Approved: March 20, 2007
Date

MINUTES OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE

The meeting was called to order by Chairman Brenda Landwehr at 1:30 P.M. on February 15, 2007 in Room 526-S of the Capitol.

All members were present except:

Committee staff present:
Norman Furse, Revisor's Office
Renae Jefferies, Revisor's Office
Melissa Calderwood, Legislative Research
Mary Galligan, Legislative Research
Tatiana Lin, Legislative Research
Patti Magathan, Committee Assistant

Conferees appearing before the committee:

Debra Billingsly - Kansas State Board of Pharmacy
Paul Silovsky - Legislative Chair Kansas Physical Therapists Association
Marcie Swift - University Of Kansas Medical Center Physical Therapy Program
John Kiefhaber & Dr. Edward McKenzie - Kansas Chiropractic Association
Norman Furse, Revisor
Tom Bell, President - Kansas Hospital Association
Sam Serrill, Wesley Medical Center
Mary Ellen Conlee - Via Christie Health Systems
Scott Chapman - Kansas Surgical Hospital Association
Mary Nan Holley - Chief Executive Officer Heartland Spine & Specialty Hospital
Phil Harness - Dr.'s Hospital LLC
Daryl Thornton - Kansas Medical Center LLC
Joe Kroll - Kansas Department of Health & Environment
Sheldon Weisgrau - Kansas Health Institute

Others Attending:
See Attached List.

Chair Landwehr opened hearings on **HB2096, Board of pharmacy, concerning meetings.**

Debra Billingsly, Executive Director of Kansas State Board of Pharmacy, explained that this is a minor change. Existing law requires the Board to hold their election of officers in June. We would like to delete the reference to the month of June. Board terms expire around April 30th of each year and often the replacement is not appointed until after June. This causes the Board to have an unnecessary election when the result may be that the Board members have changed after they have been elected to office. (Attachment 1)

Chair Landwehr closed hearings on **HB2096** and invited Revisor Norman Furse to provide an update of **HB 2483** - Physical therapists evaluation and treatment of patients. This bill was heard in committee on February 15. Mr. Furse said that per the constitution, we have to repeal the existing Section from the statute and rewrite it in its entirety. He pointed out that lines 15-21 contain language from existing law.

Chair Landwehr closed hearings on **HB2483** and opened hearings on **HB2418**, General hospital defined.

Sam Serrill, chief Operating Officer of Wesley Medical Center, Wichita, KS, said that Wesley Medical Center is a general acute care hospital Wesley provides a comprehensive range of services to south central Kansas and is affiliated with the University of Kansas Medical School, Wichita. He stated that it is important to distinguish between the services provided by a community general hospital and a specialty hospital. This distinguishment is currently not well defined in Kansas. Wesley Medical Center supports passage of **HB 2418**, which will update and revise the Kansas hospital licensure laws to be consistent with the changes in

hospital care and treatment occurring over the past 25 years, in addition to providing the distinction between the general and the specialty hospitals.

HB2418 will require medical care facilities that wish to be "general hospitals" to provide services consistent with responsibilities, such as, provision for a dedicated emergency department that operates 24 hours of every day, provide diagnosis and treatment for patients with a variety of medical conditions as opposed to selected diagnoses, participate in the delivery of emergency medical services applicable to its region, and be a participating provider in the Kansas Medicaid program.

In Kansas there are currently eleven "limited service facilities" or specialty hospitals of only about 100 total in all states. Some are single day surgery centers focused on a narrow range of the most profitable services (often cardiology, surgery, orthopedics) offered to an even narrower group of low risk, well insured patients. (Attachment 2)

Tom Bell, President of Kansas Hospital Association, discussed the blue and white "H" sign that is a universal symbol for hospitals and is placed in communities across the state to guide patients and families to a general hospital that provides care 24-hours a day, seven days a week.

Mr. Bell stated that current hospital licensure law was initially enacted in 1947. A reference was added in 1973 to a special hospital. That definition was quite similar to the revised definition of a general hospital that was adopted at the same time, with the primary difference being the general hospital would treat a "variety of medical conditions" while a special hospital would treat "specified medical conditions." Since this time there have not been any regulations that define the differences between a general and a special hospital.

Today's law allows the applicant to choose between the a general or a special license without review or scrutiny by Kansas Department of Health and Environment.. Kansas Hospital Association believes it is time to clarify the requirements of a general hospital to ensure it more accurately reflects the public understanding of what constitutes a general hospital. (Attachment 3)

Mary Ellen Conlee, representing Via Christi Health System, appeared in support of HB 2418. Updating the definition of a general hospital will better reflect the facilities that exist today. Hospitals have changed since adoption of the current definition with the development of limited service hospitals specializing exclusively in certain procedures. It is clear that special hospitals have evolved into a specific type of health care delivery model very different from general hospitals, demanding a better definition of a general hospital. With the move toward more transparent information for consumers, better definitions will help the patients know what can be expected when they chose either type of facility for treatment. (Attachment 4)

Written testimony was provided in support of **HB2418** by the University of Kansas Hospital. (Attachment 5)

Scott Chapman, Opponent, said that he is here representing the Kansas Surgical Hospital Association. The Association has nine member hospitals across the state serving communities of Wichita, Great Bend, Kansas City, Emporia, Salina and Manhattan.

Their belief is that the current definitions have worked fine for the Kansas Department of Health and Environment in their licensing responsibilities, have not caused difficulties for the surveyors, have not endangered patients in any way, or misled the public about what it means to be a hospital. Licensed hospitals in the state of Kansas must go through a vigorous inspection process on a regular basis and are held to the same high standards whether they're classified as a general, special, or critical access facility.

Mr. Chapman cautioned that the proposed requirement to provision a dedicated emergency department should be carefully considered since it is an optional service for medicare participation. If this is required by State law there are additional requirements under the medicare condition of participation services. In addition, the process of calculating and monitoring the percentage of discharges in specified categories now becomes a regulatory burden for all hospitals. (Attachment 6)

Opponent **Mary Nan Holley**, Chief Executive Officer of Heartland Spine and Specialty Hospital stated that her hospital is licensed as a level 4 trauma center. Even though my hospital does not have an emergency room department, we are required to treat any patient that walks through our doors with an emergency. This is a requirement of our general acute care license. We are also part of Federal Emergency Management Agency's (F.E.M.A.) emergency response plans for Kansas City and the State of Kansas. F.E.M.A bases these plans specifically on a state's general acute care licensed facilities and their trauma license. I have been advised by legal council that facilities defined as special hospital could possibly not be used by F.E.M.A if this legislation became law. This is due to federal laws having no definition or concept of a special hospital. After extensive review of other state licensure laws we could not find any other state that had special hospital as a category of licensure, and question that this does not seem to be a good faith attempt to actually redefine statutes. With state and federal healthcare laws being intertwined it seems prudent to seek the federal government's counsel in this case. (Attachment 7)

Opponent **Philip S. Harness**, C.E.O. of Doctors Hospital, Leawood, KS questioned whether **HB 2418** accomplishes a public or consumer oriented purpose. In the metropolitan area served by our facility there are four hospitals within a four mile radius which have emergency rooms. We strive to make best use of our health care resources and see no benefit from adding another emergency room to an area that is already within ready distance of other facilities. All medical facilities compete for nursing talent. Forcing more hospitals to add emergency rooms only spreads a thin nursing population even thinner. Mr. Harness pointed out ambiguous wording on lines 17, 19, 23-24, and 24-25, and concluded by saying that the bill as written (with the exception of the requirement of Medicaid participation) is an unpalatable solution in search of a problem. (Attachment 8)

Opponent **Daryl Thornton**, Chief Operating Officer for the Kansas Medical Center in Andover, KS. This is a licensed 58-bed general acute care hospital with state of the art medical services and 24-hour physician, nursing and emergency room services. We opened our doors to the community on October 2, 2006. We are in the process of establishing ourselves and creating new relationships, but until we have a "track record" of our patient mix, we cannot determine the effect of this proposed legislation to our facility and the impact to healthcare access for our community. The Diagnosis related groups mix should be based on two or three years of data in order to be accurate. With unknown impacts, unanswered questions and potential for unintended consequences we must oppose **HB 2418.** (Attachment 9)

Joseph F. Kroll, Director, Bureau of Child Care and Health Facilities, K.D.H.E. provided neutral testimony, saying that Kansas statute recognized three hospital types today: general, special and critical access. The statutory definitions for general and special hospitals are the same except that a general hospital provides diagnosis and treatment for a variety of medical conditions. A critical access hospital is a member of a rural network and provides services in cooperation with a supporting hospital. There are 50 general hospitals, 21 special hospitals (5 of which are state operated) and 83 critical access hospitals.

There has been considerable discussion about the impact different types of hospitals have on quality and access, and there is a national moratorium on physician owned special hospitals which is now expired. The Kansas Health Policy Authority was directed by the 2006 legislature to study the issues related to special hospitals. **HB 2418** appear to clarify the differences between general hospitals and special hospitals, but it may be premature to adopt it before evaluating the recommendations of the Health Policy Authority due to the legislature March 1. Current information indicates six currently licensed general hospitals may not meet the criteria in **HB 2418** and without amendment to the definition for special hospital there may be no valid licensing category for these six facilities. (Attachment 10)

Sheldon Weisgrau, Senior Policy Analyst with the Kansas Health Institute provided neutral testimony explaining the Kansas Health Institute recently completed a study on the impact of specialty hospitals on general hospitals in Kansas. They used previous analyses by Centers of Medicare and Medicaid Services, the Medicare Payment Advisory Committee and others to clearly identify the facilities that would be defined as specialty hospitals. Their definition was somewhat different that the definition used in **HB2418**, however the important point, is that there are clear differences between most specialty and general hospitals in the types and range of conditions that they treat. Their study did not include criteria

regarding emergency services or participation in the Medicaid program.

He offered one note of caution for the committee. The proposed legislation includes a provision that a general hospital "focuses primarily on providing treatment for patients who require inpatient care." Over the past 20 years medical practice has evolved and more and more patients who previously would have required hospitalization are now treated as outpatients. It is now common for a majority of a hospital's business to be conducted on the outpatient side. This is particularly true for small and rural hospitals. (Attachment 11)

Chair Landwehr closed hearing on **HB 2418** and asked the committee if anyone objected to working **HB2096** - Board of pharmacy, concerning meetings. There were no objections.

Representative Mast motioned to pass **HB2096** favorably. Motion seconded by Representative Hill. Motion carried.

Chair Landwehr opened hearings for **HB - 2483** - Physical therapists evaluation and treatment of patients.

Proponent **Bud Burke**, representing Kansas Physical Therapy Association, said that this is not a change in scope of practice, but does allow very limited direct access. They would consider an amendment to add a clarification regarding spinal manipulation. (Attachment 12)

Proponent **Paul Silovsky**, Legislative Chair of the Kansas Physical Therapist Association, said that limited direct access allows the public to get physical therapy evaluation and treatment for up to 30 days without a referral from one of the licensed professionals that are listed within our current statutes. This bill does not alter scope of practice, nor does it compromise patient safety, or affect third party reimbursement of services. This law does free up the trade of physical therapy by removing an unnecessary barrier for a patient seeking treatment and encourages preventative care. (Attachment 13)

Proponent, **Marcie Swift**, of the University of Kansas Medical Center Physical Therapy program, said that their curriculum includes teaching patient evaluation skills. Students learn both screening and triage tests to identify patients who are candidates for physical therapy and those requiring urgent physician evaluation.

Ms. Swift states that they anticipate amendatory language to change scope of practice regarding manual therapy as is done today. Manual Therapy and manipulation treatment for physical therapists dates back to 1928 and the Normative Model of Physical Therapist Professional Education. The current Kansas Physical Therapy Act states that any physical therapist shall be guilty of unprofessional conduct if he or she fails to refer patients to other health care providers if symptoms indicate. (Attachment 14)

Written testimony was provided from Jane M. Weinmann, patient. (Attachment 15)

Chair Landwehr announced that we would continue hearings Monday February 18 on **HB - 2483** - Physical therapists evaluation and treatment of patients. Meeting was adjourned at 3:20. Next meeting will be Feb. 18 at 1:30 P.M.

HOUSE HEALTH AND HUMAN SERVICES
COMMITTEE GUEST LIST

DATE: February , 2007

NAME	REPRESENTING
SAM SERRICK	WESLEY MEDICAL CENTER
Ron Hein	HCA
Daryl Thornton	Kansas Medical Center - Andover
Charles Moore	cmoore@KDHE.STATE.KS.US
Joseph Ciucci	KOHE
Rebecca Ross	KHPA
Allison Peterson	Kansas Medical Society
Chip Wheelen	Assn of Osteopathic Med.
EDWARD MCKENZIE	KANSAS CHIROPRACTIC ASSOC.
John Kirthaber	Ks. Chiropractic Assoc.
Jennie Ann Rowen	KAHP, Children's Mercy
Patti Krueger	Polsinelli Law Firm
Sheldon Weisgrau	Kansas Health Institute
Deb Billingsley	KBOP
Emily Geier	HLF
Phil Harness	Doctors Hospital, LLC
Nathan Adams	HSSH
JOHN C. BOTTENBERG	ADAMS/CARTER
Mary Nan Holley	HSSH
Mark Stafford	Healing Arts Board
Ron Gaches	KOTA
Mary Pilcher Cook	self

KANSAS

KANSAS BOARD OF PHARMACY
DEBRA BILLINGSLEY, EXECUTIVE DIRECTOR

KATHLEEN SEBELIUS, GOVERNOR

Testimony concerning HB 2096: relating to meetings
House Health and Human Services Committee
Presented by Debra Billingsley
On behalf of
The Kansas State Board of Pharmacy
February 16, 2006

Chairperson Landwehr and Members of the Committee:

My name is Debra Billingsley, and I am the Executive Secretary for the Kansas State Board of Pharmacy. Our Board is created by statute and is comprised of six members, each of whom are appointed by the Governor. The Board is responsible for regulating the sale and quality of drugs, medicines, chemicals and poisons in the State of Kansas.

The Board of Pharmacy asked that HB 2096 be filed to change some language that relates to their meetings. Under current law the Board is required to hold their election of officers in June. The Board would like the reference to the month of June deleted from the statute. Board terms expire around April 30th of each year and the replacement is often not appointed until after June. This causes the Board to have an unnecessary election when the result may be that the Board members have changed after they have been elected to office. The Board does not oppose having an annual election but they would like to hold elections after new board members have been appointed.

The second section of the bill is related to meetings for the purpose of examining applicants for licensure. The statute currently requires that the Board hold at least one meeting a year for this purpose. The Board no longer examines or interviews applicants. Applicants for licensure are required to be 18 years of age, be a graduate of a School of Pharmacy and have one year of supervised training. The applicant must have passed the NAPLEX test. The NAPLEX is developed nationally and assesses the competence to practice. The applicant must also take the Multistate Pharmacy Jurisprudence Exam which tests students on federal and state specific laws. Both of these tests are given nationally and the Board no longer examines or interviews applicants for licensure. Therefore, this statute has become out of date and is no longer necessary

Thank you very much for permitting me to testify and I will be happy to yield to questions.

Submitted by:

Debra Billingsley
Board of Pharmacy

House Health and Human Services
DATE: 2-15-07
ATTACHMENT 1-1

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HOUSE HEALTH AND HUMAN SERVICES COMMITTEE
HOUSE BILL 2418
FEBRUARY 15, 2007

Madame Chairman, Members of the Committee:

My name is Sam Serrill and I am Chief Operating Officer of Wesley Medical Center, Wichita, KS. Wesley Medical Center 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 6200 births a year, over 70,000 emergency and trauma visits, 28,000 inpatient admissions and 176,000 outpatient visits. Approximately 36% of Wesley's patients have Medicare, 19% have Medicaid, 42% have commercial insurance and 3% have no insurance. Wesley employs over 2400 staff with an annual payroll in excess of $116 million, provides $33.4 million in uncompensated care and pays nearly $10.2 million in state and local taxes annually. Wesley is owned by HCA, the nation's largest provider of health care services, with over 170 locally managed hospitals, including four in Kansas.

I provide this information about Wesley because it is important to distinguish between the services provided by a community general hospital and a specialty hospital, something that currently is not well defined in Kansas.

HCA, Wesley and I support passage of HB 2418, which will update and revise the Kansas hospital licensure laws to be consistent with the changes in hospital care and treatment occurring over the past 35 years and provide this important distinction.

HB 2418 will require that medical care facilities determine whether they are going to be 'general hospitals', 'special hospitals', or some other type of medical care facility. Hospitals desiring to be general hospitals must provide services consistent with the responsibilities of general hospitals, including provisions for a dedicated emergency department that operates 24 hours of every day, provide diagnosis and treatment for patients with a variety of medical conditions as opposed to selected diagnoses, participate in the delivery of emergency medical services applicable to its region and be a participating provider in the Kansas Medicaid program.

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ATTACHMENT 2-1

Currently there are medical care facilities that want to enjoy the privileges of general hospitals, but don't want to incur the costs that accompany the responsibilities required of general hospitals. These facilities selectively admit patients based on acuity and insurance type, cherry-picking the most profitable patients and services. They avoid the costs associated with care and treatment of patients with lower reimbursement rates, complicated procedures that require basic inherent risks that threaten profitability, care and treatment for uninsured or underinsured individuals, and care and treatment that is less profitable, all of which are left to be provided by the community general hospitals.

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, self-referral, fair competition, and whether the best interests of both patients and their communities are being served, or abused.

In Kansas there are currently eleven 'limited service facilities' or 'specialty hospitals', of only about 100 total in all states, and there are four such facilities in Wichita. It is important to make the distinction clear between a community hospital and a specialty facility. These are not full service hospitals open to the public with emergency rooms, labor and delivery rooms, and many other services provided by true community hospitals. They are simply single specialty surgery centers focused on a narrow range of the most profitable services (often cardiology, surgery, orthopedics) offered to an even narrower group of low risk, well insured patients.

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 part of these laws, the 'whole hospital' exception was also created. This exception is the loophole that has been exploited in Wichita by the Kansas Heart Hospital, Galichia Heart Hospital (which recently added emergency services), 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 select the least sick and most profitable patients, provide little or no emergency services, increase utilization and costs, and damage full service community hospitals leading to cutbacks in services. The impact at Wesley Medical Center with the proliferation of limited service hospitals has included a reduction in hospital financial performance, a corresponding reduction in staff through lay offs, and elimination of programs including occupational medicine, electron microscopy research center and pharmacy research program. At the same time our labor costs have increased in areas like cardiology services in order to compete for the limited supply of trained health care workers.

When these physician owned entities open, several things happen almost immediately: physician owners redirect their patients; physician owners make huge profits, 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. For example, net revenues for Wesley Medical Center's heart program decreased by $16million after the Galichia Heart Hospital opened in 2001. Similarly, net revenues in Wesley's neurosurgery program dropped considerably after the opening of the Kansas Spine Hospital in 2003.

In January 2005, the MedPAC commissioners unanimously voted to extend the federal moratorium on specialty hospitals until January 1, 2007. In 2005, the Kansas Hospital Association introduced legislation as a safety valve to temporarily hold the development of any new hospitals in Kansas for one year. This moratorium would have given 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. That legislation did not pass, despite the Senate passing a resolution memorializing Congress to extend the moratorium, and the problem facing Kansas continues.

As you know the Kansas Health Policy Authority has been charged as one of its responsibilities to conduct a review and study of issues related to specialty hospitals and the licensure law and to prepare recommendations for this legislative session.

More recently the Kansas Health Institute weighed in on this matter with completion in December 2006 of its report entitled 'Specialty Hospitals in Kansas: An Unfolding Story'.

Some of the key findings include:

"Specialty hospitals provide a limited range of services, treat fewer types of cases, and are more focused on surgical procedures than general hospitals.

Specialty hospitals treat a higher proportion of Medicare patients and lower proportions of Medicaid and uninsured patients than general hospitals.

The impact of specialty hospitals on their general hospital competitors is mixed.

In the Wichita market, increases in the number of coronary bypass surgeries at specialty hospitals coincided with a sharp decline in the volume of these procedures at competing general hospitals." (This was certainly the case at Wesley Medical Center).

Among the report's recommendations, the Kansas Health Policy Authority should:

"Assess the pros and cons of expanding the scope of licensure regulations to include issues such as provision of services to Medicaid and uninsured patients and collection of information on ownership and investor compensation arrangements."

The report also recommends the Kansas Health Policy Authority and the Kansas Department of Health and Environment, working with the Kansas Hospital Association and Kansas Surgical Hospital Association, establish a mandatory data collection and monitoring system that would assemble utilization, financial, and quality of care data from general hospitals, specialty hospitals and ambulatory care centers.

Wesley supports these recommendations and the others offered in the Kansas Health Institute study.

Community general hospitals in Kansas perform a very important role and take their responsibility as a 'hospital' very seriously. Within the capabilities each general hospital has, as defined by the medical resources available, we take care of all patients who present to us for diagnosis and treatment. Unfortunately the public, at least in Kansas, cannot distinguish between a true community general hospital and a limited service specialty hospital, as the Kansas statute is unclear in this matter. House Bill 2418 will correct this problem and fully define a general hospital to operate a dedicated emergency department providing 24/7 services to the public, that participates in the statewide trauma system plan, is a participating provider in the Kansas Medicaid plan, and does not have more than 44% of its discharges in one or 65% in two areas that focus on cardiac, orthopedic surgery or other surgical cases.

I would also like to mention a disturbing phenomenon occurring with respect to how certain patients are cared for in Kansas since the inception of these limited service specialty facilities. At Wesley we have experienced several instances of patients initially treated in a limited service hospital for some condition, usually surgical, and subsequently transferred to Wesley for more specialized care that cannot be provided at the limited service hospital. Often these patients have experienced complications and or emergent situations and are rapidly discharged from the specialty facility and then re-admitted to Wesley for further care. While it is appropriate to get the patient to the properly resourced hospital for care, the transfer situation would have been avoided had the patient, presumably with some risk factors that could lead to complications, been admitted to the full service general hospital in the first place.

A well-publicized example of this recently occurred in Abilene, Texas. A 44-year old truck driver underwent elective spinal surgery on January 23, 2007 at the physician owned 14-bed West Texas Hospital where sometime after surgery he went into respiratory arrest and the hospital staff, apparently unable to deal with the situation, called 911 for assistance. The patient was transferred to the community general hospital, Abilene Regional Medical Center, where he passed away. This was certainly a tragic situation.

This incident gained the attention of the Senators Baucus and Grassley (Senate Finance Committee) and Congressman Stark (House Ways and Means Committee) who have been actively involved at the federal level with CMS and the previous moratorium on certification of new physician owned specialty hospitals. In a February 8, 2007 letter to CMS they requested of CMS, among many items, an explanation of how this institution was granted Medicare provider status during the moratorium and how many times this hospital has called 911 to transfer a patient to another hospital in an emergency situation. I quote from their letter: "*CMS clearly must take action and ensure that physician-owned facilities that hold themselves out to the public as 'hospitals' have the requisite staff and abilities to ensure that basic lifesaving measures can be employed.*"

One last comment before closing, Kansas has adopted as part of its Manual on Uniform Traffic Control Devices, the Blue H, so common on our nations highways. Kansas requires that a hospital have 1) 24-hour service, 7 days a week; 2) Emergency department facilities with a physician (or emergency care nurse on with duty within the emergency department with a physician on call) trained in emergency medical procedures on duty; 3) be licensed for definitive medical care by the appropriate state authority; and 4) be equipped for radio voice communications with ambulances and other hospitals. This is another example of the state expecting a certain standard of care from our community hospitals.

For our state to set reasonable expectations of general hospitals is appropriate, and it is time that Kansas licensure laws reflect these responsibilities.

I urge you to study carefully the issues related to specialty hospitals and the amendment of the licensure statute to more accurately reflect the definition of a true 'general hospital' when compared to a 'special hospital'.

Thank you for the opportunity to present our position on this matter with you today. I will be happy to address any questions you have.

KANSAS HOSPITAL ASSOCIATION

Thomas L. Bell
President

February 15, 2007

TO: House Health and Human Services Committee

FROM: Tom Bell
President

SUBJECT: House Bill 2418

In communities across Kansas, the blue and white "H" sign dots the streets, promising to guide patient and families to a general hospital that provides care 24-hours a day, seven days a week. House Bill 2418 would update, and provide clarity, to the "general hospital" definition in the Kansas hospital licensure law.

The current hospital licensure law at K.S.A. 65-425 *et seq.* was initially enacted in 1947. The key provision of the hospital licensure laws is K.S.A. 65-425, which has long contained the definitions. Initially, this section defined the term "hospital." In 1971, definitions of an ambulatory surgical center and of a recuperation center were added. By then, the Kansas Department of Health and Environment had adopted hospital licensure regulations that implemented K.S.A. 65-425 and related provisions.

In 1973, K.S.A. 65-425 was amended to add a reference to a special hospital. That definition was quite similar to the revised definition of a general hospital that was adopted at the same time. However, a general hospital was defined as an establishment to treat a "variety of medical conditions" while a special hospital was to treat "specified medical conditions." Although they have been revised slightly, the 1973 definitions of a general hospital and of a special hospital remain essentially in place.

Since this time, KDHE has not adopted any regulations that define the differences between a general hospital and a special hospital. By adopting separate definitions, the Legislature obviously intended to differentiate between a general community hospital and a special hospital. Yet the laws simply do not provide any substantial differences. There are a few examples of issues that exist today with the "general hospital" category. It is our understanding that an applicant may simply choose between licensure as a general hospital and as a special hospital without any particular review or scrutiny by KDHE. This interpretation has caused confusion as to the definition of a "general hospital". KHA believes it is time to clarify the requirements of a "general hospital" to ensure it more accurately reflects the public understanding of what constitutes a general hospital.

House Bill 2418 follows many of the definitional guidelines used by the Medicare Payment

Advisory Group (MedPAC), an independent agency that advises Congress on issues affecting the Medicare program. In addition, the Kansas Health Institute closely followed the MedPAC definitions of a special and general hospital. We would suggest that a general hospital meet the following four criteria in order to receive a "general hospital" designation. A "general hospital" must:

- have a dedicated emergency department;
- participate in the statewide trauma system plan and any plan for the delivery of emergency medical services applicable to its region;
- not have more than 44% of its discharges in one or 65% in two areas that focus on cardiac, ortho- or surgical cases; and
- participate in the Kansas Medicaid program.

The Kansas Hospital Association and its members urge the committee to pass House Bill 2418. Thank you for your consideration of our comments.

Via Christi
Health System

Testimony Presented to the House Health and Human Services Committee

By Mary Ellen Conlee, Representing Via Christi Health System
February 15, 2007

Madame Chair and members of the Committee, I am Mary Ellen Conlee, representing Via Christi Health System, the largest healthcare delivery system in Kansas providing a wide array of services including acute care hospitals, a co-owned special hospital, senior care facilities, a network of family physician offices and several outpatient diagnostic services.

I appear today in support of HB 2418.

HB 2418 would revise the hospital licensure law by updating the definition of a "general hospital" to better reflect the facilities that exist today. During the thirty-four years since the Kansas statute was last revised, hospitals have changed with the development of limited service hospitals specializing exclusively in certain procedures. It is clear that special hospitals have evolved into a specific type of health care delivery model very different from general hospitals. As a result a better definition of a general hospital is demanded.

Via Christi believes that the conditions listed in HB 2418 more precisely define a general hospital. Those conditions require participation in the Kansas Medicaid Plan as well an emergency room that participates in the statewide trauma system plan. To further distinguish between a hospital that treats specified medical conditions and one that meets the standards of a general hospital HB 2418 identifies that a general hospital must demonstrate that no more than 44% of discharges relate to patients with a disease or disorder in any one major diagnostic category and the sum of inpatient discharges for the establishment's two highest major diagnostic categories shall not exceed 65% of all inpatient discharges.

With the move toward more transparent information for consumers, these provisions will help those seeking medical care better understand the hospital choices that exist in Kansas. Patients will know that the licensed general hospital will be able to address unanticipated medical conditions or emergencies, not just those related to the admitting diagnosis.

VCHS urges you to support HB 2418. Thank you.

House Health and Human Services
DATE: 2-15-07
ATTACHMENT 4

Statement to the Committee on Health and Human Services
On HB 2418
The University of Kansas Hospital
February 15, 2007

The University of Kansas Hospital supports House Bill 2418, which would amend the definition of "general hospital" to more accurately reflect the public understanding of the responsibilities and services of general hospitals.

This legislation is necessary because the definition in current law is not sufficiently specific. For example, some limited-service, or "specialty," hospitals in Kansas currently are licensed as general hospitals even though they provide a narrow range of services and typically treat patients with certain medical conditions.

Those limited-service/specialty hospitals exist because of an exception in federal law that otherwise prohibits providers from billing Medicare or Medicaid for designated health care services if the referring physician has a financial relationship with or ownership in the provider. 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. One consequence of the exception was the birth of physician-owned limited-service hospitals.

HB 2418 would require any facility licensed as a general hospital to have a 24-hour-a-day emergency department, participate in the state Medicaid program and trauma system, and have a reasonably broad case mix. The amendment is straightforward and insists only that facilities licensed as general hospitals are, in fact, operating as full-service hospitals.

Limited-service/specialty hospitals still would be able to qualify for a license under the definition of a "special hospital," which already exists in Kansas law.

House Committee on Health and Human Services
February 15, 2007

Testimony in Opposition to HB 2418

Madam Chair Landwehr & Members of the Committee:

My name is Scott Chapman. I am the administrator of Manhattan Surgical Hospital in Manhattan, Kansas. I am here representing the Kansas Surgical Hospital Association which is opposed to House Bill 2418. The Kansas Surgical Hospital Association has 9 member hospitals across the state serving the communities of Wichita, Great Bend, Kansas City, Emporia, Salina and Manhattan.

Our association's opposition to the bill is based primarily on our belief that no change is needed to the current hospital licensure definitions. As we have testified before, it is our understanding that the current definitions have worked fine for the Kansas Department of Health and Environment in their licensing responsibilities; have not caused difficulties for the surveyors; have not endangered patients in any way; or misled the public about what it means to be a hospital. Licensed hospitals in the state of Kansas must go through a vigorous inspection process on a regular basis and are held to the same high standards whether they're classified as a general, special, or critical access facility.

If this bill becomes law, all general hospitals across the state would now be required to have a dedicated emergency department as well as ensure that their

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inpatient discharges are not too narrowly grouped into certain diagnostic categories.

The dedicated emergency department requirement should be carefully considered before making it a licensure requirement. The provision of emergency services is an optional service for Medicare participation, but may be required by State law. If required by State law, as this bill sets out to do, the hospital must comply with all the requirements of the Medicare Conditions of Participation for emergency services. Standard 482.55(b)(1) of the Conditions of Participation states: *"The emergency services must be supervised by a qualified member of the medical staff."* And the corresponding interpretive guideline states: *"A qualified member of the medical staff must be on premises and available to supervise the provision of emergency services at all times the hospital offers emergency services. A qualified member of the medical staff must be physically present in the emergency department and available to directly supervise the provision of emergency care to a patient."* Making this a licensure requirement and therefore a Medicare criterion may prove quite difficult for some general rural hospitals across the state without resources to maintain on-site physician coverage 24 hours a day, 7 days a week for emergency services.

The bill also adds a requirement for measuring the percent of inpatient discharges that fall into cardiac, orthopaedic and surgical diagnostic categories. Our association questions why these three certain categories were selected and not others. What makes these categories unique in determining whether a hospital is general or special? Why not choose pregnancy and childbirth, digestive systems, cancer, respiratory systems or burns? We are just a little unclear on the rationale for carving out only certain categories of diagnoses. We are also unclear on the percentages. How have the authors of the new language determined that 44% and 65% are the correct statistical indicators for facility specialization? Additionally,

the process of calculating and monitoring the percentage of discharges in the specified categories now becomes a regulatory burden for all hospitals so as to ensure they are not illegally licensed. How often will hospitals need to break-down and report their discharges by major diagnostic category and how often must a facility move from one category to another based on changes in their patient mix?

The proposed new language raises important questions and concerns that should be fully addressed before any changes are made to the licensure definitions. As previously stated, the KSHA is opposed to this bill because we do not think it will result in better care or lower costs. In fact, it may do the opposite by adding a layer of confusion and bureaucracy where none is needed.

At the very least, our association encourages you Madam Chair and this Committee to defer any action on this bill until the Kansas Health Policy Authority completes its study on this very matter and issues its report later in the legislative session. The Health Policy Authority was directed to conduct a review and study of the Kansas hospital licensure laws and I believe they will be issuing their report and any recommendations to this Legislature soon after March 1.

Thank you very much for allowing me the opportunity to testify.

MARY NAN HOLLEY STATEMENT IN OPPOSITION
TO HB 2418

Madame Chairman and Members of this distinguished committee; my name is Mary Nan Holley, Chief Executive Officer of Heartland Spine and Specialty Hospital. I am here today to speak in opposition of House Bill 2418.

Those in favor of this legislation argue that the current statutes where written a long time ago and do not reflect the current health care industry. So they offer this legislation as to define a special hospital from a general acute care hospital.

Heartland Spine and Specialty Hospital is licensed as a level 4 trauma center. Even though my hospital does not have an emergency room department, we are required to treat any patient that walks through our doors with an emergency. This is a requirement of our general acute care license. Matter of fact, I have technology in my hospital that no other emergency department in the Kansas City area can offer Kansans.

Due to our trauma 4 license and general acute care license, HSSH is part of FEMA's emergency response plans for Kansas City and the State of Kansas if they suffered an event that lead to major loss of life. FEMA bases these plans specifically on a state's general acute care licensed facilities and their trauma license. I have been advised by legal council that facilities defined as special hospital could possibly not be used by FEMA if this legislation became law. This is due to federal laws only defining general acute care hospitals and having no definition or concept of a special hospital.

I am somewhat concerned that this does not seem to be a good faith attempt to actually redefine statutes. Specialty or Special Hospitals are not a new invention of the health care industry. Matter of fact these facilities really started in England in the late 1700's. The United States saw single focused facilities arrive and develop in the early 20th century. I believe we are all familiar with facilities that only focus on cancer treatment, burn victims and pediatric care. It seems odd to me that we need a special hospital definition for facilities that focus only on orthopedics and cardiology.

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Single specialty facilities have been around 50 years. Orthopedic and Cardiology specific facilities have existed for more than 25 years. This time period seems to suggest that current statutes are working.

After an extensive review of other state licensure laws HSSH could not find any other state that had special hospital as a category of licensure.

Obviously this committee has the great task of deliberating and debating this legislation. The health care industry is highly regulated by both federal and state governments. I simply bring this up to illustrate the following point. EMTALA is based on federal and state licensure laws. No where under EMTALA guidelines does it talk about regulatory requirements of a "special hospital". HSSH will always regardless, of this legislation care for all patients that require emergency care. However, I simply ask this committee if special hospital patients will be covered under EMTALA?

At this time I am fairly certain that HSSH would meet the definition of a general acute care hospital as outlined in this legislation. I testify in opposition to this legislation because it seems to create more questions than solve problems. I do not wish to subject members of this committee to federal bureaucrats but with state and federal healthcare laws being intertwined it seems prudent to seek the federal government's counsel in this case.

I think I have clearly shown two patient care problems that might occur unintentionally by this legislation. I hope the committee will seek answers to these genuine questions.

I would like to extend an invitation to all members of the committee to visit Heartland Spine and Specialty Hospital.

Madame Chairman I now submit myself to the questions that you or members of your committee may have for me.

Testimony before the House Committee on Health and Human Services
House Bill No. 2418
February 15, 2007

By: Philip S. Harness, C.E.O.
Doctors Hospital, L.L.C.
4901 College Blvd.
Leawood, KS 66211

House Bill No. 2418 does not seem to accomplish a public or consumer oriented purpose, as well as containing certain ambiguities, all of which leads to uncertain conclusions.

Line 17 of the bill seeks to add a requirement for "a dedicated emergency department", and Line 19 seeks to add "…and emergency department services" without defining what that really means. Besides the definitional issue, and given that even Medicare recognizes that most care is on an outpatient basis, the request for special legislation is perplexing. Our hospital is located in an area in which there are multiple hospitals. There are four (4) Emergency Rooms contained within hospitals within a four (4) mile radius: Menorah Medical Center, St. Luke's South, Overland Park Regional Medical Center, and St. Joseph's (which is actually on the Missouri side of State Line Road). This bill would require both our hospital as well as Heartland (which is on the other side of the I-435 from our facility) to mandate emergency rooms, which would now compute out to six (6) emergency rooms within less than a four (4) mile radius, some arguably within walking distance of each other. We should strive to make the best use of our health care resources and this does not seem to be the best use. We all compete for good nursing talent, and due to the present nursing shortage, we find that many of the nurses freely "job-hop" looking for the best pay, benefits, and working conditions.

Forcing more hospitals to add further emergency rooms only spreads a thin nursing population even thinner.

Lines 23-24 seeks to add a requirement that a general hospital be an establishment "…that is ***focused*** on providing treatment for patients who require inpatient care". Once again, the lack of a definition leads to uncertainty. Health care focuses on a lot of things; here, one way to focus on inpatient service is to statutorily mandate a minimum nurse to patient ratio in the inpatient unit. Our hospital never has less than one (1) nurse to four (4) patients in the inpatient area. An area hospital just opened a liver and pancreas unit – does that mean that our hospital should offer the same thing? The area probably only needs one. Why not allow facilities to specialize because eventually they all seek certain niches. In the Kansas City area, KU has the premiere burn unit, and because of the limited number of anticipated patients, most other area hospitals do not offer extensive services in that specialty. Because of the desirability of specialization, lines 25-35 are puzzling; that section seeks to add a requirement that a general hospital have "no more than (44%)" of patients presenting with any one of the major diagnostic categories, and "…the sum of the inpatient discharges for the two highest major diagnostic categories cannot exceed sixty-five percent (65%) of all inpatient discharges". No hospital can entirely control the patient population, their disorders, injuries or conditions, nor can a hospital dictate the specialty of the physicians who request privileges at certain hospitals, and not others. The proposed legislation does not indicate the amount of time that would be used as a measure, whether that would be daily, weekly, monthly, quarterly, annually, or by decade. It would be difficult to tell the medical staff that an institution is no longer a hospital if the patient population fell outside of these numerical criteria. It is uncertain

what public policy goal this section seeks to address. If we can't meet this definition, then we may not be able to participate in the FEMA response plan; these are based on state-defined general acute care hospitals. FEMA has no statutory or regulatory recognition of special hospitals.

Lines 24-25 seeks to add a requirement that the hospital be a "participating provider in the Kansas Medicaid plan". We do participate and see Medicaid patients from both Kansas and Missouri, and would agree that that is good public policy.

In conclusion, the bill as written (with the exception of the requirement of Medicaid participation) is an unpalatable solution in search of a problem.

TESTIMONY OF DARYL THORNTON
HOUSE HEALTH AND HUMAN SERVICES COMMITTEE
HOUSE BILL NO. 2418
FEBRUARY 15, 2007

Dear Chairperson Landwehr and Committee Members;

Thank you for the opportunity to submit remarks on House Bill No. 2418. My name is Daryl Thornton. I have a Masters Degree in Health Care Administration from Washington University in St. Louis, Missouri and have been an administrator since 1977. I currently serve as Chief Operating Officer for the Kansas Medical Center, L.L.C.

Kansas Medical Center, L.L.C. is a licensed 58-bed general acute care hospital in Andover, Kansas. Our new facility offers state of the art medical services, with 24-hour physician, nursing and emergency room services. We opened our doors to the community on October 2, 2006.

I appear here today in opposition to House Bill No. 2418 and I urge the Committee to reject this proposed legislation.

The key concerns we have with the bill and I want to present to you are the following thoughts.

We established our facility under the current general hospital requirements and are in the process establishing ourselves in the community and creating new doctor/patient relationships. Until we have a "track record" of our patient mix, we cannot determine the effect of this proposed legislation to our facility and the impact to healthcare access for our community. For a startup hospital like Kansas Medical Center, L.L.C the diagnosis related grouping (DRG) percentage mix should be based on two or three years of data in order to determine an accurate case mix.

Questions that need to be asked and the public policy information we need to know:

To whom do we report the data, how often do we report?
If a hospital is not in compliance, how are they notified and what is the notification method?
Would a facility be permitted to make adjustments to come into compliance?
What adjustments would be permitted?
In what timeframe could adjustments be made?
What is the process for enforcement and any appeal?
Most importantly, what is the penalty to a facility out of compliance?

What is the ultimate intent of this new hospital licensure definition?

With the unknown impacts, unanswered questions and potential for unintended consequences we must oppose House Bill No. 2418.

Thank you for your time.

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ATTACHMENT 9

KANSAS

Kathleen Sebelius, Governor
Roderick L. Bremby, Secretary

DEPARTMENT OF HEALTH
AND ENVIRONMENT

www.kdheks.gov

Division of Health

Testimony on House Bill 2418

To

House Committee on Health and Human Services

Joseph F. Kroll
Director, Bureau of Child Care and Health Facilities
Kansas Department of Health and Environment

February 15, 2007

Chairperson Landwehr and members of the committee, my name is Joseph Kroll and I am the Director of the Bureau of Child Care and Health Facilities, which administrates the licensing program for hospitals. Thank you for the opportunity to comment on HB 2418, which would amend the definition for a general hospital. The proposed definition would be more specific by requiring a general hospital to have a dedicated emergency department, provide 24 hour emergency service, participate in the statewide trauma system and meet criteria related to discharge percent based on diagnostic categories.

Kansas statute recognizes 3 hospital types, general hospital, special hospital and critical access hospital. The statutory definitions for general hospital and special hospital are the same except that a general hospital provides diagnosis and treatment for a variety of medical conditions and a special hospital provides diagnosis and treatment for specified medical conditions. A critical access hospital is a member of a rural network and provides services in cooperation with a supporting hospital. There are 50 general hospitals, 21 special hospitals (5 of which are state operated) and 83 critical access hospitals.

There has been considerable discussion in recent years about the various hospital types, at both the national and state levels, and the impact different types have on quality and access. There has been much focus on special hospitals, including a national moratorium on physician owned special hospitals which is now expired. The 2006 legislature directed the Kansas Health Policy Authority to study the issues related to special hospitals, including a study and recommendations to assure existing definitions for hospitals properly define categories of hospitals to reflect current medical facilities. We have been involved with and provided input to the Authority on this issue.

HB 2418 appears to clarify the differences between general hospitals and special hospitals, but it may be premature to adopt it before evaluating the recommendations of the Health Policy Authority due to the legislature March 1. Although current information indicates only 6 currently licensed general hospitals may not meet the criteria in HB 2418, without considering concurrent amendment to the definition for special hospital there may be no valid licensing category for these 6 to move to. These 6 may not meet the discharge or emergency room criteria and are licensed as general hospitals pursuant to application information on file. Further analysis of discharge data may also result in more than 6 hospitals no longer eligible to be licensed as they currently are.

In conclusion KDHE believes HB 2418 would better characterize what a general hospital is, but passing the bill before evaluating the study due from the Health Policy Authority March 1 may not be the best course of action for the reasons noted.

Thank you for the opportunity to comment and I will be happy to answer any questions.

KANSAS HEALTH INSTITUTE

For additional information contact:

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Topeka, Kansas 66603-3936
Tel. 785.233.5443 Fax 785.233.1168
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House Health and Human Services Committee

February 15, 2007

Defining Specialty and General Hospitals

Sheldon Weisgrau
Senior Policy Analyst
Kansas Health Institute

Healthier Kansans Through Informed Decisions

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.

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Madame Chair and Members of the Task Force,

I'm Sheldon Weisgrau, senior policy analyst with the Kansas Health Institute. Thank you for the opportunity to address you today as you consider legislation to better define general and specialty hospitals for licensure purposes.

As you may know, KHI recently completed a study on the impact of specialty hospitals on general hospitals in Kansas. A key task in that analysis was clearly identifying the facilities that would be defined as "specialty hospitals." For guidance, we looked to previous analyses that had been conducted by the Centers for Medicare and Medicaid Services (CMS), the Medicare Payment Advisory Committee (MedPAC), and others.

The criteria that we ultimately developed to define specialty hospitals were adapted from the definitions used by these organizations and are similar to some provisions in HB 2418. Specifically, we defined a specialty hospital as a facility that meets the following criteria:

- At least 45 percent of cases must be in cardiac, orthopedic, or surgical services, or
- At least 66 percent of cases must be in two Major Diagnostic Categories (MDCs), with the primary one being cardiac or orthopedic.

HB 2418 is somewhat different than the definition we used, in part because it uses these types of criteria to define a general hospital rather than a specialty hospital. The effect, however, is the same, and creates the same results. The important point, which is reflected in these definitions, is that there are clear differences between most specialty and general hospitals in the types and range of conditions that they treat.

Unlike HB 2418, our study did not include criteria regarding emergency services or participation in the Medicaid program to identify specialty and general hospitals. There have been studies, however, that do use the presence of an emergency department as one of several criteria to differentiate specialty from general hospitals. General hospitals are, in fact, much more likely to operate emergency departments than specialty hospitals. Some specialty hospitals, however, particularly those that focus on cardiac care, do have emergency departments.

I'm not aware of any previous definitions that use participation in the Medicaid program as an indicator of specialty or general hospital status. We believe, however, that such criteria are appropriate. The KHI study states: "Although licensure is generally intended as an imprimatur of quality, it may be reasonable to require certain actions that are in the public interest, such as treating a representative proportion of the population in need of care, in return for this state 'stamp of approval.'"

I do have one note of caution for the committee. The proposed legislation includes a provision that states that a general hospital is "focused primarily on providing treatment for patients who require inpatient care." When most of us think of hospitals, we certainly consider them to be inpatient facilities. Over the past 20 years, however, medical practice has evolved and more and more patients who previously would have required hospitalization are now treated as outpatients. It is now common for a majority of a hospital's business to be conducted on the outpatient side. This is particularly true for small and rural hospitals.

Thank you for your time.

Issues
MANAGEMENT GROUP, INC.

MARCH 15, 2007

TESTIMONY: HOUSE HEALTH AND HUMAN SERVICES COMMITTEE
HOUSE BILL 2483 - PHYSICAL THERAPY PATIENT ACCESS

MADAM CHAIR AND MEMBERS OF THE COMMITTEE. MY NAME IS BUD BURKE AND I APPEAR ON BEHALF OF THE KANSAS PHYSICAL THERAPY ASSOCIATION.

OVER THE SUMMER AND FALL OF 2006 MEMBERS OF THE PHYSICAL THERAPY ASSOCIATION MET WITH OUR HEALTH CARE PARTNERS TO SEEK LANGUAGE THAT WOULD AMEND THE PHYSICAL THERAPY ACT THAT WOULD NOT PRODUCE OPPOSITION.

WE MET WITH REPRESENTATIVES OF THE KANSAS MEDICAL SOCIETY, KANSAS OCCUPATIONAL THERAPY ASSOCIATION, KANSAS CHIROPRACTIC ASSOCIATION AND HAD DISCUSSIONS WITH THE KANSAS ATHLETIC TRAINERS SOCIETY.

HB 2483 IS THE RESULT OF THOSE MEETINGS AND ALTHOUGH FROM THE PHYSICAL THERAPY PERSPECTIVE, IT DOES VERY LITTLE TO PROVIDE DIRECT ACCESS TO THEIR SERVICES, IT IS AT LEAST A STEP IN THE RIGHT DIRECTION. THERE ON SOME P.T.'S THAT ARE DISAPPOINTED THAT IT DOES NOT GO FAR ENOUGH BUT WE ARE HOPEFUL THAT IN THE FUTURE WE WILL BEE ABLE TO MAKE OUR CASE THAT PHYSICAL THERAPISTS ARE TRAINED TO RECOGNIZE THE ISSUES THAT THEY CAN TREAT AND THOSE THAT WOULD CAUSE THEM TO REFER TO A PHYSICIAN.

WE HAVE A "WELLNESS" AMENDMENT, COPY ATTACHED, THAT WE ARE STILL DICUSSING WITH SOME OF THE OTHER HEALTH CARE PROVIDERS AND HOPE THAT WE CAN AMEND IN THE SENATE.

PLEASE GIVE FAVORABLE CONSIDERATION FOR HB 2483.

House Health and Human Services
DATE: 2-15-07

2009 Camelback Drive
Lawrence, Kansas 66047
(785) 749-5822 *fax* (785) 749-1502

800 SW Jackson, Suite 808
Topeka, Kansas 66612
(785) 232-2320 *fax* (785) 232-2868

ATTACHMENT 12-1

(4) A licensed physical therapist may provide physical therapy services without referral as otherwise required under subsection (b)(2-3) if the physical therapist provides physical therapy services to, (A) employees solely for the purpose of education and instruction related to workplace injury prevention; (B) special education students who, by virtue of their individualized education plan (IEP) or individualized family service plan (IFSP), need physical therapy services to fulfill the provisions of their IEP, IFSP; (C) the public for the purpose of fitness, health promotion and education. The physical therapist may not provide physical therapy services without referral as described within subsection (b)(4)(A)and(C), if the individual receiving physical therapy services has a symptomatic injury, disease or condition requiring prior approval for treatment.

(4) A licensed physical therapist may provide physical therapy services without referral as otherwise required under subsection (b)(2-3) if the physical therapist provides physical therapy services to, (A) employees solely for the purpose of education and instruction related to workplace injury prevention; (B) special education students who, by virtue of their individualized education plan (IEP) or individualized family service plan (IFSP), need physical therapy services to fulfill the provisions of their IEP, IFSP; (C) the public for the purpose of fitness, health promotion and education. The physical therapist may not provide physical therapy services without referral as described within subsection (b)(4)(A)and(C), if the individual receiving physical therapy services has a symptomatic injury, disease or condition requiring prior approval for treatment.

February 15, 2007

House Health and Human Services Committee

From:

Paul Silovsky PT
Legislative Chair
Kansas Physical Therapy Association

RE: House Bill 2483

Chairman Landwehr and Members of the House Health and Human Services Committee, my name is Paul Silovsky and I am here to testify as a proponent of HB 2483. I am the current Legislative Chair of the Kansas Physical Therapy Association and have been a Physical Therapist in Kansas for 20 years as well as a private business owner for the past 13 years.

Very simply stated, HB 2483 gives the public limited access and the choice to see a physical therapist directly for physical therapy evaluation and treatment for up to 30 days without a referral from one of the licensed professionals that are listed within our current statutes.

I would like to summarize for you what this bill will provide for all Kansans as well as provide several assurances why direct consumer access to a physical therapist will be good public policy in this state.

1. HB 2483 does not in any way alter the currently workable scope of physical therapist practice, even though amendments will be offered (and have been offered in past legislation by other groups) in an effort to limit the current scope and definition of physical therapy services.

2. This legislation allows the consumer to choose a physical therapist for physical therapy treatment within the current selective situations described in this bill. HB 2483 presents one of the most restrictive set of provisions currently allowed by law within the 44 states that do allow some form of direct consumer access for treatment from a physical therapist. Therefore, this bill will not compromise patient safety as already proven by current direct consumer access workability across the nation.

3. This bill will not affect third party reimbursement of physical therapy services in any way.

4. Current law makes it an unnecessary and costly requirement to see another provider before accessing a physical therapist for physical therapy services. HB 2483 would improve access and reduce costs to the consumer by not requiring additional physician visits in order to access a physical therapist in selected situations. This bill also allows for earlier intervention by the physical therapist which has been proven to prevent or reduce the chronicity of pain and function, improve health care outcomes, and reduce consumer costs.

5. Direct Consumer Access to a physical therapist poses no documented risk or harm to patients. There is no data available to support this past claim in those states with direct access to a physical therapist. In fact HPSO, the leading provider of professional liability coverage to the physical therapy profession states that there is "no premium differential between direct access and non-direct access states". In addition the Federation of State Boards of Physical Therapy attests to the fact that there is no increase in the number or severity of disciplinary cases in direct access jurisdictions as compared to those jurisdictions that do not have any form of direct access.

6. As a Physical Therapist and business owner, the current law limits the trade of physical therapy. It creates unnecessary barriers for the public to the care and prevention functions that are provided by the professionals with a degree in physical therapy. Many of my staff and the public that we serve are frustrated by the lack of immediate access to a physical therapist. Ironically, PT professionals with high levels of education and expertise related to the prevention, evaluation and treatment of musculoskeletal conditions are not permitted by law, to apply our skill and knowledge without prior referral. Yet less qualified or unregulated providers can access the public and apply interventions without the approval of a physician.

In conclusion, direct access to a licensed physical therapist should encourage preventative care, make physical therapy services available to more people, allow for an earlier return to work and healthy lifestyles and reduce the need for long term care by providing early intervention.

Thank you for the opportunity to testify in the support of House Bill 2483. I would be happy to answer any questions.

Respectfully submitted,

Paul Silovsky PT

HPSO
Healthcare Providers Service Organization℠

159 East County Line Road • Hatboro, PA 19040-1218
1-888-288-3534 • Fax 1-847-953-0134 • www.hpso.com

REBOUND PHYSICAL THERAPY
5220 SW 17TH ST
TOPEKA, KS 66604-2458

Dear Practice Manager:

It is with great excitement that I write to you today to announce the completion of a landmark malpractice claims study focused on the practice of physical therapy. The study was conducted by CNA, the underwriter for the HPSO program. CNA and HPSO have partnered for more than a decade to deliver insurance solutions to physical therapists, both individual practitioners and group practices. The program has grown significantly since its inception and now provides insurance services to more than 75,000 physical therapy providers.

CNA conducted this study to foster awareness of risks; to enhance the focus on patient safety among physical therapy practitioners; to identify areas of focus for risk management.

The study utilizes the claims data of the physical therapists who have been insured through the HPSO program between 1993 and 2006. This study is not intended to reflect the claims experience of all physical therapists but rather is a snapshot of data that, along with the attendant risk management recommendations, can be used to complement your risk management policies, procedures, and training.

We are pleased with the study results. There is no indication in the results that manipulation*, autonomous practice or direct access have adversely impacted the risk profile of the physical therapy profession. Rather, it is the more "routine" incidents of slips and falls, burns, insufficient supervision, and the like that have caused the most concern. These are areas that can be remedied by education, training, and awareness, which is the intent of the study recommendations.

We trust that this study provides you and your staff with important risk management information to help you in your 'day to day' practice of physical therapy. We value your comments and welcome your feedback.

Sincerely,

Michael J. Loughran
Executive Vice President

** Claims alleging "manipulation" in this Claim Study are comprised of those manual therapies used by the physical therapist to mobilize or manipulate soft tissues and joints. No claims alleging injury as a result of spinal manipulation were found in the data sample. CNA continues to take the position that there are not any trends relative to manipulation that would indicate that this procedure presents a risk factor of specific concern. Further, CNA currently does not anticipate any impact to rates in the program related to physical therapists performing manipulation.*

Dedicated to Serving The Insurance Needs of Heathcare Providers

February 15, 2007

House Health and Human Services Committee

From:

Marcie Swift PT
The University of Kansas Medical Center
Physical Therapy Program

RE: House Bill 2483

Chairman Landwehr and Members of the House Health and Human Services Committee, my name is Marcie Swift and I am here to testify as a proponent of HB 2483.

The University of Kansas Medical Center Physical Therapy program along with several other PT programs across the nation offers a clinical doctorate degree in Physical Therapy. Physical therapists are expected to determine appropriate patients for physical therapy intervention; thus the curriculum within the KU PT program includes differential diagnosis instruction in the classroom and clinical setting. Students learn screening tests to determine whether patients are appropriate for physical therapy care, or need to be referred to their physician. Students learn extensive triage tests so that they can identify symptoms that require urgent physician evaluation. At the time of graduation, students are able to perform a thorough history and physical examination and determine if the patient is appropriate for physical therapy care. If the patient is appropriate for PT care, the student designs an individualized exercise/intervention program and continually reassesses the patient's progress with each visit.

We anticipate amendatory language regarding changing the current scope and abilities of physical therapists to provide manual therapy treatment as we do today. I stand before you to offer background information with regard to the physical therapists education and application of manual therapy and manipulation dating back to 1928. The Normative Model of Physical Therapist Professional Education which determines course content necessary for physical therapy curriculum includes manipulation as a course content and a skill acquisition. Likewise the APTA's Guide to Physical Therapist Practice includes manipulation as a treatment intervention. A study by Setcliff in 1998 found that 100% of accredited physical therapy schools include manual therapy techniques.[10] The physical therapy student is instructed and tested on both their clinical decision making capability relevant to indications, contraindications and technique and their competency to perform the technique. This is determined by scientific standards in lab and clinical settings, rather than the number of hours spent performing the technique. Specifying how many hours one spends in training for manipulation does not assure competence or a mastery of the task.

Issues of manipulation practice and safety can not be validly challenged, compared, rated or standardized interprofessionally in the absence of interprofessional

cross competency. Under the Kansas Physical Therapy Act, in the section on unprofessional conduct (K.S.A. 65-2912), it states that any physical therapist shall be guilty of unprofessional conduct if he or she fails to refer patients to other health care providers if symptoms are present for which physical therapy treatment is inadvisable or if symptoms indicate conditions for which treatment is outside the scope of knowledge of the registered physical therapist. All practitioners, whether a physical therapist, chiropractor, osteopath, or physician, understand both ethically and professionally, that there must be a limitation on practice based on their field of knowledge, particular expertise and range of ability and training.

An issue raised in past testimony by the Kansas Chiropractic Association is the patient's risk of harm by physical therapists providing manual therapy. In a study of 177 published cases of injuries reported in 116 articles between 1925 and 1997, Richard DiFabio, found physical therapists were involved in less than 2% of the cases, and no deaths were attributed to manipulation by physical therapists, much less than for the chiropractors.[11] In a follow-up of DiFabio's study, Terrett "corrected" the identity of the practitioner if it was reported to be a chiropractor, but the report contained inaccurate descriptions of the practitioner. In 50 of the 78 corrected studies that resulted in significant disability and/or death, he identified the practitioner as a chiropractor. Three out of the 78 were attributed to physical therapists, two of those occurring in South Africa and New Zealand.[12] In a previous testimony regarding physical therapists and manipulation, the KCA referenced a quote from Dr. Shekelle, who was part of the collaboration of doctors of medicine and chiropractic from the Rand Corporation, that chiropractors administer 94% of the manipulations and then used this to extrapolate a higher risk of injury for physical therapists on the number of patients they treat. Dr. Shekelle, responded in an e-mail to a Washington physical therapist in February, 2000, that "there is no credible data to support a conclusion that any provider is more or less safe than any other provider in the delivery of spinal manipulation". [13]

Thank you for the opportunity to testify in the support of House Bill 2483. I would be happy to answer any questions.

Respectfully submitted,

Marcie Swift PT

February 12, 2007

House Health & Human Services Committee
Kansas State Legislature
Capitol Building
Topeka, KS 66604

Dear Madam Chairman and Fellow Committee Members:

I am writing to request your support of Bill HB-2483 allowing physical therapists to treat patients without a doctors' referral.

As a 58 year old female with degenerative discs in both neck and back, approval of this measure would allow me to obtain treatment days earlier than the present statute. When you are in pain, these days can seem like years. Not only would I be able to receive treatment earlier, it also saves me the time and expense of a doctor visitor. A saving of time and money may seem unimportant issues to you, but what corporation doesn't consider these two areas in today's world?

I do not believe the physical therapists of Kansas would abuse the privilege of treating patients without a doctor's referral. No reputable therapist would jeopardize their license by treating a patient beyond their capability.

Please, vote favorably on Bill HB-2483.

Respectfully,

Jane M Weinmann

Jane M. Weinmann
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DATE: 2-15-07
ATTACHMENT 15