Approved: March 21, 2007
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman James Barnett at 1:30 P.M. on March 15, 2007 in Room 231-N of the Capitol.

All members were present.

Committee staff present:
Emalene Correll, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Nobuko Folmsbee, Office of Revisor of Statutes
Morgan Dreyer, Committee Secretary

Conferees appearing before the committee:
Chad Austin, Vice President, Government Relations, Kansas Hospital Association
Sam Serrill, Chief Operating Officer of Wesley Medical Center
Mary Ellen Conlee, Lobbyist for Via Christi Health System
Scott Chapman, Administration of Manhattan Surgical Hospital
Philip Harness, CEO Doctors Hospital, L.L.C. in Leawood
Daryl Thornton, Chief Operating officer, Kansas Medical Center
Dr. Gregory Duick, Chairman, Kansas Heart Hospital

Others attending:
See attached list.

Upon calling the meeting to order, Chairman Barnett asked that the Committee review the Minutes for March 14, 2007 for approval at the end of the meeting.

The Chair called upon Terri Weber to read and explain **HB 2418.**

Questions came from Senators Schmidt, Wagle and Barnett regarding amendment from House, if KDHE can deny letters, participation statewide, trauma system and critical care access.

The Chair announced that the next order of business was to open the hearing on **HB 2418**.

Hearing on HB 2418 – An act concerning the definition of general hospital

With a large number of conferees, the Chair asked that the Committee hold their questions until the end of the hearing.

Chairman Barnett called upon his first proponent conferee, Chad Austin, Vice President, Government Relations, Kansas Hospital Association who stated that 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. A copy of his testimony is (Attachment 1) attached hereto and incorporated into the Minutes as referenced.

The Chair called upon his second proponent conferee, Sam Serrill, Chief Operating Officer of Wesley Medical Center who stated that Wesley and he support passage of the bill, 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. A copy of his testimony is (Attachment 2) attached hereto and incorporated into the Minutes as referenced.

Chairman Barnett called upon proponent conferee, Mary Ellen Conlee, Lobbyist for Via Christi Health System who stated that it is clear that special hospitals have evolved into a specific type of health care delivery model very different from the general hospital model. As a result, a better definition of a general hospital is demanded. A copy of her testimony is (Attachment 3) attached hereto and incorporated into the Minutes as referenced.

The Chair called upon opponent conferee, Scott Chapman, Administration of Manhattan Surgical Hospital

who stated that the associations's opposition to the bill is based on their belief that no change is needed to the current hospital licensure definitions. A copy of his testimony is (Attachment 4) attached hereto and incorporated into the Minutes as referenced.

Chairman Barnett called upon opponent conferee, Philip Harness, CEO Doctors Hospital, L.L.C. in Leawood who stated that the bill does not seem to accomplish a public or consumer oriented purpose, as well as, containing certain ambiguities, all of which leads to uncertain conclusions. A copy of his testimony is (Attachment 5) attached hereto and incorporated into the Minutes as referenced.

Chairman Barnett called upon neutral conferee, Daryl Thornton, Chief Operating officer, Kansas Medical Center who stated that if legislation is going to be enacted that specifically defines "general hospitals" and "special or specialty hospitals," to make certain together we implement a process that is more appropriate and accurate for Kansas hospitals. A copy of his testimony is (Attachment 6) attached hereto and incorporated into the Minutes as referenced.

The Chair lastly called upon opponent conferee, Dr. Gregory Duick, Chairman, Kansas Heart Hospital who stated that this bill may unintentionally jeopardize rural hospital licensure by requiring dedicated emergency departments and strict DRG percentage criteria. Written testimony was not provided to the committee.

The Chair asked that Dr. Gregory Duick provide written testimony for the Committee to review.

With no more time for conferees or questions, Chairman Barnett asked for the Committee's approval of the Minutes for March 14, 2007 and that the Committee would continue the hearing on **HB 2418** at the next meeting.

The motion was made by Senator Haley to approve the Minutes. It was seconded by Senator Schmidt and the motion passed.

Adjournment

As there was no more time, the meeting adjourned at 2:30 p.m.

The next meeting is scheduled for March 21, 2007.

Senate Public Health and Welfare Committee

Please Sign In March 15, 2007

Charles Moore	CMOORE@IADITE.STATE.KS.US
Jay Koci	KOHE
Sheldon Weisgrau	KHI
Chad Austin	KHA
Fred Lucke	Kansas Hosp. Assn.
Cynthia Smith	SCL Health System
Terry Lambert	Newman Reg. Health
Becky Ross	KHPA
Chip Wheelen	Ass'n of Osteopathic Med.
Sarah Carkhuff Fizell	KHI
Michelle Peterson	Capitol Strategies
Doug Smith	KS Medical Center, LLC
Pat Hubbell	K.S. Spine
Bill Grosz	Shawnee Miss. on Med Center
Mike Shields	KHI News
Steve Kearney	KS. Surg. Hosp. Assn.
Don Morin	KS Medical Society
Austin Hayden	Sen. Brungardt
Phil Harness	Doctors Hospital, LLC
Paul Kerens	Kansas City Orthopaedic Institute

Senate Public Health and Welfare Committee

Please Sign In

Sandra Hartlaff	Manhattan Surgical Hospital
Scott Chapman	Manhattan Surgical Hospital
Richard Samaniego	KSHA
Mary Ellen Conlee	Via Christi
Carolyn Smith	VCHS
Ron Hein	HCA
Pam Sorrell	WESLEY MEDICAL CENTER
Daryl Thornton	Kansas Medical Center
Crystal Jeffrey	Kansas Heart Hospital
[illegible]	Kansas Heart Hospital
Will Deer	Federico Consulting

KANSAS HOSPITAL ASSOCIATION

Thomas L. Bell
President

March 15, 2007

TO: Senate Public Health and Welfare Committee

FROM: Chad Austin
Vice President, Government Relations

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.

Senate Public Health and Welfare Committee
Attachment #1
March 15, 2007

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.

WESLEY
Medical Center

550 N. Hillside ▪ Wichita, KS 67214-4976
316-962-2000 ▪ www.wesleymc.com

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
HOUSE BILL 2418
March 15, 2007

Mr. 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.

Senate Public Health and Welfare Committee
Attachment # 2
March 15, 2007

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 <u>not</u> 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.

Testimony Presented to the Senate Public Health and Welfare

By Mary Ellen Conlee, Lobbyist for Via Christi Health System
March 15, 2007

Chairman Barnett 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.

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 the general hospital model. 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 as 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 patients seeking medical care better understand the hospital choices that exist in Kansas. Patients will know from the outset that the licensed general hospital will be able to address unanticipated conditions or emergencies, not just those related to the admitting diagnosis. Via Christi Regional Medical Center in Wichita receives an average of 5 transfers per month from area specialty hospitals, when a patient's condition changes and exceeds the medical capabilities of the admitting hospital.

VCHS urges you to support HB 2418. Thank you.

Senate Public Health and Welfare Committee
Attachment # 3
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March 15, 2007

Committee on Public Health and Welfare
Opposition for HB 2418

Chairman Barnett & 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, Leawood, Emporia, Salina and Manhattan.

Our association's opposition to the bill is based on our belief that no change is needed to the current hospital licensure definitions. The only reason proponents of the bill wish to see this bill passed is so that future legislation can be introduced that will be harmful to "Special Hospitals". 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. This bill does nothing to improve health care in the State of Kansas.

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

Senate Public Health and Welfare committee
Attachment #4
March 15, 2007

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 and accreditation, 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? Many hospitals exist in Kansas and elsewhere that specialize in areas other than cardiac, orthopedics and surgical procedures. We are unclear on the rationale for carving out only certain categories of diagnoses. We are also unclear on how the percentages were determined. How have the authors of the new language determined that 44% and 65% are the correct statistical indicators for facility specialization? It would seem that a greater

percentage should apply if a hospital is truly specializing. 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? Will a hospital recruit specific cases or even shut down certain services at the end of the year to maintain its "General Hospital" status?

No formal study has been conducted to see how many existing "General Hospitals" in the State will meet the new definition. Despite assurances from Kansas Hospital Association, we encourage this committee to determine with great clarity that there will be no unintended consequences on community hospitals throughout the state that may be sole providers in their area. We suggest that this committee require a study be conducted to determine which hospitals will be impacted by this new legislation prior to passing this bill.

If this committee chooses to move forward with this bill we would ask that you remove references to certain selected specialties, as it pertains to the definition of a major diagnostic category and not limit specialization to just certain medical conditions. If the intent is to differentiate a "General Hospital" from one that specializes then all hospitals that specialize should fall outside the "General Hospital" definition, not just those specializing in cardiac, orthopedics and surgery.

In summary, 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. There is no confusion in the current licensure definition. Let's not create a solution for a problem that does not exist.

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

Testimony before the Senate Public Health and Welfare Committee
House Bill No. 2418
March 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 18 of the bill seeks to add, to the definition of a general hospital, a requirement for "a dedicated emergency department", and Line 20 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. My hospital is located in an area in which there are multiple hospitals. There are four (4) Emergency Rooms contained within hospitals within a five (5) 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 five (5) 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 24-25 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. We submit that should never be less than one (1) nurse to four (4) patients. 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 29-32 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 general 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 nothing for special hospitals.

Lines 25-26 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 a solution in search of a problem.

TESTIMONY OF DARYL THORNTON
SENATE PUBLIC HEALTH and WELFARE COMMITTEE
HOUSE BILL NO. 2418
MARCH 15, 2007

Dear Chairperson Barnett and Committee Members:

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

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

I appear here today with a request to amend a specific portion of the proposed Bill. Beginning in line 32, the Bill reads as follows:

(2) the sum of inpatient discharges for the two highest major diagnostic categories shall not exceed 65% of all inpatient discharges. For the purposes of this subsection (a), "major diagnostic category" means a cardiac-related disease or disorder, an orthopedic-related disease or disorder, or any surgical procedure not related to a cardiac or orthopedic disease or disorder.

The sole amended request is to increase the above summation percentage to 75%.

House Bill No. 2418 seeks to enact legislation that specifically defines "general hospitals" in an effort to further separate "general hospitals" from "specialty hospitals". A review of the literature shows multiple definitions of specialty hospitals, and that Federal and states' definitions do not always agree. Definitions also vary across the many studies of specialty hospitals. The following are some recent examples:

1. The General Accounting Office (GAO) in October, 2003, classified a hospital as a specialty hospital if "the data indicated that two-thirds or more of its inpatient claims were in one or two major diagnosis categories (MDC), or two-thirds or more of its inpatient claims were for surgical diagnosis related groups (DRG's)."
2. The Medicare Payment Advisory Commission (MedPac) in 2005, in its report to Congress, established the following criteria to define, for their study purposes, physician owned specialty hospitals as:

    a. "be physician owned"
    b. "specialize in certain services"

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c. "at least 45 percent of the Medicare cases must be in cardiac, orthopedic, or surgical services
d. "or, at least 66 percent must be in two major diagnostic categories (MDC's), with the primary one being cardiac, orthopedic, or surgical cases" (MedPAC, 2005, pg.4)

3. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), provides this definition of a specialty hospital: "For the purposes of

   this section, except as provided in subparagraph (B), the term "specialty hospital" means a subsection (d) hospital (as defined in section 1866(d)(1)(B) that is primarily or exclusively engaged in the care and treatment of one of the following categories:
   " (i) Patients with a cardiac condition.
   " (ii) Patients with an orthopedic condition.
   " (iii) Patients receiving a surgical procedure.
   " (iv) Any other specialized category of services that the Secretary designates as inconsistent with the purpose of permitting physician ownership and investment interests in a hospital under this section."
4. The Federal Department of Health and Human Services (HHS) in August 2006, used a general definition of specialty hospitals containing core elements from the MedPAC and MMA definitions: "hospitals exclusively or primarily engaged in caring for one of the following categories of patients: patients with a cardiac condition or an orthopedic condition; or patients receiving a surgical procedure."

In December, 2006, the Kansas Health Institute (KHI) published a study entitled "Specialty Hospitals in Kansas: An Unfolding Story". Essentially, this study identifies the same criteria for defining "specialty hospitals" in the State as did MedPAC in the 2005 report. As a key part of this KHI study, the following conclusions based upon the derived data from these definitions, were obtained:

Surgical Discharges (1997 – 2003)	Aggregate	Range
Specialty Hospitals	80%	71 – 99%
General Hospitals	28%	17 – 36%

For the above study, the lowest percentage of surgical discharges to total discharges, for any studied specialty hospital, was 71%. The aggregate was 80%. By establishing the summation percentage at 75%, we will still be below the aggregate for one of the major diagnostic service (Surgical procedures not related to a cardiac or orthopedic disease or disorder). Another reason for raising the summation percentage to 75% is that we could have a general hospital experience a percentage of cardiac-related dismissals at 38% and then experience a percentage of surgical dismissals at 34%. The summation percentage of these two major diagnostic categories would then be 72%. If this hospital maintains a 24 hour Emergency Service and has always been licensed as a general acute care

community hospital, then it would be incorrect to require this facility to be licensed as a "special" or "specialty" hospital.

In summary, it is important to amend HB 2418 to increase the summation percentage to 75%. By doing so, we can make better certain there will be an ongoing distinct separation between true "general hospitals" and true "special or specialty hospitals". For example, both the MMA and HHS use a general definition of a specialty hospital as a hospital that is primarily or exclusively engaged in the care and treatment of one of the following categories: cardiac condition, orthopedic condition, or patients receiving a surgical procedure. We need to set the thresholds at higher levels, such as the summation percentage at 75%, to better match the definition of primarily or exclusively engaged. Also, Kansas does not have to precisely follow the 2005 MedPAC criteria for defining physician owned specialty hospitals. By raising the summation percentage to 75%, we will significantly reduce the unintended consequence of requiring hospitals to move from one licensure status to the other. If we are going to enact legislation that specifically defines "general hospitals" and "special or specialty hospitals", let's make certain we implement a process that is more appropriate and accurate for Kansas Hospitals.

Thank you for your time.

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