Approved: April 1, 2005
Date

MINUTES OF THE SENATE HEALTH CARE STRATEGIES COMMITTEE

The meeting was called to order by Chairman Susan Wagle at 1:15 P.M. on March 2, 2005 in Room 231-N of the Capitol.

Committee members absent:

Committee staff present: Ms. Emalene Correll, Kansas Legislative Research Department
Ms. Terri Weber, Kansas Legislative Research Department
Mr. Jim Wilson, Revisor of Statutes Office
Ms. Margaret Cianciarulo, Committee Secretary

Conferees appearing before the committee: Mr. Tom Bell, President, Kansas Hospital Association
Dr. Ed Dismuke, Dean of KU School of Medicine, Wichita Residency Program
Mr. David Nevill, President & CEO, Wesley Medical Center
Mr. Kevin Conlin, President & CEO, Via Christi Health System
Dr. H. William Barkman, Chief of Medical Staff, University of Kansas
Dr. Larry Anderson, Family Practice Physician, Wellington, KS
Dr. Debra Haynes, Family Practice Physician, Wichita, KS

Hearing on SB 235 - an act concerning hospitals; instituting a moratorium on establishment of certain hospitals prior to July 1, 2006.

The Chair began the meeting by informing the Committee they would be hearing proponent testimony on **SB235.** She then referred them to the first two handouts provided by the Kansas Health Institute (KHI) that were informational only. A copy of the KHI's brief and an overview of a collaboration with the Kansas Department of Health and Environment (KDHE) to study the impact of specialty hospitals on health care markets in Kansas are (Attachment 1) attached hereto and incorporated into the Minutes as referenced.

The Chair then asked Ms. Emalene Correll, Kansas Legislative Research Department, to provide an overview of the bill. Highlights included:

1) Section 1 amends one of the parts of the act of which hospitals are licensed to be regulated by the Secretary of Health and Environment and amends the definition of the term "hospital" to add "a critical access hospital " to the definition which currently is a general hospital or special hospital, licensed under the provisions of the hospital act. "A critical access hospital" is defined in K.S.A. 65-425, which has been amended. She stated, these are the hospitals that may keep acute care patients only a limited amount of time, 72 or 90 hours, as the definition federally changes. And she stated, they used to be called "each and peach" hospitals, basically providing a limited amount of acute care for a limited amount of time, needing to be a part of the network, affiliated with at least one other hospital and by so doing they receive some benefits as far as Medicare reimbursement is concerned;

2) Section 2 amends K.S.A. 65-451 to say that construction or modification of a hospital, as that term is implied in Section 1, may not commence prior to July 1, 2006; the language on lines 25 through 28 has been deleted (this dealt with other things that would no longer be included within this moratorium); and finally, the establishment of a new hospital would be prohibited other than a critical access hospital, which by definition, would not be a speciality hospital;

3) Section 3 includes provisions of various other statutes in the hospital licensing act amended so those provisions do not to apply to:

A) The relocation of a hospital's licensed beds from one physical facility or site to another in the same community if that hospital is the only hospital in the community,

B) Consolidation of two or more hospitals located within the same community if the licensed bed capacity would accommodate a 70% rate of occupancy based on the daily average census of the hospitals;

C) Relocation or redistribution of hospital beds within the hospital building or complex of buildings on the same site would be deleted and what could then be established is a critical access hospital or the conversion of any general hospital to a critical access hospital;

D) Also to be excluded are hospitals which are owned or operated by the federal or state government which would generally not be considered part of our definition of hospitals anyway; and,

E) K.S.A. 65-464 would allow the Secretary to enjoin any alleged violation of this act;

Finally Ms. Correll stated that all of the above statutes are "Certificate-of-Need" statutes and that basically, the bill sets a moratorium on the construction of new hospitals with the exception of critical access hospitals.

As there were no questions of Ms. Correll, the Chair called on the first proponent, Mr. Tom Bell, President, Kansas Hospital Association, who stated that there were really two issues before the committee:

1) Whether Kansas should adopt a short-term moratorium on new hospitals, and

2) What should be the policy of the state of Kansas on protecting the health care safety net in light of the proliferation of limited service hospitals?

He stated his testimony would discuss both. He also provided a recent study prepared for the America Hospital Association and Kansas, Colorado, Nebraska and South Dakota Hospital Associations by McManis Consulting which looked at the impact of limited service hospitals in four Midwest cities. A copy of his testimony is (Attachment 2) attached hereto and incorporated into the Minutes as referenced. A copy of the study is filed in Senator Wagle's office.

Next to testify was Dr. Ed Dismuke, Dean of the Kansas University School of Medicine, Wichita Residency Program, who stated that their experience at the school has been that the creation of limited service hospitals in Wichita has had an adverse effect on funding residency programs. He went on to explain: the sources provided for expenses, what happens when Medicare and privately insured patents are diverted, and an inequity of payments based on the DRG system implemented by Congress several years ago. A copy of his testimony is (Attachment 3) attached hereto and incorporated into the Minutes as referenced.

The third proponent was Mr. David Nevill, President & CEO of Wesley Medical Center, who stated that due to a well-documented pattern of utilization and abuse, Congress enacted prohibitions in 1989 and 1993 to prevent physicians from referring their patients to facilities they or their family members own. Mr. Nevill also provided a handout entitled "The Case for a Permanent Ban on Physician-Owned Limited Service Facilities and **SB235**. A copy of his testimony and handout are (Attachment 4) attached hereto and incorporated into the Minutes as referenced.

The fourth to testify was Mr. Kevin Conlin, President & CEO, Via Christi Health System, who gave a brief history of Via Christi and the role it plays in health care in Kansas, answered why they support the bill, and finished by offering a perspective on free enterprise in health care. A copy of his testimony is (Attachment 5) attached hereto and incorporated into the Minutes as referenced.

Next, Dr. H. William Barkman, Chief of Medical Staff, at the University of Kansas Hospital, stated that full -service hospitals like theirs can afford to offer services such as trauma care, burn units, and neonatal intensive care units because they can also perform more profitable procedures. He also stated, it is a balance that allows them to care for the sickest patients and to be prepared to react to any change in level of care. A copy of his testimony is (Attachment 6) attached hereto and incorporated into the Minutes as referenced.

The sixth conferee, Dr. Larry Anderson, Family Practice Physician, Wellington, Kansas, stated that nationwide there are one hundred speciality hospitals and if they were distributed according to population, Kansas would have no specialty hospitals, but at it is, Kansas has thirteen. Dr. Anderson also relayed his dealings with Certificate of Need legislation and offered a letter he wrote to the Wichita newspaper, a *Kansas Medicine* article he wrote, and a 2-page "Executive Advantage Report." A copy of his testimony, his letter, and his article are (Attachment 7) attached hereto and incorporated into the Minutes as referenced.

The last to testify was Dr. Deborah Haynes, Family Practice Physician, also from Wichita, who stated that at a national level, the American Academy of Family Physicians is supportive of an extension of a federal moratorium on specialty hospitals. She stated, she supports the bill because the community needs to take a time out to determine how both medical facility regulations and federal payment practices have created a healthcare marketplace with unsustainable delivery costs. She also stated that action will give the federal regulatory agencies time to complete their work and allow all of us to determine what about Kansas licensure laws have contributed to creating an unhealthy financial situation for the community hospitals that serve all Kansans regardless of their medical needs or their ability to pay. A copy of her testimony is (Attachment 8) attached hereto and incorporated into the Minutes as referenced.

As there was no written proponent testimony, the Chair thanked all of the conferees and asked for questions or comments. Senators Barnett, Wagle, Journey, and Haley offered questions and comments for Dr. Anderson, the Revisors, Mr. Bell, and Mr. Nevill including: where did the information come from Mr. Anderson's attachments regarding evaluating net income (MedPac numbers), when the Revisors changed the wording of "hospitals " that we banned the establishment of a new hospital but did we bother defining this; how do we define "establishment" and any thoughts why this is so broad; why is the licensure law so vague; concerning Mr. Nevill's testimony regarding Wesley Medical Center being owned by HCA, stating "this issue is about profitability and greed for the wealthiest 1% or 2% of our state or nation, who are you referring to; the indication is specialty hospitals are performing too many procedures, catherizations, tests ordered, etc. but this is also being done in regular hospitals so when is it OK to do those "unnecessary" tests if its bringing profit to hospitals; if we have to look at the definition in our licensure law what would critical access be and would there be a percentage of emergency care (or how it might be structured in the statute); concerned that someone looking down the road might see this one year moratorium and not necessarily look to invest in Kansas; feels there is a huge problem with where the uninsured can go in Kansas and where they can get full health care; what laws are in place in Missouri, and why was a Certificate of Need bill not introduced?

Adjournment

As it was going on 2:30 p.m. Senate session time, the meeting was adjourned.

The next meeting is scheduled for March 3, 2005.

SENATE HEALTH CARE STRATEGIES COMMITTEE

GUEST LIST

67 in all

DATE: Wednesday, March 2, 2005

NAME	REPRESENTING
Roderick Bremby	KDHE
Susan Kang	KDHE
Tom Bell	KHA
Dick Hay	KHA
Nathan Adams	CHCA
Patrick R. Hubbell	CHCA
JOHN C. BOTTENBERG	KHA
Kevin P. Conlin	KCHS
Debbie Haynes	physicians (PMA)
Chip Wheelen	Assn of Osteopathic Med.
BILL BARKMAN	KU Hosp. Authority
Dan Buffett	"
Lyle Zeplick	Physician
Uzo Ohaebosim	
Ron Hein	HCA
DAVID NEVILL	Wesley Medical Center
Melissa Hunsperger	KHA
Rebecca Zeplick	Doctors for affordable KS
Jane Witt	Preferred Health Systems

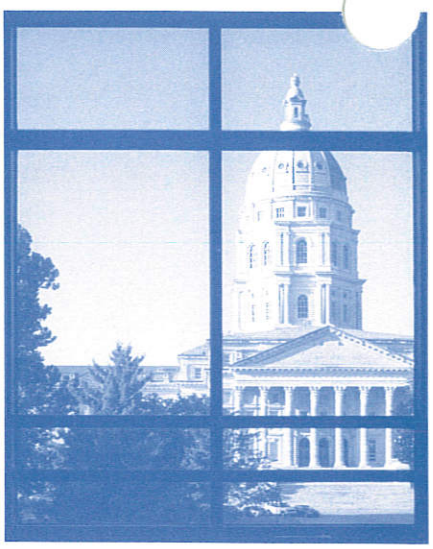
Senate
HEALTH CARE STRATEGIES

[redacted] [redacted] COMMITTEE GUEST LIST

DATE: March 2, 2005

NAME	REPRESENTING
Rebecca Bailey	KMS
Jenny Davis	Conlee Consulting
Mary Ellen Conlee	Via Christi Health System
Andy Allison	KHI
[illegible]	VISION 2000
[illegible]	KHI
Doug Smith	Ks. Medical Center
Terri Roberts	KSNA

NUMBER 15 • DECEMBER 2003



Issue Brief

KANSAS HEALTH INSTITUTE

The Growth of Specialty Hospitals in Kansas: What Effects Do They Have on Community Health Services?

Charles L. Betley, M.A.
R. Andrew Allison, Ph.D.

What are specialty hospitals?

Specialty hospitals provide services in a single medical specialty, such as cardiology or orthopedics. They can be distinguished from other facilities such as psychiatric, women's, and children's hospitals, which provide a broader range of services, and ambulatory surgical centers, which have few inpatients and do not focus on a particular specialty.

Results in Brief

This Issue Brief focuses on the growth of a new kind of health care facility that provides services in a particular specialty, such as cardiology or orthopedics, and the potential impact on the health care system in a community.

- There are nine specialty hospitals in five communities across Kansas, more than one would expect based on the nationwide total.
- The rapid growth of specialty hospitals is fueled by their profitability. The relative ease of establishing new hospitals in Kansas has contributed to their disproportionate growth here.
- Specialty hospitals threaten the revenue base that general hospitals have used to subsidize unprofitable health services such as 24-hour emergency room care, intensive care units, and care for the uninsured.
- Specialty hospital claims of higher quality services are intriguing, but have not yet been validated.
- Policymakers may have to weigh their desire for innovation and market-based solutions against the threat that specialty hospitals pose to the community health services provided by general hospitals. Avoiding this trade-off may require a more explicit source of funding for such services.

Specialty hospitals have appeared quickly in Kansas

Specialty hospitals are expanding rapidly in Kansas and in many states across the country. As of December 2003, nine specialty hospitals were operating in five communities across the state (See map on page 3), a surprising proportion of the 100-or-so specialty hospitals nationwide. All but a few specialty hospitals are located in states like Kansas that have no Certificate of Need (CON) regulations, which require hospitals to obtain state approval before building or expanding.

Profitability fuels the growth of specialty hospitals. Community general hospitals that provide a full spectrum of services are most commonly orga-

Senate Health Care Utilities Committee
Date: March 2, 2005
Attachment 1

nized as not-for-profit entities. Specialty hospitals, on the other hand, are usually for-profit firms, often with substantial investments by participating physicians. By focusing on procedures that offer higher payments from insurers, specialty hospitals are attractive to investors. High payments exist in part because Medicare, the federal health insurance program for the aged and disabled and the predominant payer for these types of procedures, may not be adjusting for changes in technology which have lowered the costs of services. Although general hospitals are also likely to be earning profits on these services, they have used these profits to cover the costs of unprofitable health care services that benefit the community, such as 24-hour emergency room care, intensive care units, and care for the uninsured.

Specialization and Quality

Specialty hospitals claim to offer high quality through newer facilities, better equipment, and specialization. To be sure, some patients will favor a new specialty hospital's amenities and location, but claims of higher quality care have not yet been validated. New specialty hospitals may have an opportunity to provide newer technologies than existing hospitals. However, newer technology does not always lead to an improvement in quality, and general hospitals can adopt these technologies as well.

Specialty hospitals also claim higher quality because of the notion that "practice makes perfect." Research confirms that experienced teams who frequently repeat procedures become more proficient, but both general and specialty hospitals can benefit from high volumes of procedures. It is unclear whether specialty hospitals' narrow focus on a specific set of procedures will lead to higher patient volume for these procedures as compared to a community's general hospitals. Moreover, even if higher volume did lead to better quality at a particular specialty hospital, the average quality of care in that community might decline if the newer hospital drew away cases that the specialist teams in general hospitals needed to maintain their skills.

Physician-owners of specialty hospitals have a financial incentive to refer patients whose conditions are less severe (which critics call "cream-skimming") to their hospitals. Because healthier patients are less expensive to treat and are more likely to have good outcomes, specialty hospitals can benefit from this selective referral both financially and in quality comparisons. The U.S. General Accounting Office found evidence that specialty hospitals benefit from selective referral, which casts doubt on the quality claims made by specialty hospitals and leaves the impression that there is an uneven playing field in the market for specialty patients.

Impact on Community Health Services

The threat posed by specialty hospitals to general hospital profitability is real, but is it a matter for public policy concern? The answer depends on the perceived value of the community services provided by general hospitals. General hospitals not only provide their communities with unprofitable health care ser-

Congress passes moratorium on new specialty hospitals

While this Issue Brief was in publication, Congress passed an 18-month moratorium on physician self-referrals to new specialty hospitals as a part of the Medicare reform and prescription drug bill. The legislation grandfathers existing specialty hospitals and those already under development, but prohibits grandfathered facilities from adding investors, expanding to other specialty categories, or increasing beds by more than 50 percent. During the moratorium period, two federal agencies will conduct analyses of the issue. This new legislation does not address immediate concerns about the impact of specialty hospitals in Kansas since no changes to Medicare payments and referral laws for existing facilities were included.

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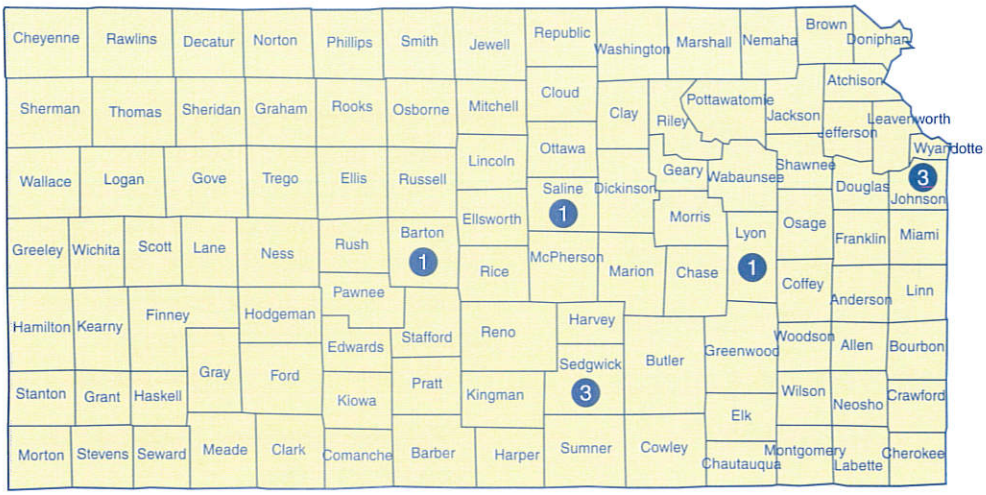
vic..., but also community health services like disease prevention screenings and health education. Many non-profit general hospitals care for the poor and underserved in fulfillment of their mission. For-profit general hospitals may also provide a certain level of charity care. General hospitals may benefit from the goodwill generated by providing such services, but the cost of providing them is implicitly subsidized by the margins earned on profitable health care services. The growth of specialty hospitals threatens the use of these implicit subsidies to fund community health services.

Specialty Hospitals in Kansas



Kansas Health Institute, 2003

In the communities where they exist, specialty hospitals already threaten these subsidies, but we do not yet know whether community services have been affected. The threat to general hospitals could lead some of them to develop strategies to compete with or pre-empt specialty hospitals. For example, they could change the way they operate surgical units, upgrade facilities or partner with physicians to build their own specialty hospitals. Their alternative is to try to scale back or find other sources of funding for the community services they provide. In communities where the threat has yet to emerge, policymakers may wish to maintain the system of subsidizing unprofitable services with overall profit margins within full-service hospitals. Maintaining this traditional method of financing community health services may require that policymakers raise barriers for specialty hospitals to make it more difficult for them to compete.

Policy Options

There are a number of responses to the emergence of specialty hospitals that policymakers could consider:

A. Wait and see.

Before taking any action, policymakers may want better information about the financial status and quality of care at general hospitals and specialty hospitals. These data may not be available for some time and could require additional reporting by hospitals of both types. In the meantime, federal reform of Medicare payments might reduce the relative profitability of specialty hospitals. If Congress does not step in, though, more specialty hospitals could be built.

B. Remove the conflict of interest for physician-owners of hospitals.

Another option for policymakers is to level the competitive playing field by removing the incentive physician-owners have to divert patients towards specialty hospitals. Medicare forbids physicians from referring patients to health care facilities in which they hold a direct investment, under provisions of federal law attributed to Representative Pete Stark (D-CA). However, the ban does not apply to physicians who have invested in hospitals. The Medicare reform and prescription drug bill recently passed by Congress temporarily extends the ban

1-3

"…he market-based innovation of specialty hospitals can be weighed against the threat they pose to the community services offered by general hospitals."

on physician self-referrals to new specialty hospitals (See box on page 2). Nevertheless, states could decide for themselves to make such a moratorium permanent and whether or not to extend the moratorium to existing facilities. Legislatures in Ohio, Illinois, New Mexico, and Washington, among others, have introduced legislation that would prohibit physician investment in specialty hospitals.

C. Require specialty hospitals to expand services.

Requiring specialty hospitals to provide broader emergency services or to meet some specified level of community or charity care would spread the costs for these services, but could also weaken any advantages that stem from specialty hospitals' narrow focus. The initial financial success of specialty hospitals has raised the question of whether it is more efficient for health care facilities to specialize or to provide centralized delivery of a wide range of health care services. Requiring specialty hospitals to broaden their mission could make it more difficult to answer this question.

D. Re-establish certificate of need requirements.

Another option for preserving critical community health care services is to reinstate a Certificate of Need (CON) process to regulate construction of new specialty hospitals. Kansas, among other states, eliminated CON in 1985 in favor of a market-oriented approach to the allocation of health care investments, patients, and profits. States that retained CON, such as Missouri, have a regulatory tool to limit the spread of specialty hospitals, and very few specialty hospitals have been built in those st… However, it may be difficult to limit the scope of CON to the specialty hospital issue, just as it may be difficult to insulate the CON process from undue political influence.

E. Provide direct financing for community health services.

Implicit subsidies within general hospitals are not the only way to finance community health services. Alternatives include increasing direct subsidies to hospitals for treating large numbers of poor and uninsured patients. Other options for ensuring access to critical health care services include expanding health insurance coverage and providing additional funding to local health departments for health care and community health services.

Conclusion

Specialty hospitals have made quick inroads in Kansas' relatively open health care markets. Claims of higher quality in specialized facilities have come up against fears that these new hospitals are disrupting the flow of health care dollars to critical health services. Policymakers must decide whether to take action to limit the impact of these hospitals in markets where they have already been built, and whether they should prevent their spread into new communities. The market-based innovation of specialty hospitals can be weighed against the threat they pose to the community services offered by general hospitals. To avoid this trade-off, policymakers may need to identify a more explicit source of funding for these services, a difficult proposition in the current fiscal environment.

KANSAS HEALTH INSTITUTE

The Kansas Health Institute is an independent, nonprofit health policy and research organization based in Topeka, Kansas. Established in 1995 with a multi-year grant from the Kansas Health Foundation, the Kansas Health Institute conducts research and policy analysis on issues that affect the health of Kansans.

KANSAS HEALTH INSTITUTE
212 S.W. Eighth Avenue, Suite 300
Topeka, Kansas, 66603-3936
Telephone (785) 233-5443
Fax (785) 233-1168
www.khi.org

NUMBER 15 • DECEMBER 2003

KANSAS HEALTH INSTITUTE

To: **Senate Committee on Health Care Strategies**

From: **Andy Allison, Director of Health Care Finance and Organization**
Jim McLean, Vice President for Public Affairs

Date: **Wednesday March 2, 2005**

The Kansas Health Institute (KHI) and the Kansas Department of Health and Environment have collaborated in designing a project to study the impact of specialty hospitals on health care markets in Kansas. The project requires collection of discharge data from specialty hospitals that do not already contribute that data to the state through the Kansas Hospital Association. The Health Care Data Governing Board has authorized the Secretary to collect the additional data required to support this study. The project is designed to compliment ongoing federal studies of specialty hospitals by the Medicare Payment Advisory Commission (MedPAC) and the U.S. Department of Health and Human Services (HHS). The need for this kind of study is explained in greater detail in the attached KHI Issue Brief (enclosed).

During a recent trip to Washington, D.C., members of the KHI staff who will help conduct the Kansas study met with the Executive Director of MedPAC, Dr. Mark Miller, and with one of the principle analysts for their study of specialty hospitals, Dr. Jeff Stenslund. They were able to provide some additional details about their study and recommended areas of focus in the study that we are planning for Kansas. They were optimistic that an intensive quantitative and qualitative study of specialty hospitals in Kansas would inform not only the ongoing policy discussions in our state, but those at the national level as well. In particular, they emphasized the value of the extended timeframe for our study (through at least calendar year 2003, compared to MedPAC's 2002 timeframe), our ability to undertake extensive site visits and interviews with a broad range of market participants, and our ability to incorporate data from all payers rather than Medicare alone.

We look forward to the cooperation of hospitals across the state in their submission of data required for the project, and to the analytic phase of our project, which will address four central questions about hospital markets in Kansas:

- How does the entry of specialty hospitals impact revenue and margins at community hospitals?
- How have specialty hospitals impacted the provision of unprofitable health services such as Medicaid, uncompensated care, and emergency room services?
- How does the entry of a specialty hospital impact market competition?
- How does the entry of a specialty hospital impact utilization at community hospitals and in the population as a whole?

MedPAC is scheduled to release its final report and recommendations relating to specialty hospitals sometime this month. Nevertheless, their key findings and recommendations have already been summarized at MedPAC commission meetings, and transcripts of these meetings are available online. Based on these transcripts and personal conversations with MedPAC staff, we summarize MedPAC's key findings and recommendations below.

212 SW Eighth Avenue, Suite 300, Topeka, Kansas 66603-3936 • Telephone (785)233-5443 • Fax (785)233-1168 • www.khi.org

Summary of findings and recommendations from MedPAC's study of specialty hospitals

MedPAC findings

- Physician-owned specialty hospitals may have *higher* costs per Medicare case than other hospitals, but these findings are not statistically significant.

  "One of the reasons that [these findings are] not significant is that…we are reaching back to the year 2002 for data on this, at which point there were relatively few specialty hospitals…[and so] we don't have a strong analytic foundation on which to base a judgment about efficiency." *Glenn Hackbarth, MedPAC Chair*

- Within the Medicare patient population, specialty hospitals were found to concentrate on procedures that are relatively more profitable than the average, and within those DRGs, on patients who are relatively more profitable than the average, i.e., patients who have a relatively low level of severity.

- Specialty hospitals tend to treat lower shares of Medicare patients than other hospitals.

- Within the limited timeframe and national scope of MedPAC's study, specialty hospitals were not found to have had a negative financial impact on community hospitals.

- MedPAC's study did not address the relative level of quality in specialty v. community hospitals. However, qualitative information obtained from site visits indicates that:

  "The entrant of a competitor hospital, a specialty hospital, had a constructive aspect on the community hospital and encouraged them to make appropriate and good changes in how they operate." *Glenn Hackbarth, MedPAC Chair*

MedPAC recommendations

- The Secretary of HHS should modify base Medicare payments to all hospitals to more fully capture differences in severity in illness, thereby reducing the gains to physician-owned hospitals in treating low-severity cases.

- The Secretary should change Medicare payments to all hospitals to so that high-cost hospitals are not rewarded with higher base reimbursement rates.

- Congress should change the way that unusually high-cost "outlier" cases are reimbursed under Medicare to limit undue variation in the profitability of certain types of procedures.

- Congress should grant the Secretary the authority to allow gainsharing arrangements between physicians and hospitals to provide physicians with a financial incentive to work with hospitals to reduce costs without distorting the physician referral process.

- To prevent growth in the specialty hospital industry while Congress and the Secretary act on these sweeping payment reforms, Congress should extend the Medicare specialty hospital payment moratorium by 18 months until January 1, 2007.

KANSAS HOSPITAL ASSOCIATION

Thomas L. Bell
President

To: Senate Health Care Strategies Committee

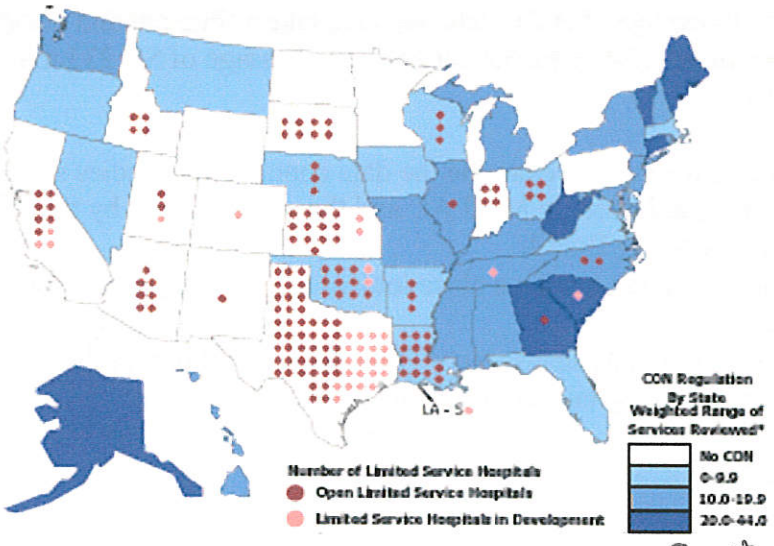
From: Kansas Hospital Association
Thomas L. Bell

Re: SB 235

Thank you for the opportunity to comment in support of SB 235. This bill would enact a one-year moratorium on the establishment of new hospitals in Kansas. Attached to our testimony is a recent study prepared for the American Hospital Association and the Kansas, Colorado, Nebraska and South Dakota hospital associations by McManis Consulting which looked at the impact of limited service hospitals in four Midwest cities.

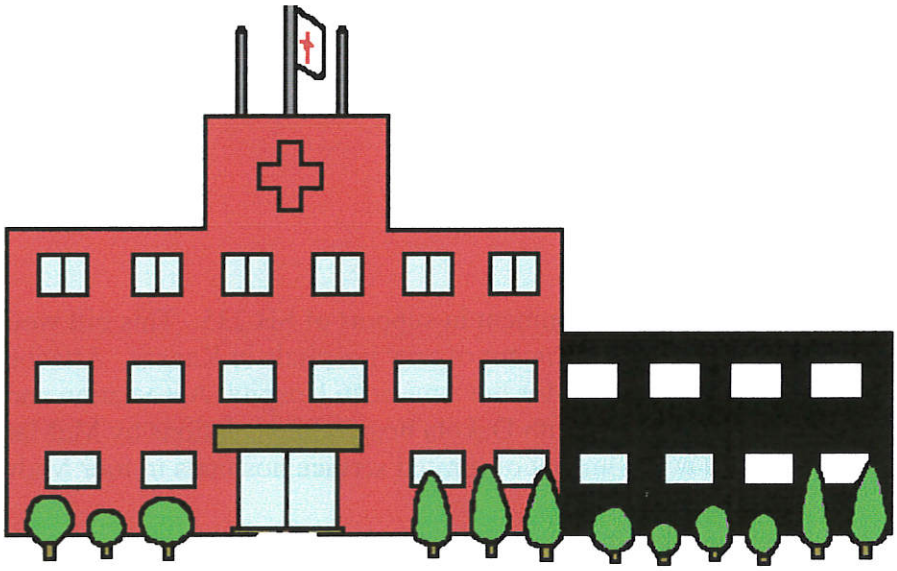
There are really two issues before the committee. One is immediate – whether Kansas should adopt a short-term moratorium on new hospitals. The other is broader and more long-term – what should be the policy of the state of Kansas on protecting the health care safety net in light of the proliferation of limited service hospitals. Our testimony today will necessarily discuss both issues.

As the map below demonstrates, Kansas has seen the development of more than its share of limited service hospitals.



Senate Health Care Strategies Committee
Date: March 2, 2005
Attachment 2

This phenomenon is the result of a combination of Medicare payment incentives and lax state licensure laws. These limited service hospitals essentially "carve out" more profitable services, leaving the less, well-reimbursed services for the full-service community hospital. In the following diagram, the part of the hospital that is "in the black", or performing more well reimbursed services, is essentially subsidizing the part of the hospital that is "in the red", or performing less well reimbursed services. If the services that are "in the black" are carved out, it makes it much more difficult for the entire hospital to continue offering services that are "in the red."



The federal government has expressed its concern about this phenomenon. As part of the Medicare prescription drug legislation, Congress adopted a federal moratorium on new limited-service hospitals, which expires this June. MedPAC, Medicare's payment advisory commission, is currently finishing up its study and will soon be making recommendations to Congress.

SB 235 would allow Kansas to enact its own moratorium on the establishment of new hospitals in Kansas. In essence, SB 235 lets our state take a time out and decide about the long-term implications on state health care policy. Passage of SB 235 makes sense for a number of reasons:

- It allows the state to examine the data contained in studies such as the one recently conducted by MedPAC and the one proposed by the Health Care Data Governing Board;
- It allows Kansas to take a close look at the shortcomings of our licensure law;
- It does not require Kansas to rely on the possibility that the federal government may take action in this area.

Thank you for your consideration of our comments.

Unintended Consequences
Testimony before Health Care Strategies Committee
March 2, 2005

My name is Dr. S. Edwards Dismuke. I am dean of the KU School of Medicine in Wichita. I would like to speak in favor of Senate Bill 235, which proposes a moratorium on establishing certain hospitals prior to July 1, 2006.

Our experience at the school has been that the creation of limited service hospitals in Wichita has had an adverse effect on funding our residency programs. We feel that a new limited service hospital in Andover will have additional adverse effects on our residency training programs.

Why should this Committee and the State Legislature be concerned? Because we train a large number of new doctors for Sedgwick County and much of Kansas. If our residencies are hurt, our ability to train doctors for Kansas could be jeopardized. A recent study from the Association of American Medical College recommends increasing medical students and residents by 15% by 2015. We are worried about maintaining our current numbers, much less supporting increased numbers. Also, our residents and residency faculty care for a large number of uninsured patients in Sedgwick County. For instance, our physicians care for almost all of the 2300 uninsured hospital stays in Sedgwick County each year and over 50,000 uninsured outpatient visits which is about 1/3 of all uninsured outpatient visits in town. If we cannot adequately fund our residency programs we will not be able to provide this level of service for the uninsured.

Explanations:

- We are talking about residents and NOT medical students. Residents have their M.D. degree and are licensed to practice medicine and receive salaries. The Legislature funds the medical school primarily to educate medical students as they obtain their M.D. degree.

- Expenses for residency training (graduate medical education – GME) in Wichita are about $38 M/year for 250 residents, plus the faculty and staff involved in their education. About $25 M of this comes from federal sources outside the state. Only $2.6 M of this amount is state general use funding that is given to the medical school. Most of this $38 M comes through Via Christi and Wesley hospitals where our residency training occurs.

- When Medicare and privately insured patients are diverted from Via Christi and Wesley hospitals to limited service hospitals, the money available for residency education is greatly reduced. In fact, over the past four years, residency education expenses have steadily increased above revenue and this change correlates with the growth of limited service hospitals in Wichita.

Senate Health Care Strategies Committee
Date: March 2, 2005
Attachment 3

- One of the major underlying problems with financing health care delivery is inequity of payments based on the DRG system implemented by Congress several years ago. In that system, reimbursement for cardiovascular surgery, for example, significantly exceeds cost. That happens for a small number of conditions/disorders. In most cases, reimbursement levels don't cover actual costs. For our current, extremely imperfect system to work, hospitals must pair the few profitable areas with all the unprofitable areas. We must have the profitable areas pay for things like the care of the uninsured and for residency training. Cross subsidization is required because our financing system is not very good.

  What is happening in Wichita and now possibly Andover is that businessmen are uncoupling profitable businesses from unprofitable businesses. The problem is that the larger community is stuck with unprofitable health care delivery. The victims are the uninsured and our residency programs.

- Limited service hospitals rarely take care of large numbers of uninsured patients or Medicaid patients. They generally care for the small segment of patients where reimbursement and profits are high, such as, cardiovascular surgery and orthopedics.

What do I want from the Legislature?

1. Passage of Senate Bill 235. A moratorium on building new non-critical access hospitals for one year until Medicare and the federal government can deal with this issue.

2. The hospitals and the medical school in Wichita need all the help we can get in caring for uninsured and underinsured patients. This is a growing community-wide crisis. We desperately need help in providing health care for these people. What we don't need is for the few profitable areas of medicine to be decoupled from the many money losers.

Testimony on SB 235
Health Care Strategies Committee
Presented by David S. Nevill
President and CEO, Wesley Medical Center
March 2, 2005

Madame Chairman, Members of the Committee:

My name is David Nevill and I am the President and CEO of Wesley Medical Center, located in Wichita, Kansas. Wesley is a general, acute care hospital licensed for 760 beds and affiliated with the University of Kansas Medical School – Wichita. Wesley provides a comprehensive range of medical services to south central Kansas with more than 5,000 births a year, 60,000 emergency and trauma visits, 26,000 inpatient admissions and 170,000 outpatient visits. Wesley supports the education and training of more than 100 doctors, several hundred nursing students, and over a hundred other health care professionals each year. Approximately 40% of Wesley's patients have commercial insurance, 38% have Medicare; 19% have Medicaid and 3% have no insurance. Wesley is owned by HCA, Inc., the nation's leading provider of health care services, with over 190 locally managed hospitals, including four in Kansas – Allen County Hospital, Menorah Medical Center, Overland Park Regional Medical Center, and Wesley Medical Center. Together we have over 1,300 licensed beds, employ 4,500 Kansans with an annual payroll of $182 million, provide $31 million of uncompensated care; and pay nearly $11 million in state taxes annually.

HCA, Wesley and I support the passage of SB 235 for several reasons. This is a complex issue, so I apologize for trying to provide a little background information to help elucidate it.

In many communities, like Wichita, some physicians are exploiting a loophole in federal law, and own limited-service "hospitals" to which they refer their own patients. This activity raises serious concerns about conflict of interest, fair competition, and whether the best interests of both patients and their communities are being served, or abused.

Since 1997 there has been a 364% increase in the number of limited service facilities – and I want to make the distinction clear. These are <u>not</u> full service hospitals open to the general public with emergency rooms, labor and delivery rooms, or cancer services. They are glorified single specialty surgery centers focused on a narrow range of the most profitable services (cardiology, surgery, orthopedics) offered to an even narrower group of low risk, well insured patients. Page 2 of the handout demonstrates the proliferation by state, with 17 in Kansas.

Due to a well documented pattern of over utilization and abuse, congress enacted prohibitions in 1989 and 1993 to prevent physicians from referring their patients to facilities they or their family members own. As shown on page 4, the "whole hospital" exception to these laws was also created. This exception is the loophole that is being exploited in Wichita by the Kansas Heart Hospital, Galichia Heart Hospital, Kansas Spine Hospital and Kansas Surgery and Recovery Center. Physician owned limited service facilities have been shown by the Government Accountability Office, MedPAC, McManis Consulting and the Lewin Group to cherry-pick the least sick and most profitable patients, provide little or no emergency services, increase utilization and costs, and damage full service hospitals leading to cutbacks in services. Some of these findings are represented on pages seven through twelve of your handout.

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When these physician owned entities open, several things happen almost immediately; physician owners redirect their patients (page 13); physician owners make huge profits – 30 to 35% margin in their first year (pages 14 and 15); and community hospitals suffer financially, bearing all the burden for Medicaid and uninsured patients, with fewer resources to serve the community and subsidize essential, yet unprofitable services (page 16).

Physician owners "double-dip" by getting paid for the procedures they perform and for their investment. As shown on page 15, the net profit to physician investors for their referrals can be $5,000 profit per referral. Community hospitals can be convicted of fraud if the value of non-monetary compensation to a physician exceeds $300 per year or is in any way related to their referrals. If it is unethical and illegal for physicians to own and refer to their own laboratories, x-ray centers, and a host of other services, how can it be legal for them to refer to their own hospitals? The answer is simple – it isn't. But the loophole has to be closed and the self-referral laws have to be enforced.

In January, 2005, the MedPAC commissioners unanimously voted to extend the current federal moratorium on specialty hospitals until January 1, 2007. If this recommendation is not passed into law before June 18, 2005, SB 235 will become very important. SB 235 is a safety valve to temporarily hold the development of any new hospitals in Kansas for one year. This moratorium will give the Kansas legislature time to study the impacts of this burgeoning trend on Kansas and decide whether it is good or not for our citizens and state. MedPAC's final recommendations are scheduled to be released on March 8, 2005. Hopefully a statute will be enacted to permanently close the loophole, or extend the moratorium at a minimum.

The information and case studies you have been given provide a factual and convincing account of this issue. Further proliferation will lead to increased utilization and costs, unfair competition, and damaging consequences to the safety net of community hospitals which serve our state.

This issue is not about patient choice or options, free enterprise or economic development, fair competition or the evolution of the health care delivery system. This issue is about profitability and greed for the wealthiest one or two percent of our state and nation.

For competition to be effective, it has to be fair, on a level playing field, and free from conflicts of interest. This is why HCA, Wesley and I support SB 235 and a permanent ban on physician self-referral behavior. I would like to close with these three points:

1. The general public understands the importance of preserving health care in their communities. They expect and deserve medical services 24/7.

2. It is unfair competition for doctors to exploit a loophole, make huge profits, and betray the trust their patients and colleagues have placed in them.

3. We strongly oppose the conflict of interest that results when a physician is an owner and controls patient referrals. Self-referral is bad medicine and our community, state and nation cannot afford the consequences.

I urge you to support the passage of SB 235. It will help preserve care, promote fair competition and prevent the proliferation of conflict of interest until a federal solution is in place.

Thank you for allowing me to testify today. I will be happy to answer any questions.

THE CASE FOR A PERMANENT BAN ON PHYSICIAN-OWNED LIMITED SERVICE FACILITIES and SENATE BILL 235

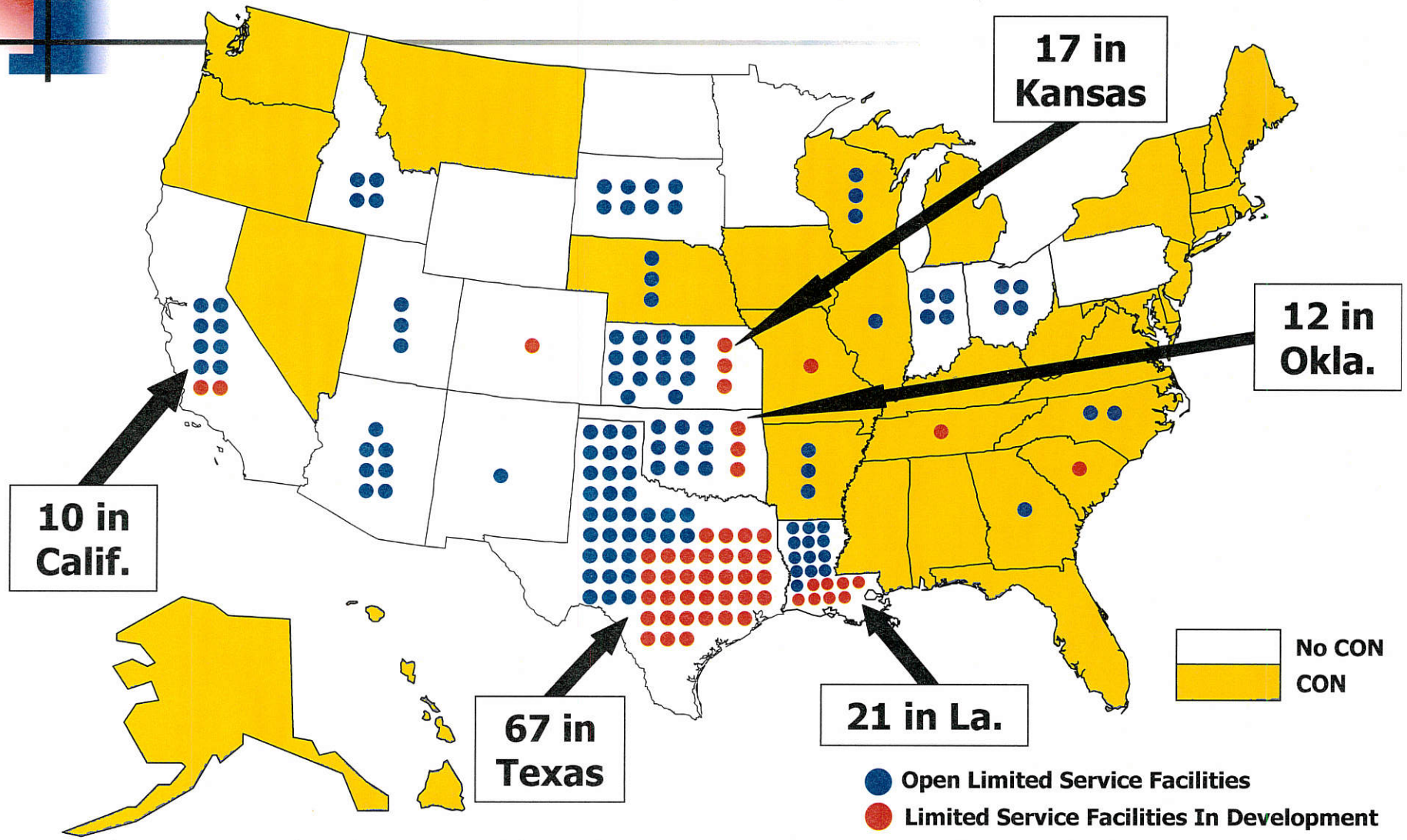
David S. Nevill

President & CEO, Wesley Medical Center

March 2005

4-3

Proliferation of limited service facilities primarily in non-Certificate-of-Need states



SOURCE: The Lewin Group analysis of American Hospital Association state survey data, 2004; American Health Planning Association, *National Directory of Health Planning, Policy and Regulatory Agencies*, Fifteenth Edition: February 2004

Why physician self-referral bans were created: the origin of the "Stark Law"

- As a response to studies which showed an unmistakable relationship between over-utilization of services and self-referring physician ownership
- To prevent inherent conflicts of interest
- To ensure patient interests were not compromised by a system that rewards physicians on a "double-dipping" basis

Why the "whole hospital" exception was created

- To allow physicians to refer patients to hospitals in which they have an interest, as long as that investment is in the entire hospital
- Intended to apply to 200- and 300-bed full-service community hospitals, not 20- and 30-bed hospital department carve-outs

Physician-owned, limited service facilities are **NOT** whole hospitals

- They are essentially hospital departments, which offer only the services their physician investors can provide *(e.g. cardiology, orthopedics, general surgery, etc.)*
- Typically, they do not provide full-service emergency departments
- Some physician owned facilities operate with less than 5 beds, allowing them to circumvent existing outpatient, self-referral prohibitions
- They frequently transfer out acutely ill or problematic cases to community hospitals because they cannot provide the more complicated and critical care services

IG studies found direct correlation between physician self-referrals and over-utilization of 10 healthcare services

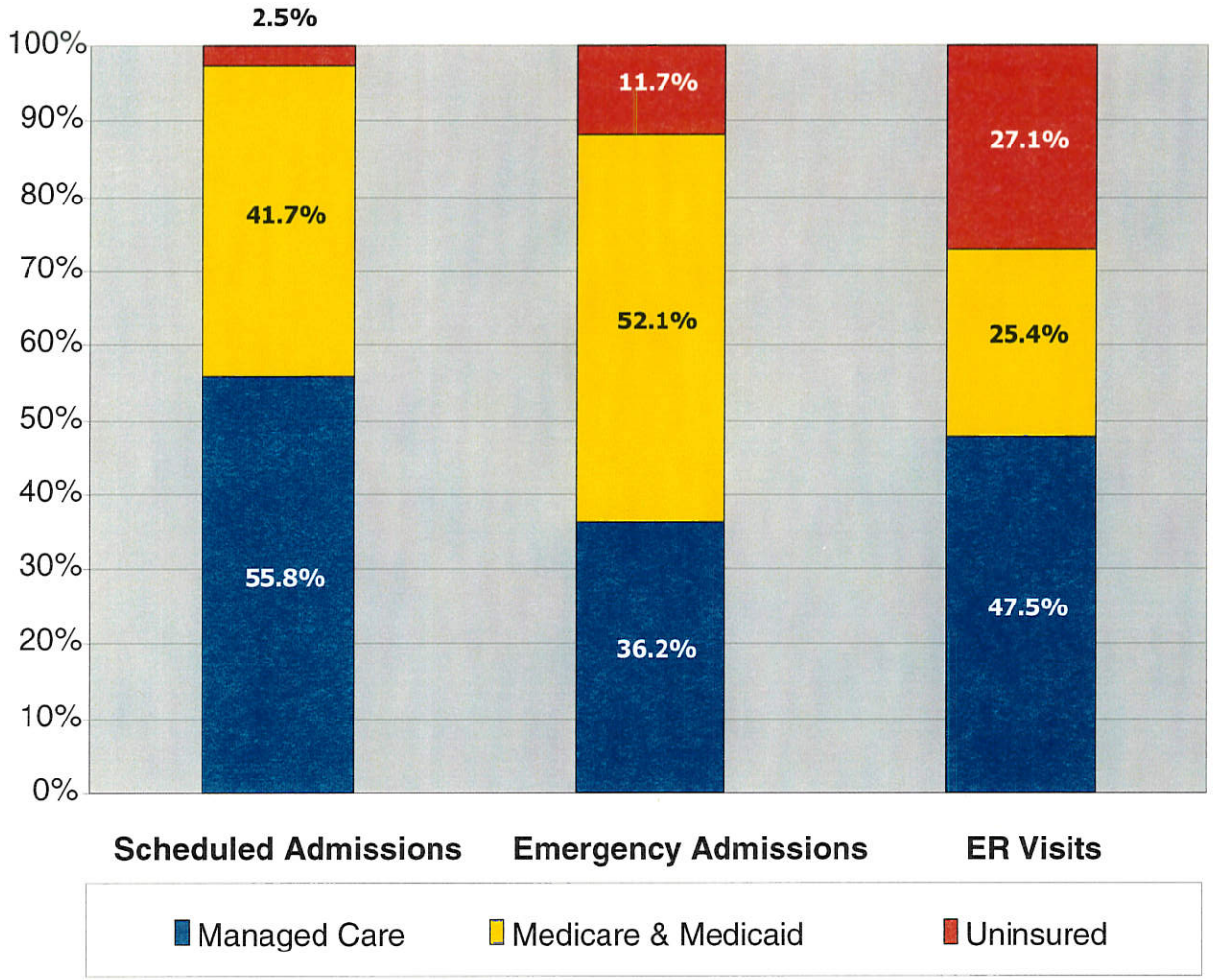
- Lab over-utilization of 45%!
- Similar over-utilization of physical therapy, home care, etc.
- "If it's unethical for doctors to refer to their own labs, why should they be able to refer to their own hospitals?"

GAO findings identified concerns with physician-owned limited service facilities

4-9

- "Much less likely to have emergency departments."
- "Treated smaller percentages of Medicaid patients."
- "Treated a lower percentage of patients who were severely ill."

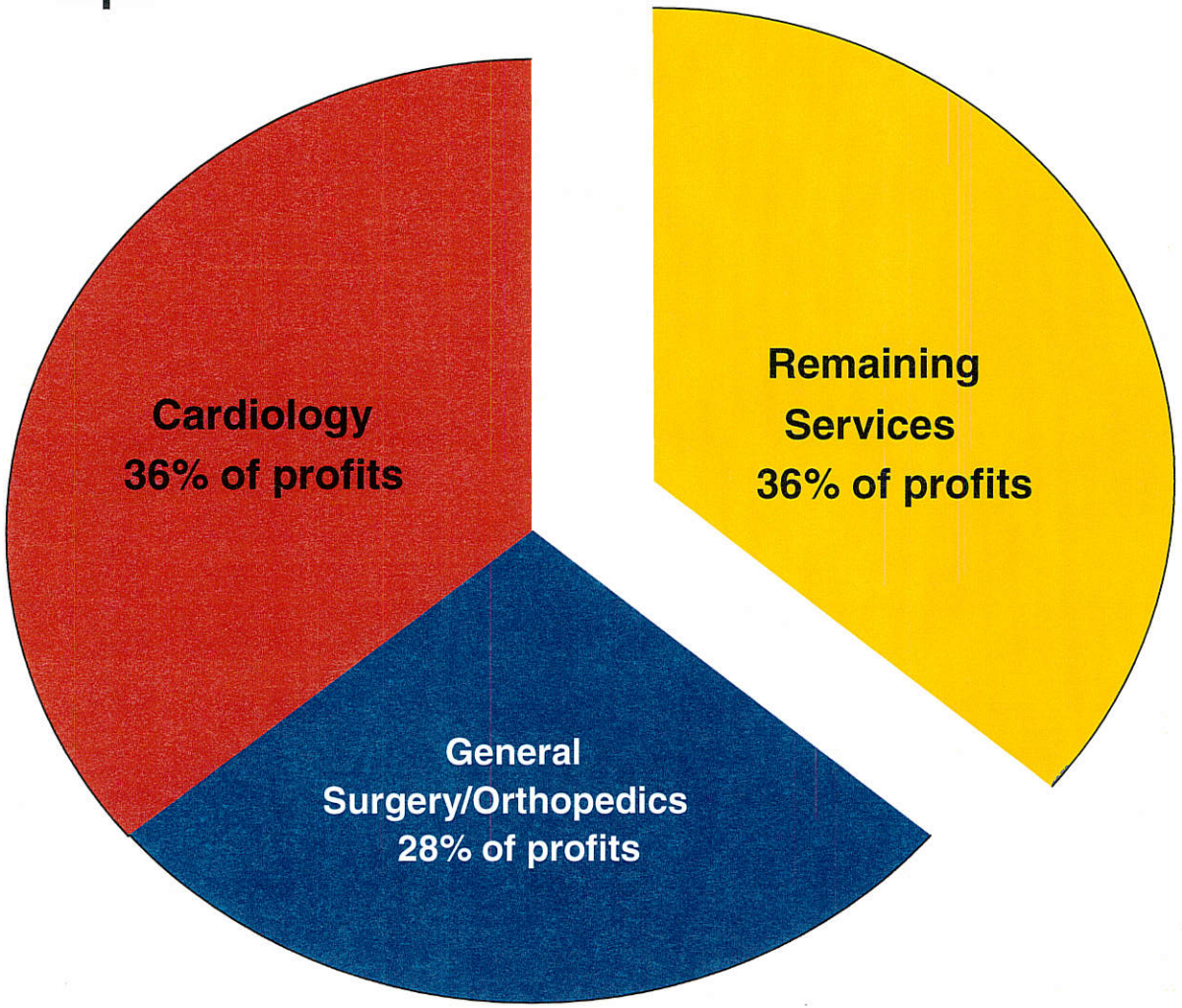
Physician-owned, limited service facilities are designed to exclude uninsured patients



- Majority of uninsured and Medicaid patients come to community hospitals via emergency rooms
- Physician-owned facilities do not have:
  - *Trained ER M.D.s & nurses*
  - *Partnerships w/ EMS*
  - *Intensive care capabilities*

Source: HCA Houston Market

Physician-owned, limited service facilities cherry-pick the most profitable services



- 64% of inpatient profits come from cardiology, general surgery & orthopedics
- Most MD owned hospitals offer these services exclusively
- Lower profit & money losing services like obstetrics, trauma, etc.

Source: HCA Houston Market

4-12

MedPAC's early findings

- "Physician-owned, limited care facilities had 'much lower' (1%-4%) shares of Medicaid patients than community hospitals (15%-16%)."
- "Physicians with admitting privileges at both the community hospital and their own specialty hospital have a financial incentive to fill their hospital with better paying patients and 'steer' unprofitable patients to the community hospital."

MedPAC's early findings

- "The majority of specialty hospitals we visited did not have emergency rooms."
- "The specialty hospitals we visited that had ERs appeared to treat very few emergencies and, as a result, retained control of their patient mix."
- "One of the (specialty hospital's) ER was clearly not a fully functional service – the lights had to be turned on to show us what appeared to be a rarely-used room."

4-13

Most physician-owned, limited service facilities don't have true ERs

"Structurally, there is an ED department, however, we will not pursue a public ER, and we will not be tied into an EMS system."

-- Patricia Porras, President & CEO
Austin Surgical Hospital

Westlake Newspaper: July 31, 2003

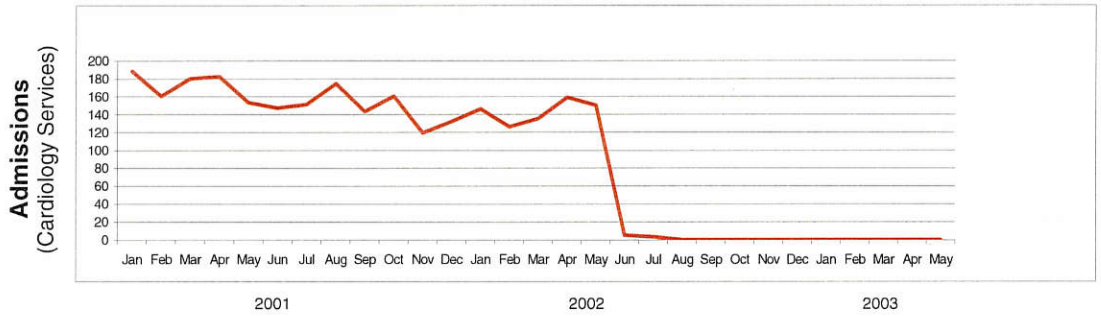
Market share moves before proof of quality

4-15

Oklahoma City, Oklahoma
Oklahoma University Medical Center

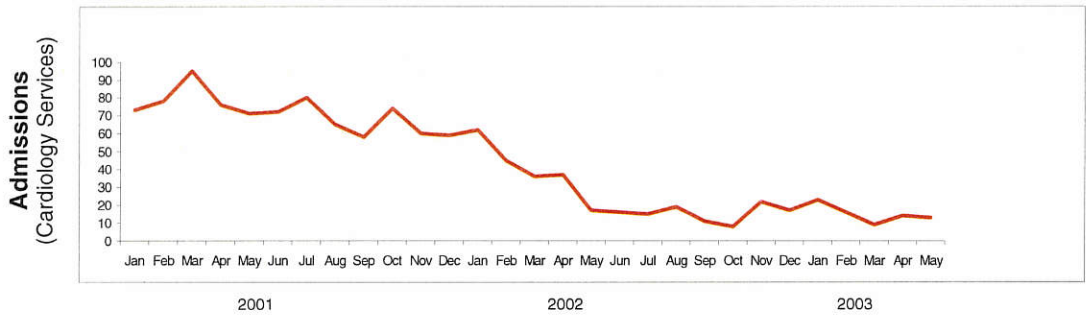
Specialty Hospital: Oklahoma Heart Hospital- Opened Summer, 2002

Inpatient Cardiology Services - Physician Investors



Wichita, Kansas
Wesley Medical Center
Specialty Hospital: Galicia Heart Hospital - Opened Winter, 2001

Inpatient Cardiology Services - Physician Investors



- Market share as a rule moves slowly and incrementally in hospital business
- With physician investors, it moves in large blocks
- Business moved for physician investors, but not for non-investors

Integris Baptist (full-service) compared to Okla. Spine Hospital (physician-owned)

4-16

Bed-Size	Medicaid Mix
Baptist: 548	Baptist: 19%
Spine: 18	Spine: 0%

Medicare Mix	Profit per Bed
Baptist: 41%	Baptist: $71,000
Spine: 11%	Spine: $1 Million!

Source: Integris Health and *The Journal Record*, Oklahoma City, June 2004

4-17

The ultimate un-level "playing field"

Kansas Heart Hospital

Net profit for physician referral → $5,000.00

In essence, profit per referral

Average Community Hospital

Non-monetary compensation limit per physician per year → $300

Deemed fraud if compensation in any way related to value of referrals

Some insurers (Blue Cross of OK and KC) concerned about physician-owned limited service facilities

4-18

- Leave community hospitals w/ Medicaid, indigents
- Siphon off financially rewarding services, forcing community hospitals to raise prices on remaining services
- Duplicate existing capacity and lead to "supply-induced" demand
- Jeopardize community safety net services
- "Their claims (cost savings, efficiency, etc.) are short-sighted and don't take into account the results of their actions on a community-wide scale."

4-19

What we ask for Nationally and in Kansas

- Enforcement of the Stark Law's prohibition on physician self-referral for any entity other than a true whole hospital
- Close this loophole forever
- Support SB 235 to protect Kansas while a federal solution is enacted

Testimony in Support of SB 235
Presented to the Senate Health Care Strategies Committee
By Kevin P. Conlin, President & CEO, Via Christi Health System

March 2, 2005

INTRODUCTION

I am Kevin Conlin. I serve as the President & CEO of the Via Christi Health System. I am here to support SB 235. I'd like to first describe Via Christi Health System and the role it plays in health care in Kansas, answer why we support SB 235 and finish by offering a perspective on free enterprise in health care.

ABOUT VIA CHRISTI HEALTH SYSTEM

The Via Christi Health System owns and operates eight hospitals, co-owns three hospitals, co-owns one specialty hospital, a number of senior housing facilities, numerous outpatient diagnostic treatment centers and a health plan in locations in Kansas, Oklahoma and California. Most of these activities are located in Kansas.

We are the largest health care delivery system in Kansas and we treat more Medicaid patients than any hospital entity in the state.

Not only do we provide services in the five cities where we operate hospitals but we serve all of Kansas by operating:

- The only verified burn unit between Denver and Kansas City
- The only heart and kidney transplant programs between Denver and Kansas City
- The primary referral center for AIDS patients in Kansas
- A Level I Trauma Center, that last year treated 1,200 patients from outside Sedgwick County
- A Level III NICU, that treated infants from throughout the state
- The primary inpatient behavioral health facility for much of the state
- One of the nations largest GME programs in association with University of Kansas School of Medicine – Wichita, which has placed family physicians in two out of three counties in Kansas

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- These programs share the following characteristics:
    - They are complex clinically and they lose money for our organization
    - They are not the only services that we offer that lose our organization money and which benefit all residents of the state of Kansas
    - Last fiscal year, the unreimbursed cost (please note that these are actual costs, not inflated charges) to Via Christi Health System of charity care, unpaid Medicare and Medicaid, health professional and GME Education and other various community benefits approximated $100 million in Kansas.

- Please hold these thoughts as I explain our position on SB 235

OUR POSITION ON SB 235

We support SB 235 because we oppose the proliferation of any facility that takes revenue from those health care organizations, like ours, that exist to serve the needs of an entire population regardless of ability to pay. We specifically oppose the development of the Kansas Medical Center in Andover because it will retain its profits for its shareholders and not return them to the community, the state or organizations like ours who offer needed but money losing services.

The proliferation of such facilities directly compromises the Via Christi Health System's ability to continue to provide unique clinical services and to provide the same level of charity care and other forms of community benefit that I outlined previously. Said differently, to allow these facilities to grow unchecked permits a further erosion of profitable cases from our organization. That lowered profitability reduces the funds we have available to operate the money losing services. With less money to fund such services, we will have no choice but to either reduce or eliminate these or ask the state or other government entities to reimburse us for our costs.

A reasonable question of us at this point would be "How can you oppose the proliferation of carve out facilities when you co-own one?" Our answer is simple: our co-ownership of the Kansas Surgery and Recovery Center produces profitability that is applied directly to the costs of other unique programs that we offer that lose money. We think this is a partnership model with physicians that works, is good for patient care, keeps costs down and returns funds that allow us to pay for services that residents of this state need.

By contrast, the proposed Andover facility will not return funds to offset the losses of our behavioral health program, or any other money losing service offered in the state. Those funds are diverted from the system and will land in the pockets of a small number of investors for their personal enrichment.

I hear that our motives in this matter have been labeled "protectionistic" of our interests. They are protectionistic, but with an important condition and that is we're attempting to protect a revenue stream that will allow us to fund those needed services and programs that I mentioned earlier.

MATTER OF FREE ENTERPRISE RELATING TO HEALTH CARE

As you study this bill, I understand you are considering the effect traditional market forces have on health care and specifically the concept that there is benefit in free enterprise in health care. A facility, such as that proposed in Andover, seems an enticing way to further permit free enterprise in health care. I offer two responses to that idea.

First, I understand one goal of free enterprise is to provide a platform for growth.

From everyone I speak with on the subject of health care, from patients to government officials to business leaders to insurers, I hear that each wants anything but growth in health care because growth in health care means a growth in health care costs. You likely saw the results of a survey conducted by the Kansas Chamber of Commerce earlier this year that reported that the single top concern of all businesses in Kansas is the rapid growth of health care costs.

This is so for one single reason: the growth of health care resources is a growth in the expenses for business.

Second, free enterprise requires a free market. Health care delivery does not operate in a free market.

A free market does not have the government as a customer for approximately half of the goods or services it offers. A free market does not have the government setting prices for the services it purchases and strongly influencing the prices that other purchasers pay.

A free market does not have one set of rules for certain competitors and another set for other competitors. To that end, as an executive of a full service hospital system, I would be placed in a federal penitentiary for enticing physician referrals by way of certain financial incentives. The laws today permit financial incentives to those who operate these competitive facilities.

We welcome the competitive forces of free enterprise, but we ask that we be allowed to compete on a level playing field.

The federal government is today considering several important measures that would level the playing field. It's because of the fact that we anticipate some guidance from MedPAC and Congress on how the competitive field might get better leveled over the next several months that we're requesting your support of the moratorium on new hospitals.

The proliferation of these facilities introduces new costs to businesses and to the government that must tax business and individuals to fund these increases in health care costs. I have difficulty seeing where this type of growth is good for free enterprise and the businesses that operate in our free enterprise system.

To: Senate Committee on Health Care Strategies

From: H. William Barkman, M.D., MSPH
Chief of Staff
The University of Kansas Hospital

Re: Senate Bill 235

Date: March 2, 2005

I appreciate the opportunity to provide comments in support of Senate Bill 235, which would impose a one-year moratorium on the establishment of new hospitals in Kansas. The moratorium would allow time for the completion and review of all state and national studies evaluating the effects of physician-owned limited-service hospitals on the health care system.

By way of introduction, I am a physician certified in internal medicine and pulmonary and critical care medicine. I am also Chief of the University of Kansas Hospital's medical staff and am on the faculty of the University of Kansas School of Medicine as Director of the Center for Environmental and Occupational Health.

As a physician in practice since 1980, I understand the financial pressure many physicians are under, especially as Medicare and Medicaid physician reimbursement has not kept up with simple inflation, let alone the rising costs of practicing medicine. Starting next year, for example, Medicare payments to physicians are scheduled to be cut an average of 5 percent each year for the next seven years. Medicaid, as you know, pays physicians even less.

I also understand the appeal of 30 percent-plus profit margins, which is what at least one Kansas limited-service facility posted in three consecutive years. Those numbers contrast sharply with the revenue crunch physicians have been under in the era of managed care.

But as a physician and chief of a medical staff, I am concerned that the negative effects of these limited-service facilities on health care in general far outweigh the profit potential they offer their physician owners.

Limited-service facilities exist because of an exception in federal law that otherwise prohibits providers from billing Medicare or Medicaid for designated health care services referred by physicians who have financial relationships with or ownership in the providers. The prohibition includes inpatient and outpatient hospital services, but there is an exception for ownership in "whole hospitals," which was intended to allow physicians a stake in general hospitals – not just certain departments. The unintended consequence of the exception was the birth of physician-owned limited-service hospitals.

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I realize the exception is in federal law, but the reality is that the result is undeniably a state issue. Kansas is one of seven states where these limited-service facilities have clustered, primarily because of accommodating licensure laws. While many of these facilities are in the Wichita area, others are located elsewhere in the state, including some on the Kansas side of the Kansas City metropolitan area. A recent American Hospital Association study demonstrated that health care costs and utilization have gone up in communities with limited-service hospitals.

The advantage these facilities offer their owners is the ability to select well-paying patients and concentrate on profitable procedures.

Limited-service hospitals typically concentrate on DRGs with the most profit potential – cardiac, orthopedic, and surgical procedures, primarily. Limited-service hospitals also focus on elective care, typically do not have emergency rooms, and treat few if any Medicaid or uninsured patients.

That's called cherry-picking. Even leaving aside the ethics of how some patients come to be referred to one facility rather than another, remember that full-service hospitals end up on the short end. We will not turn anyone away in his moment of need, and we provide a full range of services, many of which may lose money. Full-service hospitals like ours can afford to offer services such as trauma care, burn units, and neonatal intensive care units because we also perform more profitable procedures. It is a balance that allows us to care for the sickest patients and to be prepared to react to any change in level of care. Limited-service hospitals essentially perform only profitable procedures.

S.B. 235 simply would call a time out on the development of any new hospital – not just limited-service, physician-owned facilities – for one year, which would allow Kansas to make a fully informed decision on how to proceed. It is a reasonable step to take, and I urge you as public policy leaders and health care purchasers to adopt it.

Serving all patients and providing a full range of services is part of the University of Kansas Hospital's mission, and we embrace it. We believe all Kansans deserve high-quality care, and we are concerned about anything that threatens the ability of full-service hospitals to fulfill their missions.

Thank you for your consideration of my comments.

SB-235

My name is Larry Anderson. I am a family physician in Wellington, Kansas. I grew up in Williamsburg, Kansas down in Franklin County with high school friend, Joel Weigand. Joel and I wound up at K-State together, and although we went different routes from there, we both completed our military service, medical school training, and our family practice training at the same time and moved our families to Wellington, Kansas where we established the Sumner County Family Care Center in May 1976, 29 years ago this year.

We immediately started taking care of patients of all ages, delivering babies, covering the emergency room, even making an occasional house call, and we were excited, pleased and proud to be doing what we were doing. However, it became immediately clear to us that the health care system had too many **wrong incentives.**

Every time a physician sees a patient, he or she is faced with several ethical dilemmas. The first dilemma, of course, is do I as a physician know what is going on with this patient? If I do not know exactly what is going on with this patient, do I have the ability and medical resources either in my office or in my hospital, to develop an appropriate plan for diagnosis and treatment of this patient? If the answer to either of those questions is no, then it is a physician's duty to help arrange an appropriate referral or consultation with a physician and/or a facility that can provide the patient what he or she needs. The next dilemma faced by the physician is billing for the services the physician may provide. And if that patient truly needs diagnostic testing, where should that diagnostic test be performed? For decades, physicians have talked about being either cognitive "thinking" physicians or procedural "doing" physicians. As a family physician, I do a lot of thinking about my patients, but I happen to do a lot of procedural things as well. The classic cognitive physician would be the internal medicine specialist who takes care of adult men and women, really does not have any procedure that they do as compared perhaps to the general surgeon who makes most of his/her income by doing procedures. In the last few years, we have seen a third group of physicians that I have labeled the technology invested physician. These physicians come from both cognitive and procedural arenas as we see more and more internists and family physicians with ownership in diagnostic labs or orthopedic surgeons with ownership in MRIs. We now come to the pinnacle of technology investment with physician ownership in single specialty limited service hospitals.

The medical profession and insurance companies have known for years that if a doctor owns a piece of equipment, they are going to use that equipment, and in fact, they are going to overuse it. Studies published in the *New England Journal of Medicine* in 1990 showed that across 8 different specialty groups, the presence of x-ray equipment in a doctor's office promoted a 400% increase in the use of x-ray studies. In other words, if you went to a doctor who had an x-ray machine in his office, you were 4 times more likely to get an x-ray than if the doctor did not have an x-ray machine. These studies showed that the outcomes of both groups of patients was the same. That same type of study has been done regarding physician ownership in MRIs, and again ownership is associated with a 400% increase in utilization of MRI equipment.

In the 1970's, this country spent 6% of gross domestic product on health care and 6% on education. We are now a little over 15% of GDP soon to be 18% of GDP on health care. In 40 years, we will have increased spending on health care by 300% of GDP. And you guessed it, for education we are still paying that same 6% of GDP. I am not going to say that 15 or 18% of GDP is too much for health care, but I am going to say that this money should be spent in a more intelligent fashion. We have 45 million uninsured Americans and millions of other Americans just a pink slip away from being uninsured.

Physicians like to blame hospital administrators, Congressman, health insurance companies, professional liability lawyers, and patients for problems with the health care system. Each of these groups do bear some burden of guilt for the dysfunction in our current health system, but I primarily

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blame physicians. No one else really understands health care as well as we do. As a patient, you may know that you were treated with respect and dignity and you'll know whether you got better or didn't get better, but you won't have any idea whether you got the right drug, the right dosage, or the right surgical procedure. You won't know whether you had too many lab studies or too few lab studies done. Hospital CEOs don't know good health care, but they do know which physicians please their patients, they know which physicians help the hospital bottom line, but again, many of those physicians are not really the better doctors when we look at providing good cost-effective care for their population of patients.

In 1991, I was President of the Kansas Medical Society. Jerry Slaughter, whom you all know, myself, Dr. Terry Poling of Wichita, Dr. Wedel of Minneapolis met at the Marriott in Wichita with Leroy Rheault, at that time CEO of St. Joe Hospital in Wichita, and two hospital CEOs from Topeka. Early in our discussion, I made the statement that Kansas needed to bring back Certificate of Need legislation, as at that time, we were seeing a lot of diagnostic centers being developed by physicians in various communities across the state. I was immediately shot down by Leroy Rheault with his statement that we did not need CON because the Wichita hospitals and physicians could be relied upon to make appropriate decisions for the benefit of the community. Having been duly chastised, that was the last we heard of CON at that meeting. I have since learned that Leroy at that time was dealing with Wichita orthopedic surgeons to woo them away from Wesley Hospital. The consummation of that courtship was the construction of a limited surgery center in northeast Wichita with joint ownership from physicians and St. Joe Hospital. A few years later, it became known that Via Christi hospitals, at that time St. Joe and St. Francis had joined, were working with a group of cardiologists and cardiothoracic surgeons to build the first ever single specialty heart hospital in the state of Kansas. I am unaware of anyone else who spoke out against this effort, but in March of 1997, I wrote a letter to the editor in the Wichita paper and I would like to read two paragraphs. "There are already more than adequate Wichita facilities for the care of patients with cardiac needs. This new facility might be able to boast decreased cost for certain specialized services, however, all specialty hospitals skim off the cream of insured services driving up overall community health cost. This in turn drives up health care premiums and forces increasing numbers of individuals into that frightening existence of the uninsured. I hope and pray that Via Christi hospitals and the physicians involved will discontinue their planning for this proposed new construction. They could then refocus their attention to the Via Christi mission of carrying out the 'Healing Mission of Jesus'." Well, in fact, Via Christi did back out of that discussion, or in fact, was pushed out, because the physicians did not want Via Christi to have 51% ownership. So the Kansas Heart Hospital wound up being a physician investor effort alone. I would say that perhaps Leroy Rheault and Kansas community hospitals have had their objection to CON come back to bite them.

Nationwide there are one hundred specialty hospitals. If these hospitals were distributed according to population, we would have no specialty hospitals in Kansas. Unfortunately, we have thirteen specialty hospitals in the state of Kansas because we have never made a commitment to provide cost-effective health care for every Kansan. We have a plan for education, police protection, and fire protection for every Kansas citizen. Some of us are going to have to travel longer to get to school and some fire trucks have farther to run to get to our homes, but that is because we try to do the most good with a set amount of dollars. And by the way, how often do you see your fire department or local school district advertising for your business?

Now you may ask us what you should do, and I hope you do ask. Our immediate answer would be slam dunk number one **Establish An Absolute Moratorium On The Construction Of Any New Limited Service Health Facility**. The second issue is more difficult. How do we incorporate these already unneeded, already constructed, redundant health facilities into the state system? We have already allowed them to be built. What are we going to do with them? They are currently taking huge profit margins for the benefit of a few and putting some community hospitals at serious financial risk. We have to do something to recapture and redistribute these Kansas health care dollars. "A" at a minimum, Congress must do everything they can do legislatively to immediately

change the way these facilities are paid so they are paid based on the actual cost of providing services. Or "B," You could severely tax the profits. Or "C," You could close them down.

At a minimum, this legislative session should #1 pass a moratorium on construction of new limited specialty health care facilities and #2 should see a re-calibration and massive reduction in payments to these limited specialty facilities.

Larry Anderson MD

Larry R. Anderson, M.D.

No more need

This newspaper has recently presented information regarding the effort of some Wichita physicians and Via Christi hospitals to build a new Wichita hospital for cardiac care. Politics, power, prestige and profit most assuredly were major factors in the decision to go forth with construction of this new and unneeded facility.

There are already more than adequate Wichita facilities for the care of patients with cardiac needs. This new facility might be able to boast decreased cost for certain specialized services. However, all specialty hospitals skim off the cream of insured services, driving up overall community health-care costs. This in turn drives up health-care premiums and forces increasing numbers of individuals into that frightening existence of the uninsured.

I hope and pray that Via Christi hospitals and the physicians involved will discontinue their planning for this proposed new construction. They can then refocus their attention to the Via Christi mission of carrying out the "Healing mission of Jesus."

Wichita Eagle 3/6/97

LARRY R. ANDERSON, M.D.
Wellington

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Enough Is Enough

On October 16, 1991, representatives of the Kansas Medical Society and the Kansas Hospital Association met to discuss the issue of capital expenditure for new diagnostic and health care equipment and facilities (Certificate of Need). Current legislative discussion in Topeka has considered a moratorium on new construction for Kansas acute care facilities, and this KMS/KHA meeting was held to consider a joint statement to address this issue. The majority of those present at this meeting spoke against a moratorium but in favor of a comprehensive study of Kansas health care needs. Discussion substantiated the fact that earlier Kansas Certificate of Need legislation failed to truly assess community health needs, to stop any proposed construction (some of which may, in retrospect, have been unnecessary) and to consider regional and state health care needs. It also increased the total cost through bureaucratic expense and increased construction cost associated with delayed approval.

Within the last few weeks, this KMS/KHA statement has been delivered to the Joint Committee on Health Care Decisions for the 1990s. There appears to be good legislative support to work with the recently established Commission for the Future of Health Care, Inc. to accept the KMS/KHA recommendation to try to identify available funds for a comprehensive study of Kansas needs, rather than to enact legislation calling for an immediate moratorium on construction of new acute-care facilities.

It is well known that physician incomes are a small percentage of the total health care dollar, but physicians control in some way or another most of the dollars spent for health care. A quick look at many Kansas communities will show that large health care expenditures are often utilized, not necessarily for truly needed medical care but rather where a market for a medical service has been generated.

A study of Arizona physicians published in the December 6, 1990 *New England Journal of Medicine* reports that physicians with in-house x-ray equipment order four times more radiographic studies on identical patient populations than do specialty colleagues without in-house radiographic capability. An article in the September 30 *Physician Financial News* stated that Florida physicians who own laboratory facilities order twice as many lab studies at twice the cost as do physicians without laboratory ownership. These statements are not to imply that all ownership of diagnostic or treatment facilities is bad. However, I think most would agree that the entrepreneurial nature of our current health care system allows and, in fact, encourages overconstruction and overutilization even though excellent care can often be provided with less diagnostic and therapeutic intervention.

> "Excellent care can often be provided with less diagnostic and therapeutic intervention."

At the KMS/KHA meeting previously mentioned, it seemed to be generally agreed that, although Kansas citizens currently suffer from a lack of access to primary care physicians, they do not suffer from a lack of diagnostic or therapeutic equipment that could reasonably be more available than at the present time. Arnold Collins wrote in the October 7 *American Medical News* that the American health care system has been losing primary care physicians for the last several decades and has gotten to the point where "the sideshow is swallowing up the main tent." Kansas does not need more acute care facilities, cardiac cath labs, MRIs, Level III nurseries or rehab hospitals! What Kansas needs is more primary care physicians!

Many hospital administrators and physician leaders argue for a "voluntary community effort" to control overbuilding of health care facilities. I say voluntary effort is a joke unless a majority of physicians stand up in their hospital and physician group meetings to speak against new construction when this construction is plainly to enhance the image of the institution, provide a financial advantage or develop a demand where a need truly does not exist.

Larry Anderson MD

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Executive Advantage Report

Via Christi RMC-St. Francis Campus	170122	929 N St. Francis
Provider Number	11	Wichita, KS 67214
#Acute Care Facility in MSA		Wichita MSA

MEDICARE COST REPORT

Income Strength
MSA RANK 2

	09/00 - 12 mo	09/01 - 12 mo	09/02 - 12 mo
Inpatient Rev	653,762,104	723,051,908	812,260,294
Outpatient Rev	169,923,980	184,871,205	201,906,985
Total Revenue	823,686,084	907,923,113	1,014,167,279
Contractual Adj	446,993,615	502,397,044	576,289,022
Net Revenue	376,692,469	405,526,069	437,878,257
Total Operating Exp	391,089,509	418,894,047	456,038,981
Net Patient Inc	-14,397,040	-13,367,978	-18,160,724
Other Income	30,499,385	30,152,840	20,544,871
Other Expenses	0	0	0
Net Income	16,102,345	16,784,862	2,384,147
Operating Margin	-3.82%	-3.30%	-4.15%
Net Margin	4.27%	4.14%	0.54%
IP Admissions	34,666	34,666	37,567
Adj Admissions	43,676	43,529	46,905
Total Rev/Adj Adm	18,859	20,858	21,622
Net Rev/Adj Adm	8,625	9,316	9,335
Oper Exp/Adj Adm	8,954	9,623	9,723

Financial Strength
MSA RANK 5

	09/00 - 12 mo	09/01 - 12 mo	09/02 - 12 mo
Cash &Cash Equiv	23,409,840	21,969,443	29,896,179
Accounts Receivable	102,202,907	108,652,104	107,368,128
Less Allowances	24,543,337	30,008,860	29,433,967
Other	15,583,858	21,284,370	23,341,772
Total Current	116,653,268	121,897,057	131,172,112
Total Fixed Assets	215,141,502	233,724,888	228,458,598
Other Assets	148,614,763	137,381,406	134,644,743
Total Assets	480,409,533	493,003,351	494,275,453
Current Liabilities	38,300,583	36,482,758	39,247,530
Mortgages	0	0	0
Notes & Other	166,303,357	162,315,958	158,493,399
Total Liabilities	204,603,940	198,798,716	197,740,929
General Fund Balance	275,805,593	294,204,635	296,534,524
Other Fund Balance	0	0	0
Liabilities & FB	480,409,533	493,003,351	494,275,453
Current Ratio	3.05	3.34	3.34
A/R Days Outstanding	75	71	65
Debt/Equity Ratio	0.60	0.55	0.53

Medicare Performance
MSA RANK 2

	FFY 01	FFY 02	FFY 03
INPATIENT			
Medicare Reimb	119,985,600	133,604,547	133,535,293
Estimated Cost	98,414,081	108,285,749	110,035,087
Profit/Loss	21,571,519	25,318,798	23,500,206
Profit/Loss Percent	21.9%	23.4%	21.4%
AverageProfit/Loss	1,439	1,572	1,470
Profit/Loss by MDC			
1-Nervous Sys	1,313,569	1,466,459	1,440,100
4-Respiratory Sys	965,071	1,403,473	1,894,515
5-Circulatory Sys	11,249,732	11,630,788	10,084,490
6-Digestive Sys	1,242,251	1,740,104	1,465,407
8-Musculoskeletal	2,451,356	3,188,026	3,401,698
10-Nutrit/Metabolic	-1,949	379,117	454,285
11-Kidney/Urinary	292,665	557,702	185,190

Other Factors
MSA RANK 5

	09/00 - 12 mo	09/01 - 12 mo	09/02 - 12 mo
% Medicare	42%	43%	42%
Licensed Beds	763	790	756
FTE/Occupied Beds	7.9	7.4	7.1
Occupancy Rate	66.3%	67.4%	73.8%
	FFY 01	FFY 02	FFY 03
ALOS Index	1.07	1.08	1.02
Mortality Index	1.11	1.10	1.14
Case Weight Index	1.6009	1.6183	1.6155
Med/Surg Avg Cost	1767	1773	1610
ICU Avg Cost	960	1078	1037
Case Weight by MDC			
1-Nervous Sys	1.3330	1.3707	1.3927
4-Respiratory Sys	1.4074	1.5087	1.4680
5-Circulatory Sys	1.9893	1.9307	1.9490
6-Digestive Sys	1.3532	1.4163	1.3690
8-Musculoskeletal	1.5636	1.5420	1.6513
10-Nutrit/Metabolic	0.8765	0.8818	0.8828
11-Kidney/Urinary	1.3650	1.4113	1.4015

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Executive Advantage Report

MEDICARE COST REPORT

Kansas Heart Hosp.
Provider Number 170186
#Acute Care Facility in MSA 11

3601 N Webb Road
Wichita, KS
Wichita MSA

Income Strength
MSA RANK 2

	12/00 - 12 mo	12/01 - 12 mo	12/02 - 12 mo
Inpatient Rev	62,629,169	70,885,475	77,528,521
Outpatient Rev	10,818,852	14,313,591	13,362,877
Total Revenue	73,448,021	85,199,066	90,891,398
Contractual Adj	39,122,132	45,103,368	47,785,553
Net Revenue	34,325,889	40,095,698	43,105,845
Total Operating Exp	20,999,577	25,052,749	27,831,623
Net Patient Inc	13,326,312	15,042,949	15,274,222
Other Income	447,459	336,100	219,518
Other Expenses	1,368,706	1,388,536	1,593,934
Net Income	12,405,065	13,990,513	13,899,806
Operating Margin	38.82%	37.52%	35.43%
Net Margin	36.14%	34.89%	32.25%
IP Admissions	1,980	2,402	2,642
Adj Admissions	2,322	2,887	3,097
Total Rev/Adj Adm	31,631	29,511	29,348
Net Rev/Adj Adm	14,783	13,888	13,919
Oper Exp/Adj Adm	9,044	8,678	8,987

Financial Strength
MSA RANK 1

	12/00 - 12 mo	12/01 - 12 mo	12/02 - 12 mo
Cash &Cash Equiv	8,246,206	5,645,663	4,912,236
Accounts Receivable	12,206,265	12,074,634	11,088,214
Less Allowances	5,843,693	5,909,266	5,368,554
Other	1,089,089	710,494	710,747
Total Current	15,697,867	12,521,525	11,322,643
Total Fixed Assets	11,243,388	13,581,909	12,508,712
Other Assets	6,062,081	6,138,948	6,858,075
Total Assets	33,003,336	32,242,382	30,689,430
Current Liabilities	23,405,351	17,299,109	2,291,665
Mortgages	0	0	0
Notes & Other	0	1,557,088	999,567
Total Liabilities	23,405,351	18,856,197	3,291,232
General Fund Balance	9,597,985	13,386,185	27,398,198
Other Fund Balance	0	0	0
Liabilities & FB	33,003,336	32,242,382	30,689,430
Current Ratio	0.67	0.72	4.94
A/R Days Outstanding	88	56	48
Debt/Equity Ratio	N/A	0.11	0.03

Medicare Performance
MSA RANK 1

	FFY 01	FFY 02	FFY 03
INPATIENT			
Medicare Reimb	19,990,953	22,340,936	24,268,870
Estimated Cost	15,340,812	18,811,219	20,944,258
Profit/Loss	4,650,141	3,529,717	3,324,612
Profit/Loss Percent	30.3%	18.8%	15.9%
AverageProfit/Loss	3,086	2,000	1,875
	Profit/Loss by MDC		
1-Nervous Sys	316,465	249,401	311,924
4-Respiratory Sys	26,450	120,170	89,535
5-Circulatory Sys	4,276,792	3,100,759	2,885,692
6-Digestive Sys	6,963	0	0
8-Musculoskeletal	0	0	0
10-Nutrit/Metabolic	0	0	0
11-Kidney/Urinary	2,575	11,076	0

Other Factors
MSA RANK 2

	12/00 - 12 mo	12/01 - 12 mo	12/02 - 12 mo
% Medicare	70%	65%	66%
Licensed Beds	32	46	46
FTE/Occupied Beds	5.3	5.4	5.2
Occupancy Rate	72.6%	69.4%	66.8%
	FFY 01	FFY 02	FFY 03
ALOS Index	0.41	0.45	0.48
Mortality Index	0.14	0.27	0.16
Case Weight Index	2.9701	2.7846	2.9626
Med/Surg Avg Cost	1592	1388	1482
ICU Avg Cost	1192	1093	1149
	Case Weight by MDC		
1-Nervous Sys	1.4114	1.3528	1.3680
4-Respiratory Sys	1.5835	2.1167	1.9185
5-Circulatory Sys	3.2587	3.0186	3.1583
6-Digestive Sys	1.2256	0.0000	0.0000
8-Musculoskeletal	0.0000	0.0000	0.0000
10-Nutrit/Metabolic	0.0000	0.0000	0.0000
11-Kidney/Urinary	1.7319	1.9820	0.0000

7-7

Testimony in Support of SB 235
Presented to the Senate Health Care Strategies Committee
By Dr. Deborah Haynes

March 2, 2005

Senator Wagle, members of the committee I am Dr. Deborah Haynes. I have practiced family medicine in Wichita, Kansas for over 20 years. During that time I have actively participated in the Kansas Academy of Family Physicians and the American Academy of Family Physicians. While my full time job has been patient care, I have taken time from my medical practice to participate with several professional and community organizations. My volunteer work in the community has helped me understand the challenges facing hospitals, physicians and others medical providers as we work together to provide quality health care for our patients.

You may be hearing that the physician community in south central Kansas supports both the growth of specialty hospitals as well as the proposed new hospital in Andover. In reality, many physicians have stood with community hospitals in opposing this trend. At a national level as well, the American Academy of Family Physicians is supportive of an extension of a federal moratorium on specialty hospitals.

The proliferation of specialty hospitals in Kansas has threatened the bottom line of our community hospitals. As a family physician, I need quality hospital care for all of my patients as they face a multitude of medical challenges. I don't have the luxury of serving only patients with medical needs that have been predetermined by Medicare officials or other insurers to receive the highest reimbursement for care provided. If the investor owned specialty hospitals pull the most profitable business from the community hospitals, I fear that I will loose access to adequate hospital services for my patients.

Therefore, I support SB 235 because the community needs to take a time out to determine how both medical facility regulations and federal payment practices have created a healthcare marketplace with unsustainable delivery costs. While the federal government is in the middle of its analysis of this is issue, local providers are rushing in to carve out profitable segments of the market in states like Kansas that have not regulated through certificate of need or strong hospital licensure laws.

Therefore, I support a one year moratorium on issuing new hospital licenses in Kansas. This action will give the federal regulatory agencies time to complete their work and allow all of us to determine what about Kansas licensure laws have contributed to creating an unhealthy financial situation for the community hospitals that serve all Kansans regardless of their medical needs or their ability to pay.

Thank you for this opportunity to address your committee. I would be pleased to respond to questions.

Senate Health Care Strategies Committee
Date: March 2, 2005
Attachment 8