Approved: March 20, 2007
Date

MINUTES OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE

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

All members were present except:

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

Conferees appearing before the committee:

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

Others Attending:
See Attached List.

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

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

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

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

**Sam Serrill**, chief Operating Officer of Wesley Medical Center, Wichita, KS, said that Wesley Medical Center is a general acute care hospital Wesley provides a comprehensive range of services to south central Kansas and is affiliated with the University of Kansas Medical School, Wichita. He stated that it is important to distinguish between the services provided by a community general hospital and a specialty hospital. This distinguishment is currently not well defined in Kansas. Wesley Medical Center supports passage of **HB 2418**, which will update and revise the Kansas hospital licensure laws to be consistent with the changes in hospital care and treatment occurring over the past 25 years, in addition to providing the distinction between

the general and the specialty hospitals.

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

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

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

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

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

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

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

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

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

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

Opponent **Mary Nan Holley**, Chief Executive Officer of Heartland Spine and Specialty Hospital stated that her hospital is licensed as a level 4 trauma center. Even though my hospital does not have an

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

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

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

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

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

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

He offered one note of caution for the committee. The proposed legislation includes a provision that a

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

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

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

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

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

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

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

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

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

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