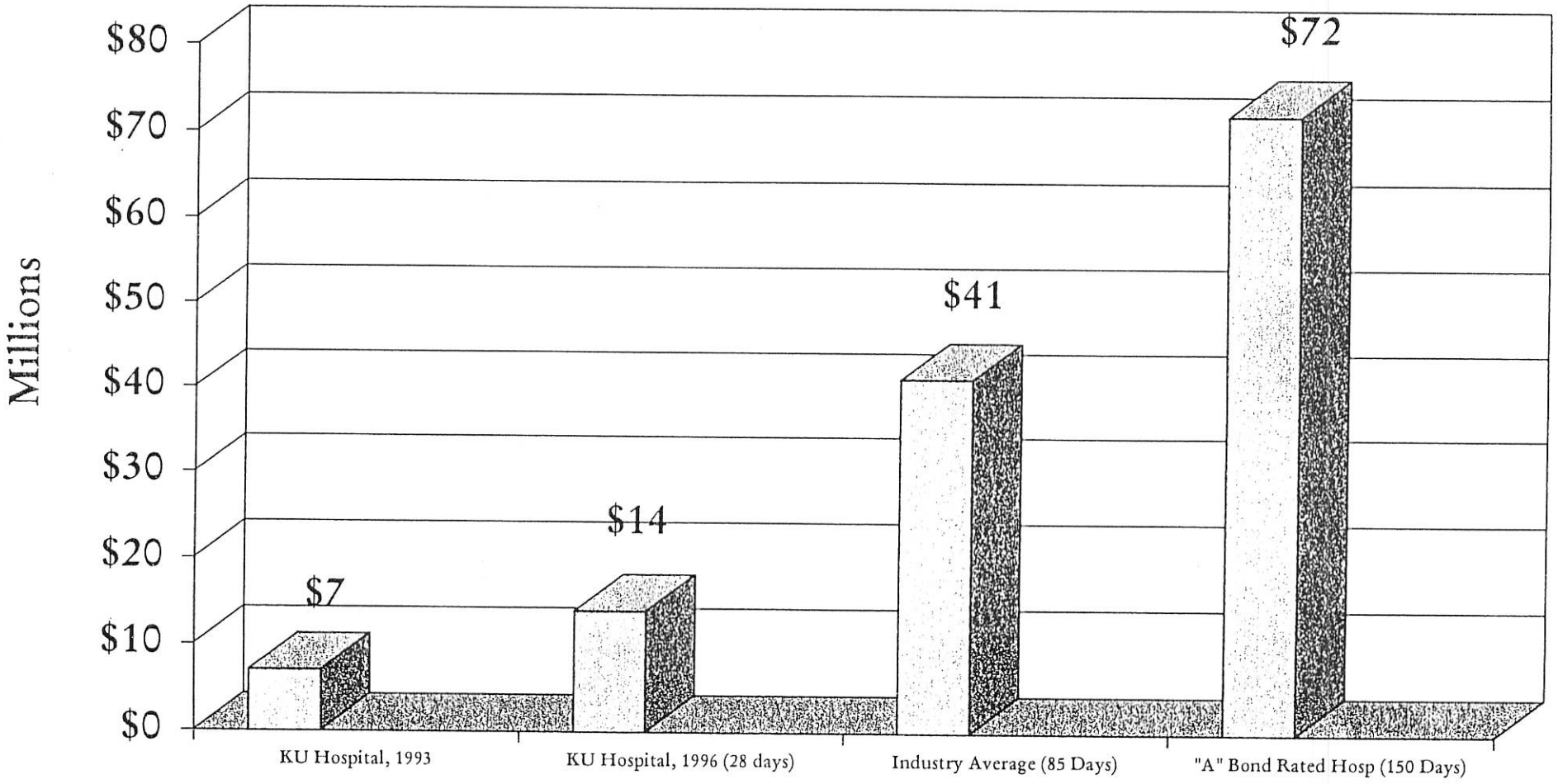
The shift in KU Hospital's payer mix from Medicaid and commercial to managed care and self pay continues to reduce reimbursement.





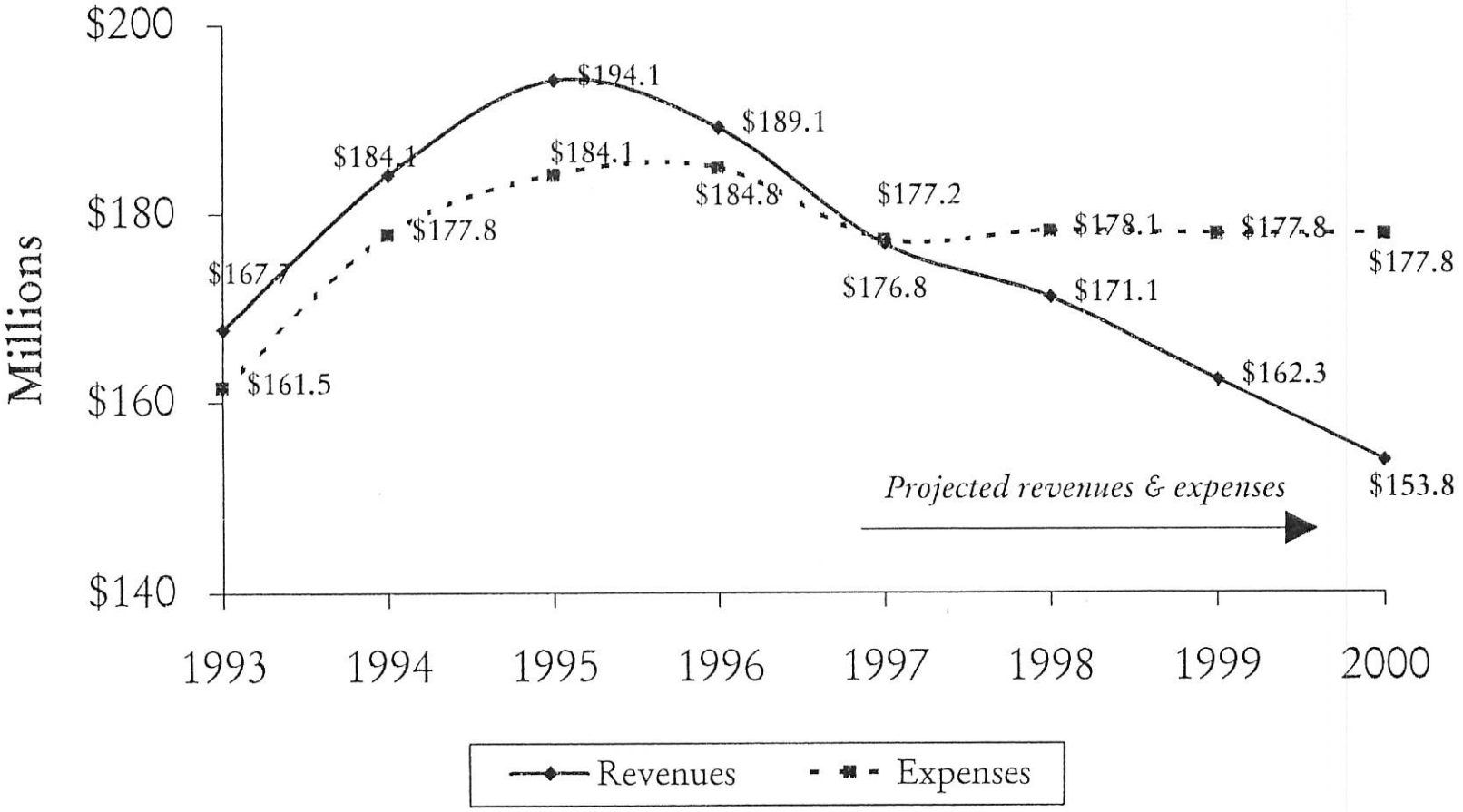
Source: Hospital Statistics, 1993-1996

Since 1993, KU Hospital has generated cumulative margins of over $26 million, but available cash balances have increased only $7 million. This balance falls well below industry and "A" bond rated hospital averages.



Source: *Hospital Statistics, 1993 - 1996*
The Center for Healthcare Industry Performance Studies (CHIPS)
Moody's Inventors Services

Projected baseline operating losses are substantial and cannot be reversed without significant market share growth and cost reduction initiatives.



Source: Hospital Statistics, 1993-1996
KU Hospital and Lash Group Projections

2-16

Over the past decade legislators have responded to KU Hospital's request for regulatory relief to address changing market conditions.

Legislative Change	Year	Relief Granted	Impact
uthority to move any classified position to unclassified status.	1980	Hospital unclassified positions in order to address salary constraints	Limited use because no funds were provided to offset expenses associated with benefits, retirement, and salary.
State established separate classifications for nursing personnel.	Early 1980's	Medical Center Nurse positions established with slightly higher salaries than at other state agencies	Provided short term relief - KUMC was not able to address continued escalation in salaries.
Authority to establish Health Care Employee category with unclassified service.	1989	Achieved salary freedom from state civil service pay structure while retaining benefits of classified employees	Hospital has taken advantage of opportunities available to reclassify employees into this category.
Removed expenditure limit from Hospital Revenue Fund.	1990	Hospital expenditures not limited by State appropriation	Hospital able to adjust its budget to support program needs subject to availability of adequate hospital revenue.
Granted KU Hospital authority to negotiate, enter into contracts and leases for purposes of affiliation, joint ventures, partnerships, and equity ownerships with other health care providers and third parties for purposes of providing medical services or partricipation in medical networks. *	1995 SB 171	Exempted such ventures from state purchasing statutes	Ventures subject to Board of Regents approval. Hospital used this authority to develop Jayhawk Primary Care.

* Authority for change initially granted through proviso and later made statutory

Regulatory relief (continued)

Legislative Change	Year	Relief Granted	Impact
Exemption from state purchasing approval for all acquisitions of data processing hardware or software by KUMC for KU Hospital. *	1995 SB 170	Allows sole source acquisition.	Requires medical center to file plan for future acquisitions with Director of Purchases. SMS contract negotiated under this exemption.
Authority to enter into contracts to lease and operate off campus medical care facilities. *	1995 SB 173	Leases not subject to state purchasing statutes or approval of Secretary of Administration.	
Authority to make direct purchases for goods and services in amounts up to $25,000 for any individual purchase.	1995 SB 174		Not very effective because very few purchases are between $10,000 and $25,000.
Authority to enter into contracts with consortiums of health care providers and other purchasing groups for acquisition of supplies and other materials.	1995 SB 174	Enabled hospital to go into contract with UHC.	
Authority to make expenditures for renovations, remodeling, or improvements to existing hospital physical plant from Hospital Reserve Fund.	1995 Proviso to Appropriation Bill on Hospital Reserve Fund	Able to expend moneys for capital improvements without a specific appropriation and allowed to make capital expenditures from general operating appropriations.	Subject to approval of Board of Regents and Department of Administration, expenditures must be presented to Joint Legislative Committee on State Building Construction.

* Authority for change initially granted through proviso and later made statutory

Source: Correspondence from KUMC 9/25/96

egulatory barriers remain, however, and continue to threaten KU Hospital by reducing its ability to rapidly develop and implement strategic initiatives.

2-18

Industry experts note that government owned teaching hospitals require greater management flexibility in five areas to address market conditions. KU Hospital lacks management flexibility and decision making autonomy in four of the five areas.

- [x] Capital financing and acquisition strategies
- [x] Human resources management
- [x] Procurement practices
- [x] Information system development
- [ ] Managed care contracting

Source: The Webb Associates/Arthur Andersen, 1994

2-19

Regulation intended to ensure fair business practices and to protect public assets has a number of unintended consequences within KU Hospital.

Internal - Operational inefficiencies

- Lack of flexibility to manage personnel for maximum productivity
- Constrained development of state-of-the-art administrative and support services
- Service delays, interruptions, and re-work which negatively affect clinical service delivery and increase operating costs
- Inter-departmental conflict over customer service priorities -- internal (hospital) versus external (state)

External - Limited attractiveness as a potential business partner

- High fixed administrative and personnel costs
- Complex and time consuming decision making processes
- Limited access to capital
- Limited debt management capacity
- Increased costs of running dual accounting systems to meet state and Medicare requirements (cost based and accrual)
- Outdated and labor intensive procurement practices

2-20

In summary, KU Hospital must overcome a significant number of vulnerabilities to sustain mission effectiveness under new market conditions.

- **Vulnerability 1 - No defined linkage strategy**

  Providers are rapidly consolidating in the Kansas City market. The absence of a strategic partnership places KU Hospital in an "at risk" position.

- **Vulnerability 2 - Lack of service differentiation**

  KU Hospital is not perceived to be strongly differentiated in the market by unique services or by quality of care delivery. This perceived lack of differentiation limits the hospital's negotiating leverage with payers.

- **Vulnerability 3 - Declining admissions/minimal outpatient growth**

  Changing market dynamics will likely contribute to a material erosion of KU Hospital's inpatient utilization to below break-even levels.

- **Vulnerability 4 - Shifting payment mechanisms**

  Growth of managed care and risk based contracts has shifted payment from fee for service to fixed payments. Aggressive negotiations are reducing already dangerously narrow margins at many teaching hospitals.

Vulnerabilities (continued)

- **Vulnerability 5 - Eroding subsidies for education**

  Historical income sources for the cross-subsidization of education and research from patient care revenues are eroding.

- **Vulnerability 6 - Inadequate funding for charity care**

  KU Hospital receives no state support for uncompensated care for indigent patients. The hospital's ability to support this important part of its teaching and service mission is becoming endangered.

- **Vulnerability 7 - Limited cash reserves**

  KU Hospital cannot close projected revenue gaps through expense management alone. KU Hospital must be able to obtain the capital, either internal or external, necessary to make investments needed to increase market share and develop clinical initiatives that provide service differentiation.

- **Vulnerability 8 - Limited management flexibility and decision autonomy**

  KU Hospital is subject to a significant degree of state government oversight of all aspects of its operation, limiting managerial autonomy in a market that demands rapid decision making.

Vulnerabilities (continued)

- **Vulnerability 9 - Lack of timely access to capital**

  KU Hospital must receive legislative approval for bond indebtedness. Competitors are able to access the same debt markets using the same conduit - Kansas Development Finance Authority (KDFA) - without incurring the time required for legislative approval.

- **Vulnerability 10 - Limited attractiveness to potential business partners**

  Private sector providers are unlikely to partner with an institution whose strategic agenda and operating practices are constrained by a high degree of regulatory control.

- **Vulnerability 11 - Inefficient and costly operating practices**

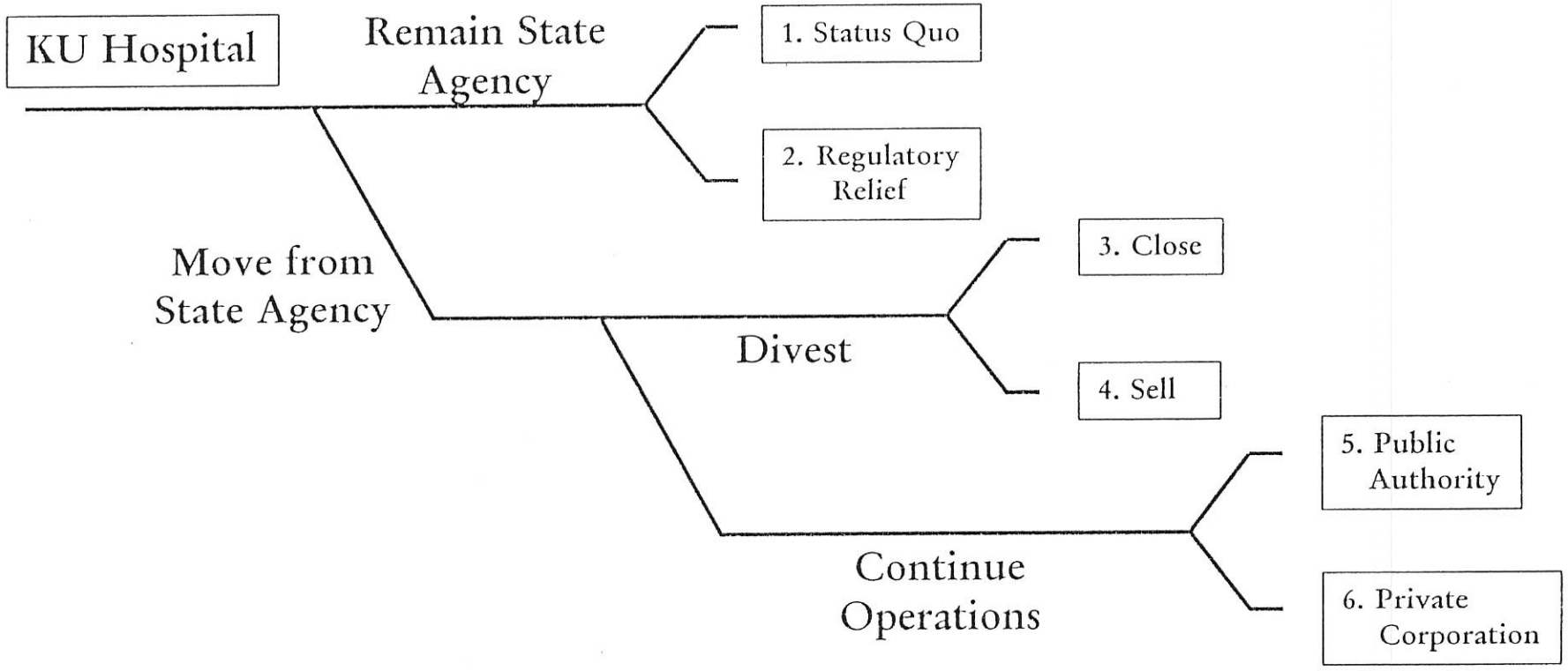
  State regulations and administrative practices add complexity and cost to department operations as compared to private sector operations, resulting in inefficient use of scarce resources and poor internal customer satisfaction.

- **Vulnerability 12 - Reduced innovation**

  Introducing cost saving innovations in departments with a high degree of state oversight is difficult and time consuming. State regulation establishes an organizational climate in which managers believe they have little ability to "think outside the box", resulting in status quo operations in a rapidly changing industry.

2-23

Six change options grouped in three categories are typically considered.



2-24

Six teaching hospitals operating under differing ownership/governance models were studied to gain insight into model attributes and their impact on organizational performance.

- University of Arkansas -- regulatory relief model
- Indiana University Hospitals-- divestiture (merger)
- University of Minnesota -- divestiture (sale)
- University of Colorado Hospital -- public authority
- Oregon Health Sciences University -- public authority
- University of Arizona Health Sciences Center -- private corporation

Market conditions for each study site varied but those in more advanced managed care markets instituted ownership/ governance change in response to current or anticipated economic pressures.

Market	% HMO Enrollment[1]	Average Length of Stay[1]	Admits/ 1000 pop.[2]	Hospital Days/ 1000 pop.[1]	Beds/ 1000 pop.[2]	Primary Care Physicians/ 1000 pop.[3]	Specialist Physicians/ 1000 pop.[3]
Little Rock	13.6	7.0	179.9	1258.2	5.4	1.6	2.7
Indianapolis	16.6	6.6	150.4	992.5	3.8	1.1	1.5
Kansas City	**20.9**	**7.1**	**115.2**	**818.0**	**3.9**	**1.0**	**1.3**
Denver	27.4	5.6	97.4	545.7	2.4	1.0	1.4
Portland	41.8	4.9	95.8	469.4	1.9	0.9	1.4
Minneapolis	39.4	6.3	104.1	597.9	2.5	0.77	0.96
Tuscon	42.0	5.1	114.5	583.9	2.5	1.2	1.6
Group Average	**28.81**	**6.09**	**122.47**	**752.23**	**3.2**	**1.08**	**1.55**

[1] Source: The InterStudy Competitive Edge, Part III: Regional Market Analysis
[2] Source: 1995/96 Hospital Stat: Emerging Trends in Hospitals
[3] Source: Claritas, Inc: 1995 MEDEC Physician List and Database -- includes FPs, GPs, Internists, OB/GYNs, and Peds; Minnesota Medical Association
(NOTE: data is not case mix adjusted)

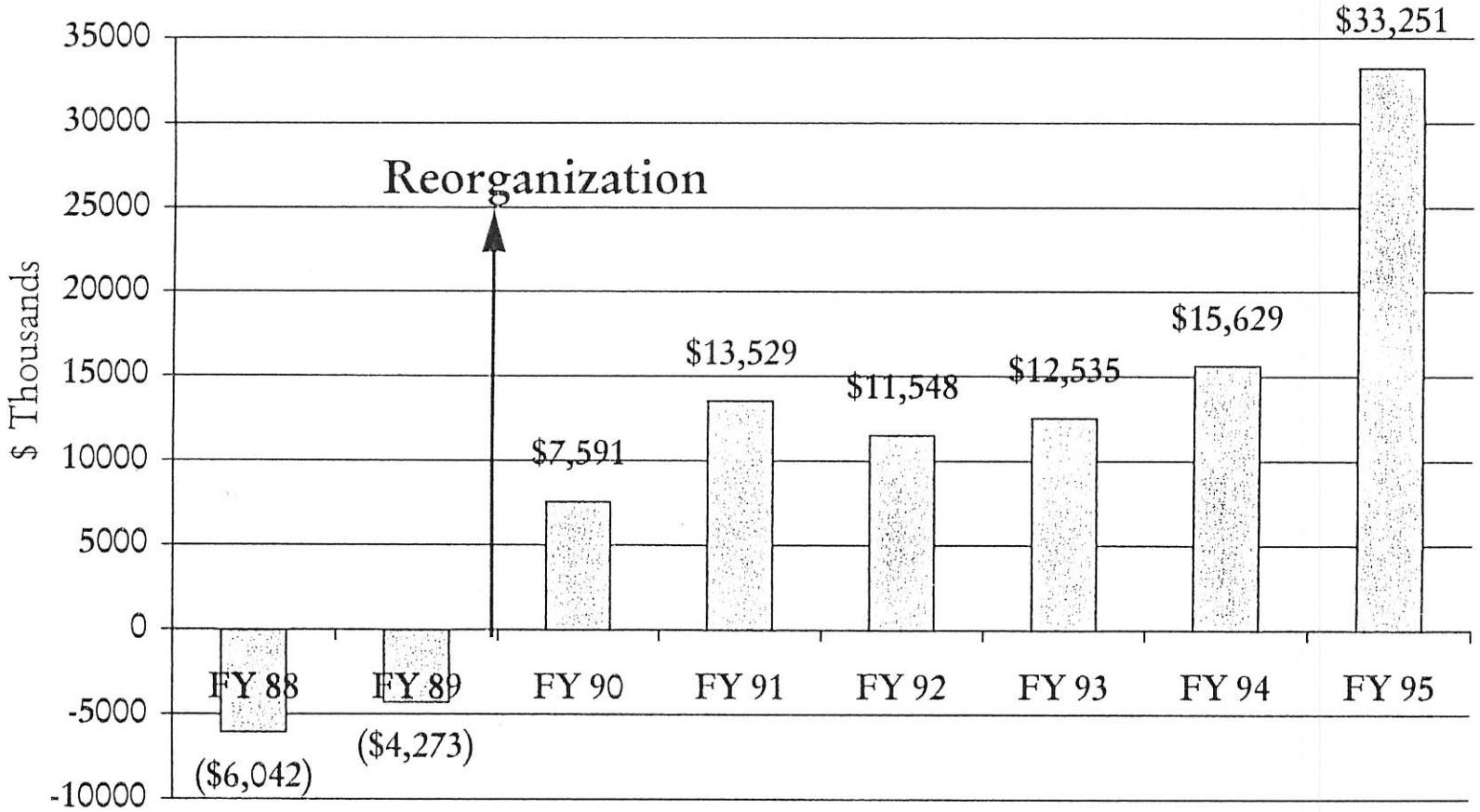
2-26

Several consistent themes emerged from the case studies.

- Two factors drove the decision for change in nearly all settings:
  - Inadequate access to capital to invest in programs
  - Inability to respond to market conditions in a timely manner
- Conversion to a new structure resulted in significantly greater managerial autonomy, but all states retained some degree of reserve power.
- Hospital performance improvements were swift and sustained.
- The change process required consensus building which took time, attention, and patience from all organizational leaders.

UH net income has been positive every year since the reorganization.

Net losses prior to the reorganization have turned to substantial net income.



Public Authority Advantages

- Meets identified goals for an ownership/governance change:

  - Sustains mission effectiveness
  - Protects public assets
  - Maintains financial viability for hospital
  - Develops a customer driven culture
  - Enhances management/governance flexibility and timely decision making
  - Supports ease of implementation