Approved: March 22, 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 21, 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:
Sheldon Weisgrau, Sr. Policy Analyst, Kansas Health Institute
Joseph Kroll, Director, Bureau of Child Care and Health Facilities, Kansas Department of Health and Environment
Marcia Nielsen, PhD, MPH, Executive Director, Kansas Health Policy Authority

Others attending:
See attached list.

Upon calling the meeting to order, Chairman Barnett called upon Emalene Correll to read and explain the three new amendment for **HB 2483**. The first amendment was offered by the Physical Therapy Association. A copy of this amendment is (Attachment 1) attached hereto and in corporate into the Minutes as referenced. The next two amendments are two variations of technical changes and clean up. A copy of the two technical amendments are (Attachment 2) attached hereto and incorporated into the Minutes as referenced.

Action on HB 2483 – An act concerning physical therapy

A copy of testimony for the hearing on **HB 2483** in which the conferees have already testified are (Attachment 3) attached hereto and incorporated into the Minutes as referenced.

Submitted written testimony was added by Charles Wheelen, Kansas Association of Osteopathic Medicine. A copy of his testimony is (Attachment 4) attached hereto and incorporated into the Minutes as referened.

The motion was made by Senator Schmidt to adopt the amendment offered by PTA (labeled #1). It was seconded by Senator Journey and the motion carried.

The motion was made by Senator Schmidt to adopt the amendment (labeled #3). It was seconded by Senator Palmer and the motion carried.

The motion was made by Senator Schmidt to move the bill out favorably as amended with technical changes. It was seconded by Senator Palmer and the motion carried.

The Chair announced that the next order of business would be to continue the hearing on **HB 2418.**

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

A copy of the testimony for the hearing on HB 2418 in which the conferees have already testified are (Attachment 5) attached hereto and incorporated into the Minutes as referenced.

Chairman Barnett called upon neutral conferee, Sheldon Weisgrau, Sr. Policy Analyst, Kansas Health Institute who stated that his testimony would address the legislation to better define general and specialty hospitals for licensure purposes. A copy of his testimony is (Attachment 6) attached hereto and incorporated into the Minutes as referenced.

The Chair called upon Joseph Kroll, Director, Bureau of Child Care and Health Facilities, Kansas Department of Health and Environment who stated that this bill adds criteria 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. A copy of his testimony is (Attachment 7) attached hereto and incorporated into the Minutes as referenced.

Chairman Barnett called upon Marcia Nielsen, PhD, MPH, Executive Director, Kansas Health Policy Authority who stated that KHPA supports the effort reflected in **HB 2418** to align state licensure law with recent developments I the hospital market and to ensure that Medicare payment policies dependent on state licensure definitions have the intended impact. Dr. Nielsen included with her testimony a Board approved study concerning A report on: The Definition and Impact of Specialty Hospitals in Kansas and a fact sheet: Sole Community Hospital. A copy of her testimony, study and fact sheet are (Attachment 8) attached hereto and incorporated into the Minutes as referenced.

Written testimony was provided by Kari Bruffett, The University of Kansas Hospital. A copy of her testimony is (Attachment 9) attached hereto and incorporated into the Minutes as referenced.

Written testimony was provided by Kevin Conlin, President/CEO, Via Christi Health System. A copy of his testimony is (Attachment 10) attached hereto and incorporated into the Minutes as referenced.

Written testimony was provided by Rick Pollack, Executive Vice President, American Hospital Association. A copy of his testimony is (Attachment 11) attached hereto and incorporated into the Minutes as referenced.

Questions and Comments came from Senator Wagle, Schmidt, Barnett, Palmer and Brungardt regarding sole community hospital, Emporia Hospital situation, KHPA study, tax exemption, possible bill introduction for the next session, pre-mature bill, member hospitals of Kansas Hospital Association, hospitals category of general vs. specialty, small rural hospital affects, trauma center, more time is needed to with progress and understanding of this bill.

With no more time, Chairman Barnett closed the hearing on **HB 2418.**

The Chair announced that the last item on the agenda was to approve the Minutes for March 15, 2007 and the Joint with Ways and Means March 15, 2007 meeting.

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

Adjournment

As there was no more time and no conferees left to testify, the meeting adjourned at 2:30 p.m.

The next scheduled meeting is for March 22, 2007.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

GUEST LIST

DATE: Public Health and Welfare 3-21-07

NAME	REPRESENTING
Chad Austin	KHA
Dick Way	Goode II, Stratton
Cynthia Smith	SCL Health System
Josh Rooe	KOHE
Sheldon Weisgrau	KHI
Pat Hubbell	KS Hearing Aid
Tom Bruno	KATS
Brad Parry	KATS
Richard Samaniego	KSHA
Paul Kerens	KSHA
Bill Grosz	Shawnee Msn Med Ctr
Chip Wheelen	Ass'n of Osteo. Med.
Larry Buesing	Board of Healing Arts
M. Martz	VIA CHRISTI HEALTH SYSTEM
Jamie Ann Rowen	KAHP / CMH
Mark Dwyer	KS Physical Therapy Association
Cindy Bahnmaier	KS Physical Therapy Assoc.
Mary Ellen Conlee	Via Christi Health System
Carolyn Smith	" " " "

Senate Public Health and Welfare Committee

Please Sign In

Julie Hein	HCA
Sam Serrill	Wesley Medical Center
Doug Smith	Ks. Medical Center LLC
Susan Kaney	ICHE
Carolyn Bloom	KPTA
Samantha Bitton	KPTA

As Amended by House Committee

Session of 2007

HOUSE BILL No. 2483

By Committee on Health and Human Services

2-8

AN ACT concerning physical therapy; amending K.S.A. 2006 Supp. 65-2901 **and 65-2912** and repealing the existing ~~section~~ **sections**.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 2006 Supp. 65-2901 is hereby amended to read as follows: 65-2901. As used in article 29 of chapter 65 of the Kansas Statutes Annotated and acts amendatory of the provisions thereof or supplemental thereto:

(a) "Physical therapy" means examining, evaluating and testing individuals with mechanical, anatomical, physiological and developmental impairments, functional limitations and disabilities or other health and movement-related conditions in order to determine a diagnosis solely for physical therapy, prognosis, plan of therapeutic intervention and to assess the ongoing effects of physical therapy intervention. Physical therapy also includes alleviating impairments, functional limitations and disabilities by designing, implementing and modifying therapeutic interventions that may include, but are not limited to, therapeutic exercise; functional training in community or work integration or reintegration; manual therapy; therapeutic massage; prescription, application and, as appropriate, fabrication of assistive, adaptive, orthotic, prosthetic, protective and supportive devices and equipment; airway clearance techniques; integumentary protection and repair techniques; debridement and wound care; physical agents or modalities; mechanical and electrotherapeutic modalities; patient-related instruction; reducing the risk of injury, impairments, functional limitations and disability, including the promotion and maintenance of fitness, health and quality of life in all age populations and engaging in administration, consultation, education and research. Physical therapy also includes the care and services provided by a physical therapist or a physical therapist assistant under the direction and supervision of a physical therapist that is licensed pursuant to this act. Physical therapy does not include the use of roentgen rays and radium for diagnostic and therapeutic purposes, the use of electricity for surgical purposes, including cauterization, the practice of any branch of the healing arts and the making of a medical diagnosis.

#1

Senate Public Health and Welfare committee
Attachment #1
March 21, 2007

(b) *(1)* "Physical therapist" means a person who is licensed to practice physical therapy pursuant to this act. Any person who successfully meets the requirements of K.S.A. 65-2906 and amendments thereto shall be known and designated as a physical therapist and may designate or describe oneself as a physical therapist, physiotherapist, licensed physical therapist, P.T., Ph. T., M.P.T., D.P.T. or L.P.T.

(2) Except as otherwise provided in ~~*this section*~~ **subsection (b)(3),** physical therapists may evaluate patients without physician referral but may initiate treatment only after ~~consultation with and~~ approval by a *licensed* physician ~~licensed to practice medicine and surgery~~, a licensed podiatrist, a licensed physician assistant or an advanced registered nurse practitioner working pursuant to the order or direction of a person licensed to practice medicine and surgery, a licensed chiropractor or a licensed dentist in appropriately related cases or a therapeutic licensed optometrist pursuant to subsection (e) of K.S.A. 65-1501, and amendments thereto.

(3) Physical therapists may evaluate and treat a patient for no more than 30 consecutive calendar days without a referral under the following conditions: (A) The patient has previously been referred to a physical therapist for physical therapy services by a licensed physician, a licensed podiatrist, a licensed physician assistant or an advanced registered nurse practitioner working pursuant to the order, direction or practice protocol of a person licensed to practice medicine and surgery, a licensed chiropractor or a licensed dentist in appropriately related cases or a therapeutic licensed optometrist pursuant to subsection (e) of K.S.A. 65-1501 and amendments thereto; (B) the patient's referral for physical therapy was made within one year from the date a physical therapist implements a program of physical therapy treatment without referral; (C) the physical therapy being provided to the patient without referral is for the same injury, disease or condition as indicated in the referral for such previous injury, disease or condition; and (D) the physical therapist transmits to the physician or other practitioner identified by the patient a copy of the initial evaluation no later than five business days after treatment commences. Treatment for more than 30 consecutive calendar days of such patient shall only be upon the approval of a licensed physician, a licensed podiatrist, a licensed physician assistant or an advanced registered nurse practitioner working pursuant to the order, direction or practice protocol of a person licensed to practice medicine and surgery, a licensed chiropractor or a licensed dentist in appropriately related cases or a therapeutic licensed optometrist pursuant to subsection (e) of K.S.A. 65-1501 and amendments thereto.

(c) "Physical therapist assistant" means a person who is certified pursuant to this act and who works under the direction of a physical therapist,

(4) Physical therapists may provide, without a referral, physical therapy services which do not constitute treatment for a specific condition, disease or injury to: (A) Employees solely for the purpose of education and instruction related to workplace injury prevention; or (B) the public for the purpose of fitness, health promotion and education.

(5) Physical therapists may provide physical therapy services without a referral to special education students who need physical therapy services to fulfill the provisions of their individualized education plan (IEP) or individualized family service plan (IFSP).

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and who assists the physical therapist in selected components of physical therapy intervention. Any person who successfully meets the requirements of K.S.A. 65-2906 and amendments thereto shall be known and designated as a physical therapist assistant, and may designate or describe oneself as a physical therapist assistant, certified physical therapist assistant, P.T.A., C.P.T.A. or P.T. Asst.

(d) "Board" means the state board of healing arts.

(e) "Council" means the physical therapy advisory council.

(f) "Physician" means a person licensed to practice medicine and surgery by the board.

Sec. 2. K.S.A. 2006 Supp. 65-2912 is hereby amended to read as follows: 65-2912. (a) The board may refuse to grant a license to any physical therapist or a certificate to any physical therapist assistant, or may suspend or revoke the license of any licensed physical therapist or certificate of any certified physical therapist assistant, or may limit the license of any licensed physical therapist or certificate of any certified physical therapist assistant or may censure a licensed physical therapist or certified physical therapist assistant for any of the following grounds:

(1) Addiction to or distribution of intoxicating liquors or drugs for other than lawful purposes;

(2) conviction of a felony if the board determines, after investigation, that the physical therapist or physical therapist assistant has not been sufficiently rehabilitated to warrant the public trust;

(3) obtaining or attempting to obtain licensure or certification by fraud or deception;

(4) finding by a court of competent jurisdiction that the physical therapist or physical therapist assistant is a disabled person and has not thereafter been restored to legal capacity;

(5) unprofessional conduct as defined by rules and regulations adopted by the board;

(6) the treatment or attempt to treat ailments or other health conditions of human beings other than by physical therapy and as authorized by this act;

(7) failure 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 licensed physical therapist;

~~(8) initiating treatment without prior consultation and approval by a physician licensed to practice medicine and surgery, by a licensed podiatrist, by a licensed physician assistant or by an advanced registered nurse practitioner working pursuant to the order or direction of a person li-~~

~~censed to practice medicine and surgery, by a licensed chiropractor, by a licensed dentist or by a therapeutic licensed optometrist pursuant to subsection (c) of K.S.A. 65-1501, and amendments thereto~~ *evaluating or treating patients in a manner not consistent with subsection (b)(2) or (b)(3), or both, of K.S.A. 65-2901, and amendments thereto*; **and**

(9) knowingly submitting any misleading, deceptive, untrue or fraudulent misrepresentation on a claim form, bill or statement.

(b) All proceedings pursuant to article 29 of chapter 65 of the Kansas Statutes Annotated, and acts amendatory of the provisions thereof or supplemental thereto, shall be conducted in accordance with the provisions of the Kansas administrative procedure act and shall be reviewable in accordance with the act for judicial review and civil enforcement of agency actions.

Sec. ~~2~~ **3.** K.S.A. 2006 Supp. 65-2901 ~~is~~ **and 65-2912 are** hereby repealed.

Sec. ~~3~~ **4.** This act shall take effect and be in force from and after its publication in the statute book.

#2

Senate Public Health and Welfare committee
Attachment #2
March 21, 2007

(b) *(1)* "Physical therapist" means a person who is licensed to practice physical therapy pursuant to this act. Any person who successfully meets the requirements of K.S.A. 65-2906 and amendments thereto shall be known and designated as a physical therapist and may designate or describe oneself as a physical therapist, physiotherapist, licensed physical therapist, P.T., Ph. T., M.P.T., D.P.T. or L.P.T.

(2) Except as otherwise provided in ~~*this section*~~ **subsection (b)(3),** physical therapists may evaluate patients without physician referral but may initiate treatment only after ~~consultation with and~~ approval by a *licensed* physician ~~licensed to practice medicine and surgery~~, a licensed podiatrist, a licensed physician assistant or an advanced registered nurse practitioner working pursuant to the order or direction of a person licensed to practice medicine and surgery, a licensed chiropractor or a licensed dentist in appropriately related cases or a therapeutic licensed optometrist pursuant to subsection (e) of K.S.A. 65-1501, and amendments thereto.

(b)(4) and (b)(5),

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(3) Physical therapists may evaluate and treat a patient for no more than 30 consecutive calendar days without a referral under the following conditions: (A) The patient has previously been referred to a physical therapist for physical therapy services by a licensed physician, a licensed podiatrist, a licensed physician assistant or an advanced registered nurse practitioner working pursuant to the order, direction or practice protocol of a person licensed to practice medicine and surgery, a licensed chiropractor or a licensed dentist in appropriately related cases or a therapeutic licensed optometrist pursuant to subsection (e) of K.S.A. 65-1501 and amendments thereto; (B) the patient's referral for physical therapy was made within one year from the date a physical therapist implements a program of physical therapy treatment without referral; (C) the physical therapy being provided to the patient without referral is for the same injury, disease or condition as indicated in the referral for such previous injury, disease or condition; and (D) the physical therapist transmits to the physician or other practitioner identified by the patient a copy of the initial evaluation no later than five business days after treatment commences. Treatment for more than 30 consecutive calendar days of such patient shall only be upon the approval of a licensed physician, a licensed podiatrist, a licensed physician assistant or an advanced registered nurse practitioner working pursuant to the order, direction or practice protocol of a person licensed to practice medicine and surgery, a licensed chiropractor or a licensed dentist in appropriately related cases or a therapeutic licensed optometrist pursuant to subsection (e) of K.S.A. 65-1501 and amendments thereto.

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, provided that any such referral was made by a person with the appropriate license, registration or certification required for the respective practice in the jurisdiction regulating such practice

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(c) "Physical therapist assistant" means a person who is certified pursuant to this act and who works under the direction of a physical therapist,

~~censed to practice medicine and surgery, by a licensed chiropractor, by a licensed dentist or by a therapeutic licensed optometrist pursuant to subsection (c) of K.S.A. 65-1501, and amendments thereto~~ *evaluating or treating patients in a manner not consistent with subsection (b)(2) or (b)(3), or both, of K.S.A. 65-2901, and amendments thereto*; **and**

(9) knowingly submitting any misleading, deceptive, untrue or fraudulent misrepresentation on a claim form, bill or statement.

(b) All proceedings pursuant to article 29 of chapter 65 of the Kansas Statutes Annotated, and acts amendatory of the provisions thereof or supplemental thereto, shall be conducted in accordance with the provisions of the Kansas administrative procedure act and shall be reviewable in accordance with the act for judicial review and civil enforcement of agency actions.

Sec. ~~2~~ **3.** K.S.A. 2006 Supp. 65-2901 ~~is~~ **and 65-2912 are** hereby repealed.

Sec. ~~3~~ **4.** This act shall take effect and be in force from and after its publication in the statute book.

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(b)(4) or (b)(5)

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#3

(b) *(1)* "Physical therapist" means a person who is licensed to practice physical therapy pursuant to this act. Any person who successfully meets the requirements of K.S.A. 65-2906 and amendments thereto shall be known and designated as a physical therapist and may designate or describe oneself as a physical therapist, physiotherapist, licensed physical therapist, P.T., Ph. T., M.P.T., D.P.T. or L.P.T.

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(c) "Physical therapist assistant" means a person who is certified pursuant to this act and who works under the direction of a physical therapist,

(b)(4) and (b)(5),

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, provided that any such approval was made by a person with the appropriate license, registration or certification required for the respective practice in the jurisdiction regulating such practice

physician

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, provided that any such referral was made by a person with the appropriate license, registration or certification required for the respective practice in the jurisdiction regulating such practice

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~~censed to practice medicine and surgery, by a licensed chiropractor, by a licensed dentist or by a therapeutic licensed optometrist pursuant to subsection (c) of K.S.A. 65-1501, and amendments thereto~~ *evaluating or treating patients in a manner not consistent with subsection (b)(2) ~~or~~ , (b)(3), ~~or both~~ of K.S.A. 65-2901, and amendments thereto*; **and**

(9) knowingly submitting any misleading, deceptive, untrue or fraudulent misrepresentation on a claim form, bill or statement.

(b) All proceedings pursuant to article 29 of chapter 65 of the Kansas Statutes Annotated, and acts amendatory of the provisions thereof or supplemental thereto, shall be conducted in accordance with the provisions of the Kansas administrative procedure act and shall be reviewable in accordance with the act for judicial review and civil enforcement of agency actions.

Sec. ~~2~~ **3.** K.S.A. 2006 Supp. 65-2901 ~~is~~ **and 65-2912 are** hereby repealed.

Sec. ~~3~~ **4.** This act shall take effect and be in force from and after its publication in the statute book.

(b)(4) or (b)(5)

2-4

March 14, 2007

Public Health and Welfare Committee

Paul Silovsky PT
Legislative Chair
Kansas Physical Therapy Association

Chairman Barnett and Members of the Public Health and Welfare 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. I have provided on this first page, a brief summary of my entire testimony on the subsequent pages.

1. **This bill will not change or alter the current scope of PT practice in Kansas.**

2. **This bill only allows a PT to initiate treatment for 30 days without referral, for those patients with a previous condition that was treated by a PT within the last year.**

3. **This bill will not affect or mandate third party reimbursement of PT services in any way.**

4. **This will improve access and reduce costs by removing unnecessary and costly barriers through early intervention, reducing chronicity of conditions and by improving functional outcomes.**

5. **There has been no documented proof of increased liability or risk to the consumer with the implementation of direct access to a physical therapist. This has been proven through both liability and state board documentation in direct access states.**

6. **We will be offering an amendment today that will allow public access to a physical therapist for prevention, education and fitness instruction to public without a condition, disease or injury. PT's are the only currently licensed provider in this state who can not perform prevention, education or fitness instruction activities to the public without prior referral or authorization.**

Senate Public Health and Welfare Committee
Attachment #3
March 21, 2007

Very simply stated, HB 2483 gives the public limited access and the choice in to see a physical therapist 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 doses not in any way alter the currently workable scope of physical therapist practice.

2. This legislation allows the consumer to choose a physical therapist for physical therapy treatment within the selected 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 or mandate 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 will 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 the skill and knowledge that we have acquired without prior referral. Yet less qualified providers 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

March 14, 2007

Senate Public Health and Welfare Committee

From:

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

RE: House Bill 2483

Chairman Barnett and Members of the Senate Public Health and Welfare Committee, my name is Marcie Swift and I am here to testify as a proponent of HB 2483. I am a physical therapist, licensed in the state of Kansas for 11 years. I have been a faculty member for the Physical Therapy program at the University of Kansas for 7 years. I have provided a bullet summary of my testimony below that outlines the educational training of a physical therapist. The remaining pages of this letter include detailed supports of the summary provided below.

1 The University of Kansas' Physical Therapy program, along with 75% of other physical therapy programs across the nation, offers a doctoral degree in Physical Therapy. The doctoral degree is a 3-year doctoral program that is rigorous and includes extensive training in recognition of patient examination findings that are appropriate for physical therapy treatments.

2 There are several consensus documents containing curricular guidelines that **all** physical therapy programs must adhere to in order to maintain their accreditation status. These documents clearly articulate required course content related to the ability of knowing when to refer a patient to a physician. The first document is **The Guide to Physical Therapist Practice** that clearly describes our scope of practice. Two documents, **The Normative Model of Physical Therapist Professional Education and the Minimum Required Skills of Physical Therapist Graduates at Entry-Level,** outline the educational training that must be taught within physical therapy programs.

3 One area of educational training in physical therapy programs includes promoting wellness to the healthy individual of all ages. In fact, as one of the top-ranked physical therapy programs in the country, the faculty of the Department of Physical Therapy and Rehabilitation Science at KUMC currently has obtained over 5 million dollars in external grants. The funded research projects include over 3 million dollars in grants focused on exercise and diabetes.

4 Manipulation is one of many interventions that are taught to physical therapy students based on the documents mentioned above that guide curriculum development of all physical therapy programs in the United States.

5 Physical therapy programs meet the appropriate standards of education through accreditation by the **Commission on Accreditation of Physical Therapy Education (CAPTE).** CAPTE is the **ONLY** agency in the United States recognized to accredit educational programs for the preparation of physical therapists. It is the only agency with the expertise and credentials to pass judgment regarding the scope and quality of physical therapists' training.

Background to Physical Therapist's Education:

The University of Kansas' Physical Therapy program along with many other physical therapy programs across the nation offers a doctoral degree in Physical Therapy. The doctoral degree is now the entry level degree with more than 75% of physical therapy programs offering this degree with the expectation that by 2010 all physical therapy programs will be at the DPT level.

Physical Therapy programs include a select group of students who, prior to physical therapy school, have achieved on average a 3.8 GPA in a science-based undergraduate 4-year curriculum

with numerous extra-curricular activities including working in the health field with patients. Once this select group of students has been accepted into the physical therapy programs, they go through a 3-year doctoral program that is rigorous and includes extensive training in recognition of patient examination findings that are appropriate for physical therapy treatments.

There are several consensus documents containing curricular guidelines that **all** physical therapy programs must adhere to in order to maintain their accreditation status. These documents clearly articulate required course content related to the ability of knowing when to refer a patient to a physician. This curricular content is found in all examination/ evaluation courses and throughout the programs' clinical science tracks. The first document is **The Guide to Physical Therapist Practice** that clearly describes our scope of practice. How do we know if graduates from PT programs are competent practitioners? Two documents, **The Normative Model of Physical Therapist Professional Education and the Minimum Required Skills of Physical Therapist Graduates at Entry-Level,** outline the educational training that must be taught within physical therapy programs. Based on these two documents, KU's physical therapy program includes differential diagnosis instruction in the classroom and clinical setting. Students learn screening tests and extensive triage tests to determine the appropriateness of a patient for physical therapy care or if the patient needs to be referred to their physician. 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.

Physical therapy programs meet the appropriate standards of education through accreditation by the **Commission on Accreditation of Physical Therapy Education (CAPTE).** CAPTE is the **ONLY** agency in the United States recognized to accredit educational programs for the preparation of physical therapists. It is the only agency with the expertise and credentials to pass judgment regarding the scope and quality of physical therapists' training.

Support For Inclusion of Wellness as an Amendment to HB 2483

As one of the top-ranked PT programs in the country, the faculty of the Department of Physical Therapy and Rehabilitation Science currently has obtained over 5 million dollars in external grants. The funded research projects include over 3 million dollars in grants focused on exercise and diabetes. The KU Diabetes Research Laboratory is directed by faculty in the Department of Physical Therapy and Rehabilitation Science with grants from the National Institutes of Health, the Juvenile Diabetes Research Foundation, and the American Heart Association. Using animal models the group examines the molecular effects of exercise in pre-diabetes and diabetes. In addition, a human exercise laboratory studies the positive effects of exercise on weight loss and diabetes management. This work is managed by Drs. Lisa Stehno-Bittel PT, PhD, Irina Smirnova PhD, and Yvonne Searls, PT, PhD.

Other human studies in the department are directed by Dr. Nandini Deshpandi, PT, PhD. She has grant funding from NIH to study the effects of exercise on the quality of gait in healthy aging. This work is important as falls in the healthy elderly often lead to admission to a nursing home. Dr. Wen Liu, PhD, is a Bioengineer in the department working with Dr. Patricia Kluding examining the effects of exercise and joint mobilization in improving ankle movement and gait in the healthy elderly and elders who have had strokes. Dr. Liu's laboratory has funding from the National Institutes of Health, the National Science Foundation and the American Heart Association. Dr. Kluding has funding from the US Department of Education.

Dr. Janice Kluding, PT, PhD, focuses on healthy adolescents in sports. She, in collaboration with other faculty, designed and tested a screening tool for high school athletes to predict future knee and ankle injuries. In this manner, the athletes at high risk for injury could be given exercise programs to avoid the injury or diminish its severity. Neena Sharma PT, is a PhD student in our department and is studying the ability of aerobic exercise to decrease muscle pain

over time. Dr. Yvonne Searls, PT, PhD, is studying the effect of yoga-like exercises for people with Parkinson's disease with local funding. Dr. Patricia Pohl, PT, PhD examines the ability of exercise and activity to help the brain recover after a stroke with funding from the American Heart Association.

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

1.

KANSAS MEDICAL SOCIETY
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To: Senate Public Health and Welfare Committee

From: Jerry Slaughter
Executive Director

Date: March 14, 2007

Subject: HB 2483; concerning physical therapists

The Kansas Medical Society appreciates the opportunity to submit the following comments on HB 2483, which amends the licensing statute for physical therapists. The bill allows PTs to initiate treatment on individuals without a physician referral, under certain conditions. Under current law, PTs may only initiate treatment after a patient has been referred to them by a physician, or certain other health care providers.

Over the past few months we have met with and had continued discussions with representatives of the Kansas Physical Therapy Association on this issue. We sincerely appreciate the willingness of the KPTA to meet with us and discuss our concerns and questions. Physical therapists and physicians work very closely together all across this state to provide quality health care to Kansans. We believe the structure of our current framework, which requires physician referral for physical therapy treatment, promotes high quality care and ensures that physicians and PTs work together for the benefit of patients. This legislation would not disrupt that structure, but would authorize PTs to initiate treatment for thirty days without a physician referral for previously diagnosed and referred conditions. It also requires that physicians be notified when the PT commences treatment in those situations. We have also seen and discussed the amendment that will be offered by the PTs to address education and wellness services. We support the amendment. The structure of this legislation is based on a model that some other states have adopted, and we believe this change is reasonable.

Thank you for the opportunity to offer these comments.

Kansas
Chiropractic
Association

TESTIMONY

Before the Senate Committee on Public Health and Welfare
March 14, 2007

Thank you, members of the committee, for the chance to speak on HB 2483 concerning physical therapy. I am Dr. Travis Oller, Chair of the KCA Legislative Committee, and I practice here in Topeka.

As doctors we have an obligation to take part in discussions about policy changes that may have an effect on public health issues, especially when those issues are within our area of expertise. As such, the Kansas Chiropractic Association stands opposed to any additional amendments to HB 2483. It is our opinion that the Kansas Physical Therapy Association has not shown evidence that the education level of physical therapists in Kansas is such to support additional access beyond the language of HB 2483 as passed by the House Health and Human Services Committee.

We have been in discussion with the Kansas Physical Therapy Association about our concerns with this amendment language as well as our concerns about education levels; however, at this time we have not resolved these issues.

Currently, physical therapists in Kansas are working to upgrade their education levels of graduates from both the University of Kansas Medical Center and Wichita State to doctorate level degrees. Unfortunately, KU has graduated only one class with the DPT degree and Wichita State University will not graduate their first class until 2008. Additionally, we have not been shown the differences in education between the prior Master's degree and the current DPT degree. According to the APTA website, each institution decides which degree to offer, but the requirements are the same to offer a DPT vs. an MsPT degree.

We feel that further discussion between all parties involved; the Kansas Physical Therapy Association, the Kansas Medical Society, the Kansas Association of Osteopathic Medicine, and the Kansas Chiropractic Association should be undertaken prior to any changes being made to HB 2483.

Thank you for your time on this matter. Mr. John Kiefhaber, KCA Executive Director, and I would be willing to answer any question you may have.

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MARCH 12, 2007

SENATE COMMITTEE ON PUBLIC HEALTH & WELFARE
KANSAS STATE LEGISLATURE
CAPITOL BUILDING
TOPEKA, KS 66604

MR. CHAIRMAN AND FELLOW COMMITTEE MEMBERS:

I am writing to request your support of Bill HB-2483 allowing physical therapists to treat patients without a doctor's 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
1320 SW 27th Street, Apt F-34
Topeka, KS 66611

Kansas Association of Osteopathic Medicine
1260 SW Topeka Boulevard
Topeka, Kansas 66612
Phone (785) 234 5563
Fax (785) 234 5564

March 16, 2007

The Honorable James Barnett, MD
Chairman, Senate Public Health and Welfare Committee
120S, Statehouse, Topeka, Kansas
Via Electronic Mail

Re: House Bill 2483

Dear Senator Barnett:

Please add this letter to the public record of comments submitted in regard to HB2483.

During the hearing on HB2483 an impression was created to the effect that all interested parties had endorsed both the House version of the bill and the proposed additional amendments. Please be informed that the Kansas Association of Osteopathic Medicine chose not to be a party to the negotiations that resulted in HB2483. We did not oppose the bill in the House Health and Human Services Committee because the original amendment is worded in such a way that the exemption from the normal referral requirement would be very limited.

Until the hearing in your Committee on March 14, we were unaware of the additional proposed amendments. Upon reviewing this language, we are somewhat disappointed that it does not follow the precedent established by the Legislature in subsection (d) of K.S.A. 2006 Supp. 65-5418 pertaining to occupational therapists. I will reprint that subsection below substituting [physical] in lieu of "occupational."

> Education related therapy services provided by [a physical] therapist to school systems or consultation regarding prevention, ergonomics and wellness within the [physical] therapy scope of practice shall not require a referral, supervision, order or direction of a physician, a licensed podiatrist, a licensed dentist or a licensed optometrist. However, when in the course of providing such services [a physical] therapist reasonably believes that an individual may have an underlying injury, illness, disease, disorder or impairment, the [physical] therapist shall refer the individual to a physician, a licensed podiatrist, a licensed dentist or a licensed optometrist, as appropriate.

Our lack of opposition to HB2483 should be interpreted as an indication of our respect for the Kansas Medical Society, rather than an endorsement of the bill. Thank you.

Respectfully yours,

Chip Wheelen

Charles L. Wheelen
Executive Director

C: Bud Burke
Jerry Slaughter

Senate Public Health and Welfare Committee
Attachment #4
March 21, 2007

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 #3
March 21, 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

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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.

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.

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.

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.

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.

KANSAS HEART HOSPITAL

March 15, 2007

Honorable James Barnett
Chairperson
Senate Public Health and Welfare Committee
C/o Kansas Senate
300 S.W. 19th Avenue, 120-S
Topeka, Kansas 66601

Dear Senator Barnett,

Thank you and the Senate Public Health and Welfare Committee for affording me the opportunity to address my opposition to House Bill 2418 on March 15th, 2007. I am concerned that House Bill 2418, as passed by the House of Representatives, would place into law a statute which may have unintended adverse consequences for rural hospitals, and, secondarily, indirect and unknown consequences, for specialty hospitals.

BACKGROUND: I am a co-founder, former CEO and current Chairman of the Kansas Heart Hospital (KHH) in Wichita, Kansas. As a practicing cardiologist I have traveled extensively throughout the state since arriving in Wichita in 1977 to begin my professional cardiology career and have, personally, served and continue to provide outreach heart clinics at Iola, Chanute and Garden City and have done so for the past 25-28 years. I was Chairman of Cardiology at Via Christi: St. Francis from 1979 through February 1999. KHH opened its doors on February 15th, 1999. KHH is an acute cardiovascular hospital and has fifty-four (54) beds of which fourteen (14) are ICU beds, four (4) operating rooms, two (2) heart catheterization laboratories, one (1) electrophysiology laboratory and 250 full / part time employees. KHH self-mandates fixed nursing ratios: 1 RN: 2 patients in ICU and 1 RN: 4 patients on the regular floor. There are no nurse aides or LPN's. 70% of KHH's admissions are Medicare and KHH accepts Medicaid patients. KHH pays greater than $600,000 per year into the state of Kansas Medicaid Tax fund. 80% of KHH's admissions are from outside Sedgwick county. 30% of KHH's admissions are emergent and about the same number of patients are urgent transfer admissions. KHH does not have a full-service ER for two reasons: (1) non-cardiac patients would fill up a great number of beds, thus, excluding access to cardiac patients who truly need our specialty care and (2) KHH's statewide referral pattern essentially admits seriously ill / critically ill patients from ERs throughout the state, ie., rural ERs are our surrogate ER. Healthgrades, a nationally recognized and independent rating agency, ranks

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Wichita, KS 67226 (800) KS-HEART **Web** www.kansasheart.com

KHH #1 in overall cardiac services in the state of Kansas and in the top 10% in the nation for cardiac surgical services. KHH has on site dialysis, ventilators and 24 x 7 physician coverage. At night, KHH has cardiologists, cardiothoracic surgeons or general surgeons functioning as emergency physicians who stay overnight in the hospital providing seven day per week call coverage.

MUCH TO DO ABOUT WHAT? Patients in urban and rural Kansas do not care whether they are being referred to a general hospital or a specialty hospital. However, they are concerned about the quality of care they will receive at either hospital and whether or not their insurance will help pay their bill. In cardiology, referring doctors, above all, want their patients admitted to a hospital with an excellent reputation. No physician or patient has ever asked me if they were being referred to a general hospital or a specialty hospital. K.S.A. 65-425 *et. seq.* was enacted in 1947 and has withstood the test of time. Any change in a statute should not be grounded in reaction to current events nor champion special interests. House Bill 2418 would possibly "hurt" (my term) some existing specialty hospitals and "not hurt" others. KHH is in the latter category. Today, in committee hearings, I heard no forward discussions as to the potential consequences, adverse or otherwise, put forth by the proponents of House Bill 2418. The proponents at today's committee hearings represented big hospitals and KHA but I did not see one small rural hospital administrator present.

In summary, House Bill 2418 is much to do about big general hospitals, and very little to do about the critical issues of healthcare, namely, access, affordability and quality of care. Unfortunately, if passed, time may shed further light on the unknown future for specialty hospitals and that should be of concern and pause for all, particularly, when terms like "limited service" are still referenced by Via Christi as we heard today in our committee hearings.

ANALYSIS OF HOUSE BILL 2418: House Bill 2418 has five (5) essential components which I addressed today:

1) DEDICATED EMERGENCY DEPARTMENT : In order to be a general hospital, House Bill 2418 would require that a hospital have a full-time ER department. This is not a problem for urban general hospitals but could have unintended negative implications in the future for small rural hospitals. If consolidation for emergency services between cities and / or counties occurs in the future or ER maintenance costs become prohibitive, a small rural hospital may have to forsake or "give-up" its ER department and, thus, forfeit its license as a general hospital. Critical access hospitals are federally sanctioned and funded. They are the current safety net for small rural Kansas hospitals. However, they, too, in the future could evaporate depending on federal government policy. If so, ER costs would no longer be "passed through" and reimbursed by Medicare (as they are now), placing an immediate and substantial financial burden on small rural hospitals.

2) STATEWIDE TRAUMA SYSTEM AND LOCAL EMERGENCY MEDICAL SERVICES: Urban general hospitals provide great *specialty* (my addition) care in the areas of trauma and burns. However, KHH also stood shoulder-to-shoulder with Wesley and Via Christi during the Katrina crisis and was prepared to accept transfer patients from Louisiana. In times of crisis, acute care hospitals, be they either general or specialty, can provide a tremendous service to our state and its patients. I do not see participation in this important sector, necessarily, differentiating a general hospital from an acute care specialty hospital such as KHH.

3) FOCUS ON PROVIDING INPATIENT CARE: KHH provides 24 x7 care for inpatients with a variety of illnesses including such life-threatening conditions as acute heart attack, ruptured abdominal aortic aneurysms, cardiogenic shock, dissecting aneurysms, acute respiratory failure etc. As an acute care cardiovascular hospital, KHH parallels general hospitals in the acuity of its patients, ie., a so called "sickness" factor. Non-elective admissions are the hallmark of an acute inpatient care facility, which is shared by KHH and general hospitals. Thus, I do not see a substantive difference between a heart hospital, like KHH, and a general hospital relative to the issue of inpatient care.

4) MEDICAID PARTICIPATION: All hospitals, general and specialty, should as a matter of ethical responsibility and public policy support the poor in our state. I do not see that there is a difference between KHH and general hospitals in this very important social area.

5) DRG PERCENTAGES: This complicated area highlights the problem and unintended consequences wherein an arbitrary set of percentages define policy as to what constitutes a general hospital. As our Kansas population grows older and baby-boomers enter the Medicare age, there is the likelihood that rural general hospitals, in particular, could experience DRG discharge cardiovascular rates which exceed the House Bill 2418 threshold of 44% for an individual disease category. For example, the number one most frequent DRG hospital discharge diagnosis is congestive heart failure which is predominantly a Medicare associated DRG. Since some rural Kansas hospitals achieve a 70% inpatient Medicare population, one could potentially envision a violation of the general hospital licensure bill due to excessive cardiovascular related DRG's. On the otherhand, urban general hospitals generally do not exceed a 50% inpatient Medicare population and would not be subject to such an unintended aberration.

SUMMARY: House Bill 2418 may unintentionally jeopardize rural hospital licensure by requiring dedicated emergency departments and strict DRG percentage criteria. The Kansas Heart Hospital (KHH) does not meet the ER requirement and by its very cardiovascular specialization exceeds the DRG thresholds for a general hospital designation. However, KHH provides

outstanding quality, intense inpatient services, may participate in local emergency medical plans as well in Medicaid and Medicare. It is truly a specialized *acute care* facility and not a "limited service" facility as alluded to today by one of the proponents. Urban hospitals have the most to gain by changing the status quo. However, the current statute has served all hospitals well for many years and is much more inclusive, less problematic, and is time tested. Additionally, House Bill 2418 does nothing to address the concerns of specialty hospitals if House Bill 2418 is passed, ie., the great unknown looms into the future. Many pro-specialty hospital individuals are concerned about further dismantling of the licensing statutes or differential reimbursement schemes which might favor general hospitals.

The stakes are too high and the future too uncertain to make such a leap of faith in order to promote an untried experiment.

Sincerely,

Gregory F. Duick MD

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"

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.

Daryl W. Thornton
Chief Operation Officer
Kansas Medical Center

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KANSAS HEALTH INSTITUTE

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Senate Public Health and Welfare Committee
March 15, 2007

HB 2418
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.

Senate Public Health and Welfare Committee
Attachment #6
March 21, 2007

Mr. Chairman 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.

In December 2006, KHI completed a study on the impact of specialty hospitals on general hospitals in Kansas (the study can be found on our website at http://www.khi.org/resources/Other/236-SpecialtyHospitalsDec06.pdf). A key task in that analysis was clearly identifying the facilities that would be defined as "specialty hospitals." For guidance, we looked to previous studies 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 of the provisions of 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 they treat. This is not surprising – specialty hospitals are specifically designed to focus on a narrow range of services, while general hospitals are intended to serve a broader group of patients.

For example, our analysis found that from 1997 to 2003, the number of diagnosis related groups (DRGs) treated in Kansas specialty hospitals ranged from 38 to 180, with an average of 85. In three specialty hospitals, a single DRG comprised more than two-thirds of all cases. In contrast, the number of DRGs treated in general hospitals ranged from 351 to 500, with an average of 412. Only six general hospitals had a single DRG that made up even 10 percent of their cases.

Similarly, specialty hospitals are far more focused on surgeries than general hospitals. From 1997 to 2003, 80 percent of all Kansas specialty hospital discharges were surgical cases, with a per hospital range of 71 percent to 99 percent. In contrast, surgical cases made up 28 percent of all cases in general hospitals, with a per hospital range of 17 percent to 36 percent. Even the most surgically intensive general hospitals, therefore, had a far lower proportion of surgical cases than the least surgically intensive specialty hospitals. Again, these figures illustrate that there are clear and substantial differences in the types of services provided by most specialty and general hospitals.

There is no "magic" or science to the percentages of cases used to define specialty and general hospitals in the studies that have been conducted or in HB 2418. These figures are used because they provide an empirical separation between general and specialty hospitals. Using the percentages in HB 2418 (or even lower percentages) clearly identifies specialty hospitals as those that specialize to a great degree (which is exactly their intent). Using higher percentages will classify some very specialized facilities as general hospitals and therefore dilute the intent of the legislation.

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 general from specialty 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.'" Furthermore, the KHI study recommended that the state 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.

There is one issue with the legislation that I would like to raise for the Committee's consideration. HB 2418 states (page 1, lines 32-36): "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."

As you may know, the concept of Major Diagnostic Categories (MDCs) was first developed for use in the Medicare inpatient hospital prospective payment system and is now in common use by payers, researchers, and others. MDCs are broad classifications of diagnoses, usually grouped by body system (e.g. Diseases and Disorders of the Circulatory System, Diseases and Disorders of the Musculoskeletal System and Connective Tissue). There are 25 MDCs that encompass all DRGs and constitute the range of cases treated in hospitals. Most MDCs include both surgical and medical DRGs.

The definition of MDC proposed in HB 2418 is more limited than the common usage of the term. If at some point in the future, hospitals are created that focus, for example, only on nervous system or respiratory system diseases, they would not be included as specialty hospitals under the definition of MDC used in the legislation. Redefining MDC for the purposes of this legislation seems unnecessary and will likely create confusion.

Thank you for your time and consideration of these comments.

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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

Senate Committee on Public Health and Welfare

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

March 15, 2007

Chairman Barnett 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 has 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 had the opportunity to provide input to the Authority on this issue.

Senate Public Health and Welfare committee
Attachment #7
March 21, 2007

HB 2418 adds criteria 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. Current information indicates 6 currently licensed general hospitals may not meet the criteria in HB 2418. New Sec. 2., added by the house, provides hospitals affected by the new definition time to decide how they wish to remain licensed.

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

KHPA
Kansas Health Policy Authority
Coordinating health & health care for a thriving Kansas

MARCIA J. NIELSEN, PhD, MPH
Executive Director

ANDREW ALLISON, PhD
Deputy Director

SCOTT BRUNNER
Chief Financial Officer

Testimony on:
House Bill 2418: Definition of general hospital

presented to:
Senate Committee on Public Health and Welfare

by:
Marcia J Nielsen, PhD, MPH
Executive Director

March 21, 2007

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Senate Public Health and Welfare committee
Attachment #8
March 21, 2007

Senate Committee on Public Health and Welfare
March 21, 2007

House Bill 2418: Definition of general hospital

Good afternoon, Mr. Chairman and members of the Committee. My name is Marci Nielsen and I am the Executive Director of the Kansas Health Policy Authority (KHPA). Thank you for the opportunity to speak to you today about our recently completed study of definitions related to hospital licensure in Kansas, which was directed by legislative proviso and approved yesterday by the KHPA Board. We have a copy of the Board-approved study attached to my testimony today.

During the 2006 legislative session, KHPA was directed to conduct a study of the issues concerning Kansas hospital licensure, specifically how general and special hospitals are defined in Kansas and whether those definitions "properly define specific categories of hospitals for licensure...." As with all studies directed by legislative proviso, the KHPA Board reviews the content of the study for two weeks, and then suggests any changes before approving. The draft of this study was completed in February and reviewed by the KHPA board at their February meeting. At that meeting, two significant changes to the study were requested by Board members. Staff were asked to, first, make specific recommendations regarding definitions as requested in the proviso, and second, narrow the study significantly to focus specifically on hospital definitions. The study that you have was reviewed and approved by the KHPA Board yesterday and sent to the Legislature today.

Kansas licensure definitions currently do not include any specific requirements that distinguish general hospitals from other kinds of hospitals. Hospitals are allowed to designate whether they want to be classified as general or special hospital. Our review of other states' hospital licensure requirements indicates that most make no distinction between general and either special or specialty hospitals. There are some exceptions. Arkansas requires general hospitals to provide obstetrical care, and South Dakota facilities that provide medical, surgical, obstetrical, and emergency services are automatically classified as general hospitals. No state relies on the Medicare Payment Advisory Commission's (MedPAC) definition of a specialty hospital as our report recommends and reflected in HB 2418. One reason that other states may not have updated their licensure requirements to address the new class of specialty hospitals that has arisen in recent years is many have a certificate of need requirement that precludes the licensing of any new hospital without a review by a committee and justification of the need for a new hospital in the community.

Our report expresses concerns that the state's definition of a general hospital may have an adverse impact on Medicare reimbursements to Kansas hospitals that are designated as Sole Community Hospitals by Medicare. Kansas has approximately 30 hospitals with this designation. Medicare rules presume upon state licensure classifications when determining the presence of another community hospital in each area, raising the possibility that a mis-classified specialty hospital could undermine a Sole Community Hospital's designation and the supplemental Medicare payments that go along with that designation. A clearer distinction between general and specialty hospitals could facilitate better targeting of future state policies and could ensure Medicare payment policies that depend on state licensure rules have the intended impact.

The bill proposes to require hospitals seeking licensure as a general hospital to provide a dedicated emergency department, participate in the statewide trauma plan, participate in the Kansas Medicaid program, and have 44% or less of its discharges in major diagnostic category or 65% or less of its discharges in cardiac, orthopedic or surgical diagnostic categories. This last requirement was developed by MedPAC to specifically describe the new class of hospitals that arose in Kansas and other deregulated hospital markets. It is also consistent with the definition used by Congress to enforce a recently-expired moratorium on Medicare payments to new facilities of this type.

HB 2418 attempts to provide a clearer distinction between general, or community, hospitals and other types of facilities. To implement this proposed legislation, KHPA will need to collect data, including unique hospital identifying information, from all hospitals in the state. This information will need to be regularly analyzed to inform KDHE licensing staff and to monitor any unintended effects of the proposed legislation, such as hospitals moving in and out of categories over short periods of time.

KHPA supports the effort reflected in HB 2418 to align state licensure law with recent developments in the hospital market and to ensure that Medicare payment policies dependent on state licensure definitions have the intended impact.

This concludes my prepared remarks. I would be glad to answer any questions you might have.

KHPA
Kansas Health Policy Authority
Coordinating health & health care for a thriving Kansas

MARCIA J. NIELSEN, PhD,
Executive Dire

ANDREW ALLISON, PhD
Deputy Director

SCOTT BRUNNER
Chief Financial Officer

Report on:
The Definition and Impact of Specialty Hospitals in Kansas

Presented to:
2007 Kansas Legislature

March 21, 2007

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Introduction

The 2006 Kansas Legislature included a proviso in the appropriations bill for the Division of Health Policy and Finance (now the Kansas Health Policy Authority – KHPA) that required the agency to:

> ...conduct a review and study of the issues relating to specialty hospitals and a review and study of the Kansas licensure laws and to prepare and adopt recommendations concerning these issues and, in particular, appropriate definitions for "general hospital," "special hospital" and "specialty hospital" so that the definitions under the Kansas hospital licensure laws properly define specific categories of hospitals for licensure as necessary to reflect current medical facilities...[1]

The requirements of this proviso reflect issues and concerns that have recently been raised at both local and national levels regarding specialty hospitals. These concerns, as well as the complexity of the associated issues, have led to a significant amount of investigative analysis at the federal level and the number of studies and research articles published over the past three years.

Hospital – Definitions and Licensing

While there is no federal licensure of hospitals, most hospitals participate in the Medicare program, so statutes, regulations, and other guidance concerning Medicare apply to most hospitals. Title 18 of the Social Security Act, which authorizes the Medicare program, defines a hospital as:

> ...primarily engaged in providing, by or under supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons...[2]

Federal regulations governing Medicare specify that any hospital participating in the program "...must be licensed; or (a)approved as meeting standards for licensing established by the agency of the State or locality responsible for licensing hospitals."[3] In Kansas, that agency is KDHE. The State can impose any licensing requirements it deems appropriate as long as they are not in conflict with any Medicare statutes or regulations.

The Hospital Manual, Publication 10, published by CMS defines a hospital as "...an institution which is primarily engaged in providing to inpatients, by or under the supervision of physicians"[4] diagnostic, therapeutic, or rehabilitative services. The term "inpatient" is defined as:

> ...a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally a person is considered an inpatient if formally admitted as an inpatient with the expectation that he will remain at least overnight and occupy a bed even though it later develops that he can be discharged or transferred to another hospital and does not actually use a hospital bed overnight.[5]

So, for the purpose of Medicare reimbursement, the two critical factors in CMS' designation of a facility as a hospital in Kansas appear to be that it provides care primarily to inpatients and that it is licensed as a hospital though not necessarily a general hospital) by KDHE.

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1 HB 2968 Sec. 35(i)
2 Section 1861 of the Social Security Act.
3 42 CFR 482.11.
4 CMS. Publication 10, Section 200, Revision 479, p. 19.
5 Ibid. Section 210, Revision 559, p. 21.3a.

KDHE defines a hospital as "'general hospital,' 'critical access hospital,' or 'special hospital'."[6] A **general** hospital is defined as:

> ...an establishment with an organized medical staff of physicians; with permanent facilities that include inpatient beds, and with medical services, including physician services, and continuous registered professional nursing services for not less than 24 hours every day, to provide diagnosis and treatment for patients who have a *variety* of medical conditions.[7] *[emphasis added]*

A **critical access** hospital (CAH) is defined in Kansas statute[8] as a member of a rural health network that provides limited inpatient care (25 beds or less), provides 24-hour nursing care whenever there are inpatients, and may use physician assistants, clinical nurse specialist or nurse practitioners – under physician supervision – to provide inpatient care.

There is no category in the Kansas hospital licensing statute for a "specialty" hospital; however, a **special** hospital is defined, by KDHE, as:

> ...an establishment with an organized medical staff of physicians; with permanent facilities that include inpatient beds; and with medical services, including physician services, and continuous registered professional nursing services for not less than 24 hours every day, to provide diagnosis and treatment for patients who have *specific* medical conditions.[9] *[emphasis added]*

For KDHE licensure, the primary distinction between a general hospital and a special hospital is the breadth of medical conditions the patients in a facility have; however, KDHE does not determine which of the two categories a facility is in, but allows hospitals to self-select. Neither type of hospital is required by Kansas statutes to maintain an emergency department. Kansas statutes also do not make a distinction between the two hospital categories regarding the amount of inpatient care. Examples of special hospitals in Kansas include orthopedic hospitals, heart hospitals, surgical hospitals, rehabilitation hospitals, and mental health hospitals. Children's and women's hospitals are relatively common in the U.S., although none are located in Kansas.

In Kansas, fifty hospitals are licensed as general hospitals. Twenty are licensed as special hospitals, and 83 are licensed as critical access hospitals. A number of Kansas hospitals are also designated as sole community hospitals (SCH) by Medicare. These hospitals must be in locations that are 35 miles from similar hospitals or must be isolated from similar hospital by severe weather or topography. Many of the SCH's in Kansas are licensed as CAH's. The SCH designation results in some additional Medicare revenue.

The location of a specialty hospital in a community with a SCH could result in the loss of the extra Medicare revenue if the specialty hospital is in the same State licensing category. The determination by Medicare of what constitutes a "similar hospital" is not clearly defined and appears to rely heavily on State licensing categories.

Specialty Hospitals in Kansas

The types of hospitals at issue in this report, and that have generated so much policy interest nationally in the last few years, do not coincide with the licensure class of special hospitals in Kansas. A KHI issue brief released in December 2003 observes that:

> "specialty hospitals provide services in a single medical specialty, such as cardiology or orthopedics. These hospitals however are not the same as psychiatric, women's or children's hospitals. Those types of hospitals offer a range of services. They are also different from ambulatory surgical centers, which are restricted by Federal regulation from offering inpatient services, and do not focus on a particular specialty." (Bentley and Allison, 2003)

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6 K.S.A. 65-425 (j).
7 K.S.A. 65-425 (a).
8 K.S.A. 65-468 (f).
9 K.S.A. 65-425 (b)

Typically, specialty hospitals in Kansas offer a significantly narrower range of services than are found in general hospitals. For instance, specialty hospitals do not generally offer emergency department services, nor do they provide obstetrical care. Eleven hospitals in Kansas meet the definition outlined by KHI; however, four of these eleven are currently licensed as general hospitals.

In addition to the various definitions, specialty hospitals are organized under three basic operational structures: national management chains that partner with local physicians, joint ventures between a general hospital and local physicians, and physician groups that go it alone. In Kansas, 45 percent of specialty hospitals are joint ventures with management companies, 22 percent are joint general hospital-physician operations, and 33 percent are solely physician-owned.

Potential Definitions of Specialty Hospitals

A review of the literature shows multiple definitions of specialty hospitals, and that Federal and state definitions do not always agree. Definitions also vary across the many studies of specialty hospitals. The General Accounting Office – now known as the Government Accountability Office (GAO) has conducted studies which describe specialty hospitals as those that predominately treat certain diagnoses or perform certain procedures. The GAO (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)." (p.2)

In its report to Congress, MedPAC established these criteria to define physician owned specialty hospitals as:

- "physician owned,
- "specialize in certain services,
- "at least 45 percent of the Medicare cases must be in cardiac, orthopedic, or surgical services,
- "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, p. 4)

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 1886(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."[10]

In its final report and accompanying recommendations, HHS uses 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." (CMS Press Release, August 8, 2006)

Other States' Definitions

KHPA surveyed other states concerning their definitions of general and special or specialty hospitals and found most of them make no distinction. This may be because in many cases, these states have a certificate of need requirement that precludes the building of any new hospital without a review by a committee and justification of the need for a new hospital in the community.

South Dakota, a state that has twelve specialty hospitals, distinguishes between general and specialized hospitals by the number of categories of service checked on the licensing application. A facility that checks all four (medical, surgical, obstetrical, and emergency services) is automatically classified as a general hospital. Arkansas, which has three specialty

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10 MMA, Section 507, Clarifications to Certain Exceptions to Medicare Limits on Physician Referrals, (B) Definition – Section 1877(h) (42 U.S.C. 1395nn(h)) amended.

ho , requires general hospitals to provide obstetrical care in order to be licensed in that category. Other states are Kan... in that they allow the applicant to select the category.

Discussion

State licensure laws do not clearly reflect the classes of hospitals in the State. While this present lack of correspondence does not currently affect Medicare payments to hospitals in Kansas, some supplemental Medicare payments may hinge on the proximity of facilities designated as general hospitals by the State licensing process. More cleanly distinguishing between general and specialty hospitals could facilitate better targeting of future State policies, and could ensure that Medicare payment policies that depend on State licensure rules have the intended impact.

KHPA will monitor the impact of specialty hospitals and other facilities on the quality and cost of care in Kansas. To provide information necessary to apply service-related licensing criteria, data to support ongoing analysis and monitoring will be collected and maintained by KHPA. This data will include information that specifically identifies each hospital, its license category and the names of each owner. Hospitals which are designated as SCH's by Medicare will be required to report this status as a part of this data collection effort to allow the State to monitor the potential impact of licensing new hospitals.

The recommendation below is designed to accomplish those directives, drawing directly on MedPAC's definition of a specialty hospital, which was in large part also used in the MMA to apply the moratorium on Medicare payments to the new specialty hospitals.

Recommendation

I. State hospital licensure statutes should include hospitals that meet the following set of criteria among those defined as special hospitals:
   a. "physician owned,
   b. "specialize in certain services,
   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, p. 4)

References

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FACT SHEET

Sole Community Hospital

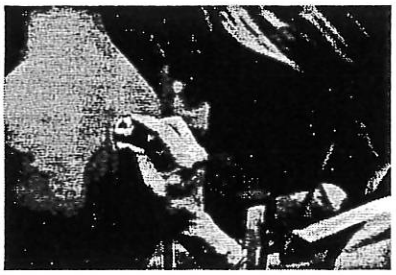
A Hospital is Eligible to be Classified as a Sole Community Hospital (SCH) if it is located more than 35 miles from other like hospitals or it is located in a rural area AND meets at least ONE of the following three conditions:

1) The hospital is located between 25 and 35 miles from other like hospitals AND meets ONE of the following criteria:

   - No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital or, if larger, within its service area
   - The hospital has fewer than 50 beds and would meet the 25 percent criterion above were it not for the fact that some beneficiaries or residents were forced to seek specialized care outside of the service area due to the unavailability of necessary specialty services at the hospital or
   - Other like hospitals are inaccessible for at least 30 days in each of two out of three years because of local topography or prolonged severe weather conditions

2) The hospital is located between 15 and 25 miles from other like hospitals but because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each of two out of three years.

3) Because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest hospital is at least 45 minutes.



Statement to the Public Health and Welfare Committee
On HB 2418
The University of Kansas Hospital
March 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 language 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.

Senate Public Health and Welfare committee
Attachment #9
March 21, 2007

Via Christi
Health System

3720 E. Bayley Street
Wichita, KS 67218-3002

Tel 316-858-4942
Fax 316-858-4185

Kevin P. Conlin
President and
Chief Executive Officer

March 12, 2007

The Honorable Jim Barnett
Kansas Senate
300 SW 19th Avenue, 120-S
Topeka, KS 7698

Dear Senator Barnett: Jim

I am writing to ask for your support of HB 2418 which proposes to update the definition of a "general hospital" in Kansas. It has been over thirty-five years since this statute was last revised and we believe the conditions listed in HB 2418 more precisely define today's 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 requires a general hospital to 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 (percentages are ones used by MedPAC).

Again, I urge your support of HB 2418 and encourage you to call me at (316) 858-4942 should you have particular questions or concerns about the bill. I look forward to working with you as this bill moves forward in the Senate.

Sincerely,

Kevin Conlin
President & CEO

Senate Public Health and Welfare committee
Attachment # 10
March 21, 2007

American Hospital Association

Contact: Matt Fenwick, (312) 422-2820
Amy Lee, (202) 626-2960

STATEMENT ON JAMA STUDY
Rick Pollack
Executive Vice President
March 6, 2007

Does physician ownership result in potentially unnecessary care? That's the question rightly answered in today's Journal of the American Medical Association study. It found that the number of certain heart procedures performed per Medicare beneficiary grew twice as fast in communities with a new physician-owned heart hospital than in communities without new heart programs or with new programs sponsored by an existing community hospital. The study comes as no surprise. Congress has long known that a federal loophole allowing physicians to own limited-service hospitals and self-refer their patients to these facilities increases the use of certain health care services. It's time to close the loophole.

The study also raises questions about whether all patients who received care actually required the treatment they were given. Patients rely almost exclusively on the advice of their physicians when deciding where to have a procedure performed. But physicians clearly have more of a financial incentive to perform a procedure at a hospital they own. The practice raises a critical question – is the physician doing what is in the best interests of the patient, or what's best for their own business?

This study confirms past research finding a strong link between physician self-referral and increased health care costs. It's especially critical as we look for ways to control health care spending that Congress protect patient care and ensure that what is in the best interest of the patient is a health care provider's top priority. Again, it's time to close the loophole.

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Senate Public Health and Welfare committee
Attachment #11
March 21, 2007

Opening of Specialty Cardiac Hospitals and Use of Coronary Revascularization in Medicare Beneficiaries

Brahmajee K. Nallamothu, MD, MPH
Mary A. M. Rogers, PhD
Michael E. Chernew, PhD
Harlan M. Krumholz, MD, SM
Kim A. Eagle, MD
John D. Birkmeyer, MD

Context Although proponents argue that specialty cardiac hospitals provide high-quality cost-efficient care, strong financial incentives for physicians at these facilities could result in greater procedure utilization.

Objective To determine whether the opening of cardiac hospitals was associated with increasing population-based rates of coronary revascularization.

Design, Setting, and Patients In a study of Medicare beneficiaries from 1995 through 2003, we calculated annual population-based rates for total revascularization (coronary artery bypass graft [CABG] plus percutaneous coronary intervention [PCI]), CABG, and PCI. Hospital referral regions (HRRs) were used to categorize health care markets into those where (1) cardiac hospitals opened (n=13), (2) new cardiac programs opened at general hospitals (n=142), and (3) no new programs opened (n=151).

Main Outcome Measures Rates of change in total revascularization, CABG, and PCI using multivariable linear regression models with generalized estimating equations.

Results Overall, rates of change for total revascularization were higher in HRRs after cardiac hospitals opened when compared with HRRs where new cardiac programs opened at general hospitals and HRRs with no new programs ($P<.001$ for both comparisons). Four years after their opening, the relative increase in adjusted rates was more than 2-fold higher in HRRs where cardiac hospitals opened (19.2% [95% confidence interval {CI}, 6.1%-32.2%], $P<.001$) when compared with HRRs where new cardiac programs opened at general hospitals (6.5% [95% CI, 3.2%-9.9%], $P<.001$) and HRRs with no new programs (7.4% [95% CI, 3.2%-11.5%], $P<.001$). These findings were consistent when rates for CABG and PCI were considered separately. For PCI, this growth appeared largely driven by increased utilization among patients without acute myocardial infarction (42.1% [95% CI, 21.4%-62.9%], $P<.001$).

Conclusion The opening of a cardiac hospital within an HRR is associated with increasing population-based rates of coronary revascularization in Medicare beneficiaries.

JAMA. 2007;297:962-968 www.jama.com

SPECIALTY HOSPITALS, WHICH PROVIDE care limited to specific medical conditions or procedures, are opening at a rapid pace across the United States.[1] Proponents argue that specialty hospitals provide higher-quality health care and greater cost-efficiency by concentrating physician skills and hospital resources needed for managing complex diseases.[2,3] Critics claim that specialty hospitals focus primarily on low-risk patients and provide less uncompensated care, which places competing general hospitals at significant financial risk.[4,5]

However, specialty hospitals raise an additional concern beyond their potential to simply redistribute cases within a health care market. Specialty hospitals are typically smaller than general hospitals and have high rates of physician ownership.[6] Physician owners may have stronger financial incentives for providing services that fuel greater utilization. Evidence for the potential of "physician-induced" demand of services exists in other health care settings like clinical laboratory and diagnostic imaging centers where self-referral by physician owners is restricted by federal law.[7,8] Thus, the opening of a specialty hospital may be expected to raise utilization more than by simply adding increased capacity for procedures to a market.

We sought to assess whether the opening of specialty cardiac hospitals was

For editorial comment see p 998.

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associated with greater utilization of coronary revascularization services. We focused on cardiac hospitals since two thirds of Medicare payments to specialty hospitals are related to cardiac conditions.[9] To better distinguish the particular effects of specialty hospitals from the simple addition of capacity to a market, we separately compared areas where a cardiac hospital opened with those where new cardiac programs were introduced at general hospitals.

METHODS

Data Sources and Study Population

We obtained from the Centers for Medicare & Medicaid Services (CMS) Medicare Provider and Analysis Review (MEDPAR) Part A, Denominator, and Provider of Service files from 1995 through 2003. Part A files include data on acute care hospitalizations. Denominator files contain data on eligible Medicare beneficiaries for that year including demographic and enrollment information. Provider of Service files contain data on hospital providers including facility characteristics and ZIP code locations. Data on all Medicare beneficiaries aged 65 years or older enrolled in fee-for-service programs within the United States were included.

We used the *International Classification of Diseases, Ninth Revision, Clinical Modification* (*ICD-9-CM*) procedural codes to identify patients undergoing coronary revascularization with coronary artery bypass grafting (CABG) (*ICD-9-CM* procedural codes 36.10-36.19) without concomitant aortic or valvular surgery and/or percutaneous coronary intervention (PCI) (*ICD-9-CM* procedural codes 36.01, 36.02, 36.05-36.07, 36.09). Hospitals that performed these procedures during the study period were identified using the same *ICD-9-CM* procedural codes. We included all hospitals with at least 3 CABG and/or PCI cases during one of the years in which the hospital reported data. The Institutional Review Board of the University of Michigan and the CMS approved this protocol prior to its initiation. The requirement for informed consent was waived and approved.

Specialty Hospital Identification

We categorized all hospitals that performed coronary revascularization into cardiac or general hospitals using an approach similar to the General Accounting Office and Cram et al.[10] Specifically, we constructed a cardiac specialty index based on the percentage of cardiac-to-total admissions in Medicare beneficiaries in 2002 and 2003. From this cardiac specialty index, we reviewed the top 100 facilities and selected those that (1) had proprietary or corporate ownership, and (2) did not provide broad medical or pediatric services. Data on additional services available at these hospitals were obtained from the American Hospital Association Annual Survey, the American Hospital Directory, and online hospital Web sites.[11,12] One cardiac hospital was excluded due to concerns regarding inconsistent participation within the Medicare program during the study period. To supplement this strategy, we also included any cardiac hospitals identified by the CMS during their recent national survey.[13]

As we were specifically interested in examining changes in use of coronary revascularization after the opening of a cardiac hospital, we excluded those that opened prior to January 1, 1996, and after December 31, 2002, to ensure at least 1 year of follow-up data. The year of opening was considered the first year that data were reported to the CMS for either procedure.

Statistical Analysis

We used hospital referral regions (HRRs) from the *Dartmouth Atlas of Cardiovascular Health Care* to identify health care markets.[14] Hospital referral regions are large geographic units representing distinct markets for tertiary care that were developed by studying patterns of hospital utilization for major cardiac surgery among Medicare beneficiaries in the early 1990s. Based on their ZIP code, patients and hospitals were assigned to 1 of 306 HRRs. Hospital referral regions were categorized into 3 types: (1) HRRs where a new cardiac hospital opened; (2) HRRs where a new cardiac program in CABG and/or PCI opened at a general hospital; and (3) HRRs where no new programs opened during the study period.

We calculated population-based rates for CABG and PCI in each of the 306 HRRs during each year of the study period. The numerator for these rates was the total number of eligible beneficiaries within the HRR who underwent the procedure during that calendar year. The denominator was the total number of eligible beneficiaries within the HRR in June of that year. Rates were adjusted for differences in age (65-69, 70-74, and 75 years or older), sex, and race (black, nonblack) across HRRs and years using direct standardization.[15]

Population-based rates of total revascularization (CABG plus PCI), CABG, and PCI were plotted by calendar year with general trends visualized using fractional polynomial regression.[16] We constructed multivariable linear regression models to assess the statistical significance of rates of change across the 3 types of HRRs after the opening of new programs. Repeated measures within HRRs were accounted for using generalized estimating equations with robust variance estimators with a first-order autoregressive correlation matrix structure assumed.[17,18] Additional correlation matrix structures (second-order autoregressive, exchangeable) were explored and results were robust to this assumption.

Models accounted for trends in time by including year as a categorical variable. We included interaction terms consisting of time since a new program opened by the type of HRR, ie, HRRs where cardiac hospitals opened and HRRs where new cardiac programs opened at general hospitals. Interaction terms took the value of "0" for HRRs with no new programs. Models adjusted for the following HRR-level variables: (1) annual population-based rates of acute myocardial infarc-

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tion; (2) per capita number of cardiologists and cardiovascular surgeons at the midpoint of the study period; (3) geographic region (Northeast, South, Midwest, West); (4) the opening of multiple new programs (2 or more) over the study period; (5) tertiles of the annual percentage of managed care penetration; and (6) tertiles of a summary score of socioeconomic status[19] calculated from US Census data at the ZIP code level. Nonlinear relationships in rates of change were also evaluated using quadratic terms; results were similar and are not reported.

We performed 3 additional analyses. For PCI, we separately analyzed rates among patients with and without an acute myocardial infarction as identified by *ICD-9-CM* diagnostic code 410.x1 during their hospitalization. This analysis assessed how our results were influenced by procedural indication. Next, we evaluated rates of change in HRRs prior to the opening of cardiac hospitals or new cardiac programs at general hospitals. This analysis assessed whether cardiac hospitals were selectively opening in already growing markets. Finally, we examined procedural volumes at cardiac hospitals and new cardiac programs at general hospitals as well as their relative contributions to the number of coronary revascularizations performed within an HRR at the end of the study period. All analyses were performed using Stata version 9.0 (StataCorp, College Station, Tex) and *P* values of <.05 were considered significant. All tests were 2-sided.

RESULTS

We identified 13 HRRs with 14 new cardiac hospitals, 142 HRRs with 245 new cardiac programs at general hospitals, and 151 HRRs with no new programs during the study period. In 2003, the mean (SD) number of beds at the 14 cardiac hospitals was 55 (16), the mean volume of CABG was 233 (151), and the mean volume of PCI was 575 (247). Eleven (79%) of the 14 cardiac hospitals reported providing emergency services, while 1 (7%) reported any affiliation with a medical school. (Specific information regarding the 14 cardiac hospitals available from the authors on request.) TABLE 1 lists key summary characteristics of the 3 types of HRRs. Hospital referral regions with no new cardiac programs had fewer Medicare enrollees, but rates of total revascularization, CABG, and PCI were not significantly different at the start of the study period. Eleven (85%) of the 13 HRRs where cardiac hospitals opened had at least 1 additional new program open during the study period compared with 50 (35%) of the 142 HRRs where new cardiac programs opened at general hospitals.

FIGURE 1 and FIGURE 2 display population-based rates for total revascularization, CABG, and PCI between 1995 and 2003 across the 3 types of HRRs. There was noticeable separation of rates in HRRs where cardiac hospitals opened starting in approximately 1999, coinciding with the median year of opening for these facilities. The rate of change for total revascularization was significantly greater in HRRs after cardiac hospitals opened when compared with HRRs where new cardiac programs opened at general hospitals (difference, +4.2/10 000 per year [95%

Table 1. Key Summary Characteristics of Hospital Referral Regions (HRRs) by the Presence of New Programs During the Study Period

Characteristic	HRRs With New Cardiac Hospital (n = 13)	HRRs With New Cardiac Programs at General Hospitals (n = 142)	HRRs With No New Programs (n = 151)	*P* Value
Medicare fee-for-service enrollees per y, mean (SD), No. [1995-2003]	147 097 (78 583)	125 031 (112 202)	56 696 (38 003)	<.001
Medicare managed care enrollees per y, mean (SD), % [1995-2003]	12.6 (13.3)	11.6 (12.9)	11.1 (13.1)	.90
Rates of AMI per 10 000 per y, mean (SD) [1995-2003]	80.7 (13.4)	91.8 (20.0)	87.8 (22.8)	.09
Cardiologists and cardiothoracic surgeons per 100 000, mean (SD), No. [1999]	6.4 (1.2)	7.6 (2.3)	7.2 (2.3)	.12
No. (%) by US region				
Northeast	0 (0)	22 (15)	21 (14)	.38
Midwest	4 (31)	34 (24)	46 (30)	
South	5 (38)	62 (44)	52 (34)	
West	4 (31)	24 (17)	32 (21)	
Regions with >1 new program, No. (%)	11 (85)	50 (35)	NA	<.001
Adjusted rates per 10 000, mean (SD) [1995]*				
Coronary revascularization	111.6 (22.6)	107.3 (22.5)	105.6 (26.8)	.64
CABG	52.3 (14.2)	52.4 (11.6)	50.9 (13.2)	.58
PCI	59.2 (10.6)	54.9 (16.9)	54.7 (20.0)	.69
PCI with AMI	20.0 (3.0)	19.0 (6.1)	20.1 (6.3)	.29
PCI without AMI	39.3 (9.0)	35.9 (12.5)	34.5 (15.5)	.42

Abbreviations: AMI, acute myocardial infarction; CABG, coronary artery bypass grafting; PCI, percutaneous coronary intervention.
*Adjusted for age, sex, and race.

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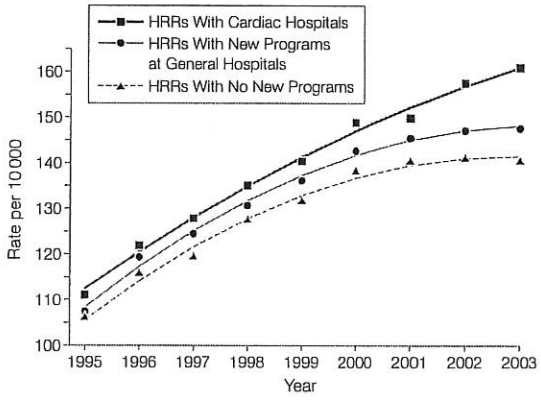
confidence interval [CI], 2.0-6.5]; $P<.001$) and HRRs with no new programs (difference, +4.0/10 000 per year [95% CI, 1.8-6.3]; $P<.001$). Four years after their opening, the relative increase in rates of total revascularization was more than 2-fold higher in HRRs where cardiac hospitals opened when compared with other HRRs (TABLE 2).

Similar findings were noted when we considered rates for CABG and PCI separately (Table 2). Although rates for CABG declined throughout the study period, the rate of change was less in HRRs after cardiac hospitals opened when compared with HRRs where new cardiac programs opened at general hospitals (difference, +2.1/10 000 per year [95% CI, 0.8-3.4]; $P=.001$) and HRRs with no new programs (difference, +1.9/10 000 per year [95% CI, 0.6-3.2]; $P=.005$). The rate of change for PCI also was higher in HRRs after cardiac hospitals opened when compared with HRRs where new cardiac programs opened at general hospitals (difference, +2.4/10 000 per year [95% CI, 0.5 to 4.2]; $P=.012$) and HRRs with no new programs (difference, +2.4/10 000 per year [95% CI, 0.5-4.2]; $P=.011$).

For PCI, these results varied when we considered the strength of the procedural indication (FIGURE 3). Among patients with acute myocardial infarction, no significant differences were seen in the rate of change for PCI across HRRs after cardiac hospitals opened (difference, −0.4/10 000 per year [95% CI, −0.9 to 0.1]; $P=.15$ when compared with HRRs where new cardiac programs opened at general hospitals; and difference, −0.3/10 000 per year [95% CI, −0.8 to 0.2]; $P=.26$ when compared with HRRs with no new programs). In contrast, the rate of change was significantly higher for PCI among patients without acute myocardial infarction in HRRs after cardiac hospitals opened when compared with HRRs where new cardiac programs opened at general hospitals (difference, +2.7/10 000 per year [95% CI, 1.1-4.3]; $P=.001$) and HRRs with no new programs (difference, +2.6/10 000 per year [95% CI, 1.0- 4.2]; $P=.002$).

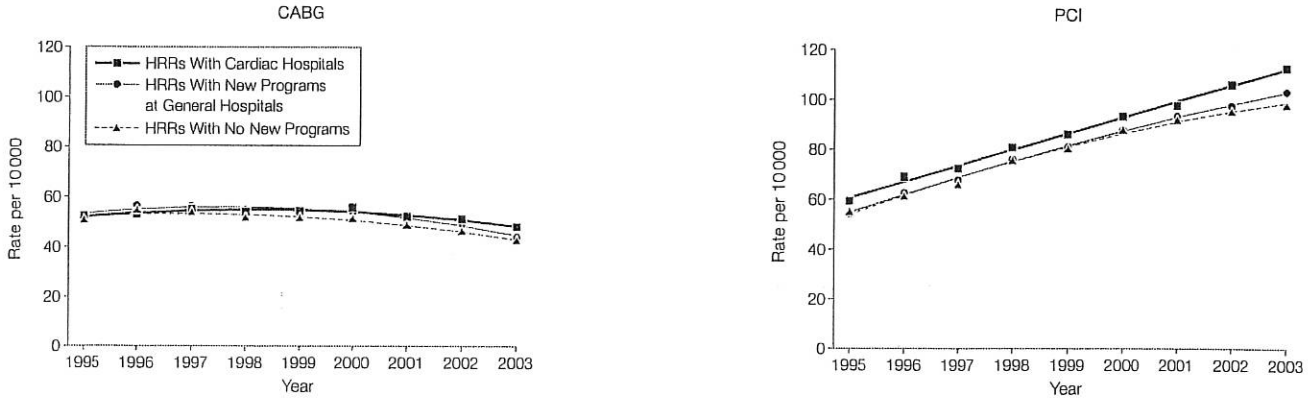
We also examined whether cardiac hospitals were selectively opening in already growing markets. Prior to their introduction, the rate of change for total revascularization was not significantly different in HRRs where cardiac hospitals opened than in HRRs where new cardiac programs opened at general hospitals (difference, +0.7/10 000 per year [95% CI, −0.8 to 2.2]; $P=.39$) or HRRs with no new programs (difference, +0.8/10 000 per year [95% CI, −0.5 to 2.0]; $P=.24$). Finally, we found that at the end of the study

Figure 1. Population-Based Rates of Total Revascularization by Year in Hospital Referral Regions (HRRs) With Cardiac Hospitals, HRRs With New Cardiac Programs at General Hospitals, and HRRs With No New Programs



Rates were adjusted for age, sex, and race using direct standardization. Trend lines were generated using fractional polynomial regression.

Figure 2. Population-Based Rates of Coronary Artery Bypass Graft (CABG) and Percutaneous Coronary Intervention (PCI) by Year in Hospital Referral Regions (HRRs) With Cardiac Hospitals, HRRs With New Cardiac Programs at General Hospitals, and HRRs With No New Programs



Rates were adjusted for age, sex, and race using direct standardization. Trend lines were generated using fractional polynomial regression.

11-5

period cardiac hospitals contributed substantially to the utilization of total revascularization within markets when compared with new cardiac programs at general hospitals. The mean procedural volume of cardiac hospitals in Medicare beneficiaries was 4-fold higher than that of new cardiac programs at general hospitals, while the percentage of coronary revascularizations within the HRRs that was performed at cardiac hospitals was approximately 2-fold higher (TABLE 3).

COMMENT

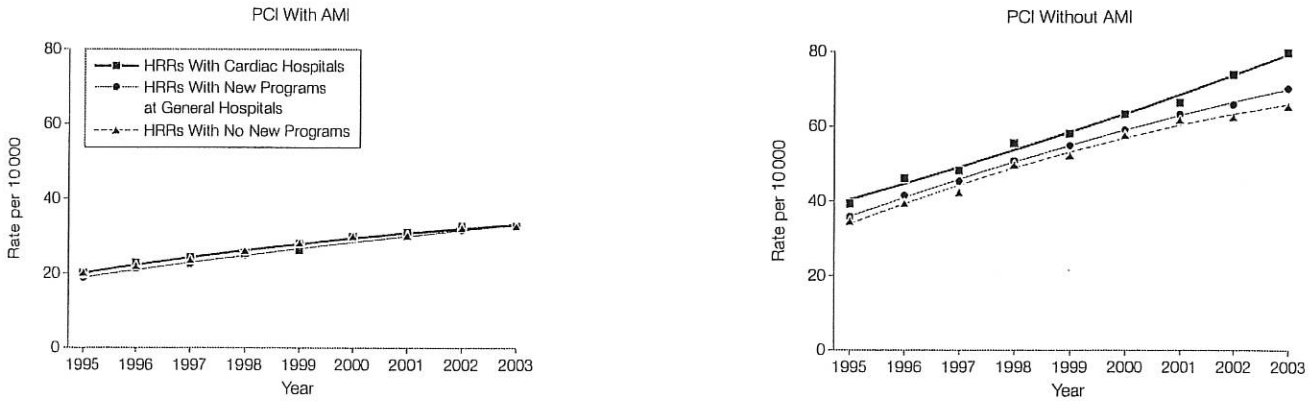
We found that rates of change for total revascularization, CABG, and PCI were higher for Medicare beneficiaries in HRRs after the opening of cardiac hospitals when compared with HRRs where new cardiac programs opened at general hospitals and HRRs with no new programs. The incremental number of coronary revascularizations in these 13 HRRs that was associated with the opening of cardiac hospitals was approximately 3032 between 1999 and 2003. Although we are unable to comment directly on the appropriateness of these procedures, these findings raise the concern that the opening of cardiac hospitals may lead to greater procedural utilization beyond the simple addi-

Table 2. Adjusted Rates of Coronary Revascularization per 10 000 After the Opening of New Programs*

Type of Procedure	Rates Per 10 000 (SE)			% Change (95% CI)
	Baseline Year†	Year 2	Year 4	
Coronary revascularization				
HRRs with cardiac hospital	134.4 (5.5)	151.2 (7.0)	160.2 (9.0)	+19.2 (+6.1 to +32.2)
HRRs with new cardiac program at a general hospital	136.1 (2.4)	144.5 (2.3)	145.0 (2.3)	+6.5 (+3.2 to +9.9)
HRRs with no new program	132.8 (2.5)	141.6 (2.6)	142.6 (2.8)	+7.4 (+3.2 to +11.5)
CABG				
HRRs with cardiac hospital	51.6 (2.7)	52.4 (2.9)	49.6 (3.6)	−3.9 (−17.6 to +9.9)
HRRs with new cardiac program at a general hospital	54.4 (1.0)	51.0 (0.9)	44.1 (0.8)	−18.9 (−21.7 to −16.0)
HRRs with no new program	52.4 (0.8)	49.3 (0.8)	42.8 (1.0)	−18.3 (−22.1 to −14.5)
PCI				
HRRs with cardiac hospital	82.4 (4.0)	98.8 (4.9)	110.9 (6.2)	+34.6 (+19.8 to +49.4)
HRRs with new cardiac program at a general hospital	81.9 (2.0)	93.6 (2.0)	100.9 (2.1)	+23.2 (+18.2 to +28.2)
HRRs with no new program	80.5 (2.0)	92.1 (2.1)	99.4 (2.4)	+23.5 (+17.5 to +29.4)
PCI with AMI				
HRRs with cardiac hospital	27.0 (1.1)	29.4 (1.1)	31.2 (1.2)	+15.6 (+6.7 to +24.8)
HRRs with new cardiac program at a general hospital	26.8 (0.6)	29.9 (0.5)	32.5 (0.6)	+21.3 (+17.2 to +25.7)
HRRs with no new program	27.8 (0.6)	30.7 (0.5)	33.2 (0.7)	+19.4 (+14.7 to +23.7)
PCI without AMI				
HRRs with cardiac hospital	55.6 (3.6)	69.4 (4.6)	79.0 (5.9)	+42.1 (+21.4 to +62.9)
HRRs with new cardiac program at a general hospital	55.4 (1.7)	63.8 (1.7)	68.1 (1.8)	+22.9 (+16.4 to +29.2)
HRRs with no new program	52.9 (1.7)	61.5 (1.8)	66.0 (2.0)	+24.8 (+17.4 to +32.3)

Abbreviations: AMI, acute myocardial infarction; CABG, coronary artery bypass grafting; CI, confidence interval; HRRs, hospital referral regions; PCI, percutaneous coronary intervention.
*Adjusted for age, sex, race, US region, baseline year of 1999, presence of multiple new programs within the HRR, and mean socioeconomic status of the HRR.
†The baseline year of 1999 was used to reflect the midpoint of the study period when calculating the adjusted rates.

Figure 3. Population-Based Rates of Percutaneous Coronary Intervention (PCI) With and Without Acute Myocardial Infarction (AMI) by Year in Hospital Referral Regions (HRRs) With Cardiac Hospitals, HRRs With New Cardiac Programs at General Hospitals, and HRRs With No New Programs



Rates were adjusted for age, sex, and race using direct standardization. Trend lines were generated using fractional polynomial regression.

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Table 3. Coronary Revascularizations Performed in Medicare Beneficiaries by Cardiac Hospitals and New Cardiac Programs at General Hospitals at the End of the Study Period (2003)

	Cardiac Hospitals		New Cardiac Programs	
	Coronary Revascularizations per Hospital, Mean (SD), No.	Coronary Revascularizations in the HRR Performed at Cardiac Hospitals, Mean (SD), %	Coronary Revascularizations per Hospital, Mean (SD), No.	Coronary Revascularizations in HRR Performed at New Cardiac Programs, Mean (SD), %
HRRs with cardiac hospitals	808.6 (370.5)	35.2 (20.2)	152.5 (143.0)	14.3 (14.2)
HRRs with new cardiac programs at general hospitals	NA	NA	161.1 (175.1)	18.0 (19.2)

Abbreviations: HRRs, hospital referral regions; NA, not applicable.

tion of capacity to a market. This is particularly worrisome since cardiac hospitals may not substantially improve clinical outcomes when compared with general hospitals with similar procedural volumes.[10]

An additional finding was that among patients with acute myocardial infarction, the subset of patients who are likely to gain the most clinically from PCI,[20,21] there was no association between the opening of cardiac hospitals and the rate of change for PCI. The rate of change for PCI in patients without acute myocardial infarction, in contrast, was significantly higher in HRRs where cardiac hospitals opened. Although we could not assess appropriateness, the benefits of PCI are frequently less clear in this group of patients,[22] suggesting that our findings may be partly driven by more discretionary cases. Finally, we found that cardiac hospitals had significantly higher procedural volumes than new cardiac programs at general hospitals and were responsible for more than twice the share of revascularizations within an HRR performed by the end of the study period.

Our findings differ somewhat from a recent study performed by the Medicare Payment Advisory Commission (MedPAC).[23,24] In that study, HRRs where cardiac hospitals opened had a mixed association with utilization of CABG and PCI between 1996 and 2002. The likely explanation for the discrepancy between reports is that the MedPAC study did not account for the specific years that a specialty hospital was open. As a result, HRRs where cardiac hospitals opened in 2002 were considered the same as those that opened in 1997, although the former would be expected to only briefly affect utilization. A shorter study period also may have restricted the ability to detect potential associations. Another key difference between the 2 reports is that ours also examined rates of change in HRRs after the development of new cardiac programs at general hospitals. Distinguishing between the particular effect of cardiac hospitals and the mere addition of new cardiac programs at general hospitals is critical given recent growth in hospital-based services for coronary revascularization over the last decade.

Among potential mechanisms underlying our findings, the most concerning is the influence of physician ownership on decisions regarding the use of coronary revascularization. Self-referral of patients by physician owners to facilities where they have significant financial interest is generally prohibited by federal antikickback laws with the exception of "whole" hospitals.[25] Hospitals—including specialty hospitals—are exempted because they typically provide a diverse enough array of services so that physician owners are thought to gain little from self-referral. However, specialty hospitals are smaller and provide fewer services than general hospitals making them more analogous to departments within general hospitals, which are regulated by federal antikickback laws.[25]

Our findings could also be explained by issues unrelated to physician ownership. Specialty hospitals may lead to higher utilization of these procedures through improved efficiencies in patient care that do not directly reflect financial incentives. Cardiac hospitals might have opened in markets already predisposed to higher rates of coronary revascularization due to patient factors or local market conditions, although we found no direct evidence that this was occurring. Finally, anecdotal reports suggest that higher utilization of these procedures within a market may be due to general hospitals positioning themselves more aggressively after the opening of a specialty hospital.[9,26] However, a national survey of 603 US hospitals by the General Accounting Office found little evidence this was occurring.[27]

Our study should be interpreted with the following limitations in mind. First, this analysis cannot comment on the "correct" population-based rate for coronary revascularization. In fact, it may be that the opening of cardiac hospitals leads to more appropriate use of these procedures. Future studies will need to focus on this issue at both cardiac and general hospitals.

Second, in this type of analysis we are unable to fully attribute higher rates of coronary revascularization in HRRs where cardiac hospitals opened to these specific facilities. Instead, changes in the use of coronary revascularization after the opening of cardiac hospitals reflect the environment in which they and other competing hospitals exist. Our findings of higher procedural volumes at cardiac hospitals and their greater market share at the end of the study period are only suggestive of their role in higher rates of coronary revascularization.

Third, we were unable to evaluate the extent to which physician ownership at cardiac hospitals—which report-

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edly ranges from 21% to 49%—influences utilization given a lack of publicly available information.[23] Fourth, data in this analysis were limited to Medicare beneficiaries (although this group does represent a majority of the patients undergoing coronary revascularization in the United States). Finally, we identified only 14 cardiac hospitals that opened during the study period. Although specialty hospitals have generated great controversy among policy makers, they are a relatively new phenomenon and important differences may exist across individual facilities. Expiration of the moratorium on new specialty hospital construction is expected to increase their numbers in the coming years.

Despite these limitations, our findings may have important policy implications. The CMS recently issued their final report to Congress implementing a strategic plan for specialty hospitals.[13] Their plan primarily involves revisions to the inpatient prospective payment systems to "level the playing field" between specialty and general hospitals and limit financial incentives for investing in certain services simply due to profitability. It also proposes new "gainsharing" and value-based payment approaches to better align physician and hospital incentives toward improving care at general hospitals. Reforms directly related to physician ownership include enhanced transparency of financial relationships. More stringent measures, such as limiting investments by physician owners, were not included. The extent to which additional measures are needed will require further data on appropriateness of care at specialty hospitals as well as the impact of greater utilization of these procedures on patient outcomes.

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Acquisition of data: Nallamothu, Birkmeyer.
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