Approved: 3-31-93
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chairperson Joann Flower at 1:30 p.m. on March 23, 1993 in Room 423-S of the Capitol.

All members were present except:

Committee staff present:
William Wolff, Legislative Research Department
Norman Furse, Revisor of Statutes
Sue Hill, Committee Secretary

Conferees appearing before the committee:
Carolyn Exley, Administrator of Surgicare, Wichita, Kansas
Margaret Orman, Regional Director for Medical Care International (Managing Partner at Surgicare of Wichita/Surgicenter of Johnson County
Marvin Fairbanks, Executive Director, Topeka Same:Day Surgery Center
Robert L. Goolsbee, M.D., Medical Director, Surgicenter of Kansas City
Greg Reser,Medical Facilities Certification Administrator, Bureau of Adult/Child Care Department of Health and Environment

Others attending: See attached list

Chair called the meeting to order, drawing attention to Committee Action on bills previously considered.

CHAIR DREW ATTENTION TO SB 313, noting there were no opponents, and no concerns expressed during the hearing, therefore the Chair decided to dispense with requesting an up-date from Staff.

Rep. Rutledge made a motion to pass SB 313 favorably, seconded by Rep. Swall. There was discussion in regard to placing SB 313 on the consent calendar, however, the Chair reminded members there would not be adequate time to allow for the three days required for this action. No further discussion. Vote taken. Motion carried.

CHAIR DREW ATTENTION TO SCR 1606, and requested staff give an update. Dr. Wolff did so, then answered questions.

Noted: Written testimony given by Sen. Bond on March 3, 1993 had been received by this Committee after that date, and was distributed to members today and is indicated today as (Attachment No. 1)

Rep. O'Connor moved to pass SCR 1606 out favorably, second by Rep. Freeborn. No discussion. Vote taken. Motion carried.

CHAIR DREW ATTENTION TO SB 84, (Civil penalties for violation of the Pharmacy Act).

Rep. Wagle moved to amend SB 84 conceptually by amending HB 2117 into SB 84. Motion seconded by Rep. Bishop

Rep. Wagle detailed rationale, noting HB 2117 is legislation on the freedom of pharmaceutical choice that passed the House Insurance Committee a few weeks ago but has not yet appeared on the House floor.

She noted also she moved to amend SB 84 further in Sec. 1, first paragraph, fourth sentence, following "by a

health maintenance organization", to add, "The freedom of pharmacy act is in force, except when a HMO owns and operates its own pharmacies and such HMO is in operation at the date of enactment of this legislation." (See Attachment No. 2)

Dr. Wolff gave an explanation of HB 2117 as enacted in the Insurance Committee. He noted that managed care was the main topic of discussion, and along the way some technical concerns in the language have not been addressed, and language is not coming together as it should. He detailed the items, i.e., clarification of the description of HMO contracts and as opposed to life insurance policies; a need to cross reference Blue Cross/Blue Shield statute in Sec. (1) which is the freedom of choice statement.

Rep. Wagle then restated her motion to amend SB 84 to also include the technical clean-up detailed by Dr. Wolff, along with amendments proposed earlier in her motion. Rep.Bishop, who had seconded the motion, agreed.

Discussion began. Dr. Wolff explained both HB 2117 and SB 84 to members for clarification.

Vote taken to amend SB 84. Motion carried.

On the bill as a whole, Rep. Wagle moved to pass SB 84 out favorably as amended, seconded by Rep. Freeborn. No discussion. Motion carried.

CHAIR DREW ATTENTION TO SB 120.

Rep. Wagle, Chair of the Subcommittee on SB 120 stated , she, Rep. Neufeld, and Rep. Goodwin have met with interested parties. All are still looking for a compromise between the Psychologists and Social Workers. The Subcommittee has requested from the Board of Healing Arts and Board of Behavioral Sciences to reply with information on how each of these Boards view "under the supervision of," and "under the direction of". The Board of Healing Arts has replied, the Board of Behavioral Sciences reply has yet to be reviewed by the Subcommittee members. She noted there still is controversy, but interested parties are still trying to come together on these issues. The Subcommittee does plan to meet again when the information on the definitions specified arrives from the Board of Behavioral Sciences, and if there is new information regarding a compromise from these groups.

CHAIR DREW ATTENTION TO HB 2526.

Chair requested a Subcommittee report on HB 2526 from Subcommittee Chair, Rep. Wells.

Rep. Wells offered a balloon amendment on HB 2526, (Attachment No.3). She stated she, Rep. Morrison, and Rep. Weiland had worked together with interested parties on the recommendations indicated in the balloon. She detailed each proposed change shown in the balloon, offered rationale. She stated the Senate had worked on moratorium legislation, then have requested it be studied during Interim session. She indicated if the House Committee on Public Health and Welfare can forward HB 2526, it will be legislation that can be looked at during Interim. The Committee will in effect be saying they want a moratorium on new beds, but not as restrictive as the initial House bill, or the Senate version.

At this point , Rep. Wells moved to adopt the Committee report and amend HB 2526 with recommendations provided in (Attachment No. 3) . Motion seconded by Rep. Samuelson.

Discussion began, i.e., clarification urged for adoption of rules and regulations;

Mr. Furse indicated, when asked, page l, Sec. (3) lines 39-40-41 could be deleted if Sec. (3) is deleted.

Rep. Wells restated her motion to further amend HB 2526 conceptually including the technical amendment explained by Mr. Furse in regard to the rules and regulations, seconded by Rep. Samuelson.

The certificate of need was detailed. Specifics on the number of beds used for Medicaid or Medicare was unknown; some view the moratorium as very restrictive; some view this situation as having some restrictions placed on expansion of beds; some members have facilities in their Districts that have long waiting lists, therefore the moratorium is difficult to understand for some areas that are under-bedded; some members stated concerns regarding a moratorium are absolutely vital and if not implemented, the increased costs will break the budget of SRS; some members noted this ban on new beds should have been implemented 10 years ago as Oregon did, and perhaps by now the situation would be better under control as related to costs of services; costs for care in institutional settings versus home settings were discussed. Commissioner Epps responded to questions. It was requested that the Department of SRS provide Committee members with information in respect to costs on services offered in home community based services vs. nursing home services in some communities in the State. This situation was discussed in length.

Rep. Wells closed, noting changes take place quickly in the medical field, and services provided by the state can also quickly change. She noted that after the moratorium date expires, a review could be conducted again to see if the moratorium has helped, and if there is a need to continue the moratorium. She also drew attention to an amendment that would answer concerns about the Soldiers Home.

At this point the Chair asked for a vote on motions thus far to amend SB 2526. Vote taken. Motion carried.

Noted: Representative Bishop recorded as a NO vote.

Rep. Wells requested the balloon be distributed by Mr. Furse. Mr. Furse detailed the balloon on HB 2526, (see Attachment No. 4)., noted the proposed amendment would eliminate the prohibition on conversion from another licensure category by deleting items (2) and (3) on page 2 of HB 2526. Rep. Wells moved to further amend HB 2526 by adding the amendments detailed by Mr. Furse and indicated in (Attachment No. 4). Motion seconded by Rep. Neufeld. Discussion ensued.

Vote taken. Motion carried.

Noted: Representative Bishop recorded as a NO vote.

Rep. Wells moved to report HB 2526 favorably as amended, seconded by Rep. Rutledge. No discussion. Vote taken. Motion carried.

Noted: Representative Bishop recorded as a NO vote.

CHAIR DREW ATTENTION TO SB 402

Chair requested a briefing by Staff. Dr. Wolff gave a detailed explanation of SB 402.

CHAIR OPENED HEARINGS ON SB 402.

Carolyn Exley, Administer of Surgicare, offered hand out, (Attachment No. 5) She noted regulations governing Ambulatory Surgical Centers (ASC) were developed in the 1970s when surgical technology was not as complex as is today. Patients using these facilities today are not critical and do not need hospitalization, but do require individualized care with all their needs being met regarding pain control, safety, nutrition, convenience and cost considerations. She noted that with the capability to keep patients overnight, when necessary, surgeons will be more beneficial to the patient, and for the care-giver. The proposed language in SB 402 relates to a patient being kept in an Ambulatory Surgical Center for up to 24 hours. She drew attention to (Attachment 5-A) that indicates an overview of proposed statutory change.

Margaret Orman, Regional Director for Medical Care International offered hand out, (Attachment No. 6). She noted, by allowing the Ambulatory Surgical Centers to keep patients for up to 24 hours, better continuity of care can be offered patients for pain management, additional monitoring or observation, replacement of fluids with infusion therapy, and administration of intravenous medications if necessary. She detailed the high quality of care being offered patients in these facilities, and noted these facilities are accredited with commendation by the Joint Commission for Accreditation of Health Care Organizations. She stated recent data released by Blue Cross/Blue Shield indicate ambulatory surgical centers are cost effective; are far less expensive than hospital-based outpatient facilities; provide free or very low cost services to unemployed, uninsured, or indigent persons. She urged support.

Marvin Fairbanks, Executive Director of Topeka Single Day Surgery, offered hand out, (Attachment No. 7). He stated the delivery of ambulatory surgery has changed radically in the past 20 years. No one anticipated the widespread of the highly technical treatments available that are used today. He detailed numerous surgical procedures that are offered in ambulatory surgical centers today. He noted on occasion, a patient's condition requires overnight observation. Rather than experience an expensive transfer and overnight admission in a hospital, the patient would be better served if they could remain in the facility where the treatment had been given. He noted, at present hospitals may monitor outpatients overnight without admitting them. There is no reason to believe that ambulatory surgical centers would offer less safety for the patients requiring post operative observation overnight than they receive in hospitals. He urged support.

Dr. Goolsbee, M.D., Medical Director, Surgicenter, offered hand out, (Attachment No. 8) He listed numerous procedures done in surgicenters today, noting 60% of all surgeries that used to be done on an inpatient bases, now are done on an outpatient basis. Factors restricting use of one day surgery include pain not controlled by oral medications, no one at home to stay with the patient the first post-op night, excessive blood loss, severe heart or lung or other diseases requiring special care. He explained current treatments for pain management, minimizing blood loss, the use of self-donated blood. He noted, the next logical step for surgicenters is to adopt the hospital oriented 23 hour observation mode and further expand the use of low-cost, high quality, high patient satisfaction outpatient surgicenter.

Greg Reser, Medical Facilities Certification Administrator, Department of Health and Environment, offered hand out (Attachment No. 9) drew attention to the amendment to SB 402 which would authorize physicians to leave the facility after patients had recovered from the obvious effects of anesthesia would still require that physicians be "available" whenever a patient is in the facility. He noted Medicare regulations, i.e., 42 CFR 426.42 (a), require each patient be evaluated by a physician for proper anesthesia recovering "before discharge." He stated staff from the Department of Health and Environment assisted with the development of new language found in SB 402, page 2, lines 2-4. He stated earlier concerns related to anesthesia recovering "before discharge" have been addressed, in proposed amendment. He stated support.

Numerous questions were asked. It was stated that surgicenters are under the regulated authority of the Department of Health and Environment. There is an annual inspection done by the Department of Health and Environment; inspections for Medicare are done concurrently, and they reserve the right to a follow-up or validation visit. Insurance premiums should not be affected by this proposed change, it was noted by some conferees.

CHAIR CLOSED HEARINGS ON SB 402.

Chair drew attention to Committee discussion and possible action on SB 402.

Rep. Mayans moved to pass SB 402 out favorably, seconded by Rep. Sader. Discussion began.

Rep. Neufeld made a substitute motion to amend SB 402 on page 1, line 37, after "staff of", to add, "one or more physicians". This substitute motion was seconded by Rep. Wells.

Rep. Neufeld offered rationale. No discussion.

Vote taken, motion carried.

Rep. Scott moved to amend SB 402, on page 2, line 2, to delete "overnight", seconded by Rep. Neufeld. He offered rationale. Discussion began, i.e., concerns expressed in regard to some rural hospitals having economic difficulties with being left with only patients that are indigent, and others who do not pay their hospital bills. It is the concern of some members a continuation of this type of practice will cause further decline in the paying base of hospitals. Some members agreed to remove "overnight" would prevent the main intent of SB 402. It was suggested perhaps it is time to be more consumer oriented in the delivery of the health care system.

Vote taken. Chair in doubt. Show of hands indicated 7 in favor, 7 against. Motion failed.

Rep. Wagle moved to pass SB 402 favorably as amended, seconded by Rep. Bruns. Motion carried.

Chair stated the agenda for today is concluded. There will be no meeting at 5:00 p.m. today, however there may be a need to call another Committee meeting later. Chair adjourned the meeting.

Date uncertain for next Committee meeting.

VISITOR REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE March 23, 1993

NAME	ORGANIZATION	ADDRESS
Chip Wheelen, M.P.A.	KS Med Soc	Topeka
Cammie Tiede	Ks Bd of Healing Arts	Topeka
Tom Hitchcock	Bd of Pharmacy	"
Bob Williams	Ks Pharmacists Assn	Topeka
KEITH R LAUDIS	CHRISTIAN SCIENCE COMM ON PUBLICATION FOR KS	TOPEKA
Sandra Strand	KINH	Lawrence
GREG FESER	KDHE	TOPEKA
Robert Epps	SRS	Topeka
Judi Taggers	Surgicenter of Johnson County - Overland Park	
Carolyn Exley	Surgical of Wichita	Wichita
MARVIN FAIRBANK	TOPEKA SURGICENTER	TOPEKA
Margaret Oman	Med Care Int'l	Wichita
Minnie Liston	Ks Gov. Consulting	Topeka
Joseph F. Kroll	KDHE	Topeka
Pamela John Betts	KDHE	Topeka
[illegible]	KS SENATE	[illegible]
Michelle Kristinat	Observer	Maple Hill
Tom Bell	KHA	Topeka
Myra Myers	Lobbyist	Denver
Sandra S. Constant	Syntex	Denver
Margaret Lenz	Boehringer Ingelheim	Columbia, MO
Pat Statt	KS Funeral Directors Assn	Topeka
John Ensley	Medco	Topeka
Tom Reese	Bottenberg Assn.	Topeka

STATE OF KANSAS

DICK BOND
SENATOR, EIGHTH DISTRICT
JOHNSON COUNTY
9823 NALL
OVERLAND PARK, KANSAS 66207

TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNMENTS

ASSISTANT MAJORITY LEADER/WHIP
CHAIRMAN: FINANCIAL INSTITUTIONS AND INSURANCE
VICE CHAIRMAN: JUDICIARY
MEMBER: ASSESSMENT AND TAXATION
ELECTIONS, REAPPORTIONMENT & GOVERNMENTAL STANDARDS
JOINT COMMITTEE ON HEALTH CARE DECISIONS FOR THE 90'S
JOINT COMMITTEE ON CHILDREN AND FAMILIES
JOINT COMMITTEE ON PENSIONS, INVESTMENT AND BENEFITS
HEALTH CARE STABILIZATION OVERSIGHT COMMITTEE

March 8, 1993

TESTIMONY OF SENATOR DICK BOND ON SCR 1606 BEFORE THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE

In researching health care issues, one of the major concerns is the critical shortage of primary care physicians in rural and underserved areas. To immediately address that need, the concurrent resolution as offered to approve the expansion of the University of Kansas Medical Loan Program from this year's level of 30 primary care medical students to approximately 50 students. The resolution further directs that money from the Loan Repayment Fund be used to establish two faculty positions--one at the University of Kansas Medical Center in Kansas City and one at the University of Kansas Medical Center in Wichita--to be designated as *locum tenens* physicians. These locum tenens physicians will be available to provide support, relief and respite for primary care physicians who practice in rural and/or underserved areas. Availability of this type of support will reduce the stress and enhance the appeal of such practices, especially in rural Kansas.

Additionally, this resolution directs the funding of the **Medical Resident Bridging Program** through the Loan Repayment Program. The Bridging Program is a contractual agreement between the state, the medical resident and the local community that assists the smaller communities in attracting and retaining University of Kansas medical residents in primary care to underserved and rural communities.

PH&W
3-23-93
attm# 1.

I am deeply concerned that the Student Loan Repayment Program has been annually raided to supplement the State General Fund, which is contrary to the goal of encouraging physicians to serve in areas of need.

P&W
3-23-93
Attm #1.
Pg 2 of 2

In Section 1, first paragraph, fourth sentence, following "by a health maintenance organization..." add the following:

as defined in KSA 40-3202, except when the health maintenance organization owns and operates its own pharmacies and ~~those pharmacies~~ such HMO are in operation at the date of enactment of this bill,

PHeed
3-23-93
Attm #2

Subcommittee Recommendations

Session of 1993

HOUSE BILL No. 2526

By Committee on Appropriations

3-9

AN ACT concerning medical nursing facilities; limitations on new and converted uses.

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

Section 1. As used in this act:

(a) "Medical nursing facility" means a nursing facility except it does not include any nursing facility that is operated as an intermediate care facility for the mentally retarded or a continuing care contract home.

(b) "Bed" means an equipped location at which a patient, client or other individual may receive 24 hour-a-day board and skilled nursing care and treatment.

(c) "Nursing facility" means a nursing facility as defined in subsection (a)(2) of K.S.A. 39-923 and amendments thereto.

(d) "Continuing care contract home" means a home as defined in subsection (c) of K.S.A. 1992 Supp. 40-2231 and amendments thereto where a provider, as defined in subsection (d) of K.S.A. 1992 Supp. 40-2231 and amendments thereto, provides continuing care under a continuing care contract, as defined in subsection (a) of K.S.A. 1992 Supp. 40-2231 and amendments thereto.

(e) "Commenced construction" means all necessary local, state and federal approvals required to begin construction have been obtained, including all zoning approvals and contracts for construction have been signed.

(f) "Permanent financing" means the owner of the project has a commitment letter from a lender indicating an affirmative interest in financing the project subject to reasonable and customary conditions, including a final commitment from the lender's loan committee or other entity responsible for approving loans or the owner demonstrates sufficient assets, income or financial reserves to complete the project with less than 50% in outside financing.

Sec. 2. On and after the effective date of this act, except as otherwise specifically authorized by rules and regulations adopted under section 3 and amendments thereto:

(a) No license as a nursing home under subsection (a)(2) of K.S.A. 39-923 and amendments thereto and no certificate of registration as

except that such term shall

an intermediate personal care home, long-term care beds which are part of a medical care facility, any licensure category of adult care home established subsequent to the effective date of this act

,

facility

PA/rcw 3-23-93 attm #3

[a continuing care provider under K.S.A. 1992 Supp. 40-2235 and amendments thereto] shall be issued for a medical nursing facility which, after the effective date of this act, (1) is constructed, (2) is created by conversion from another licensure category, (3) enlarges the licensed capacity of an existing medical nursing facility, or (4) changes a place which is not a medical nursing facility, including any existing nursing facility that is operated as an intermediate care facility for the mentally retarded, into a medical nursing facility, except nothing in this [subsection (a)] shall apply [to facilities which have commenced construction on the effective date of this act or have permanent financing on a project on the effective date of this act].

[(b) no medical nursing facility beds that are for all individuals shall be converted to medical nursing facility beds exclusively for individuals receiving mental health care and treatment; and

(c) no medical nursing facility beds that are exclusively for individuals receiving mental health care and treatment shall be converted to medical nursing facility beds that are for all individuals.]

Sec. 3. The secretary of health and environment may adopt rules and regulations, with the concurrence of the secretary of social and rehabilitation services and the secretary on aging, which establish procedures and standards under which the secretary of health and environment may grant a waiver of the limitations on the granting of licenses on an individual, regional, or other geographic categorization, or state-wide basis.

Sec. 4. The provisions of this act shall [expire on July 1, 1998].

Sec. 5. This act shall take effect and be in force from and after its publication in the statute book.

by not more than 10% of the licensed capacity or 25 beds, whichever is greater

(1)

, (2) to facilities which

, (3) to the replacement of beds licensed on the effective date of this act or (4) tc facilities which have filed with the secretary of health and environment prior to July 1, 1993, a written notice of intent to construct and operate a nursing facility which includes identification of the owner, specific site location, including legal description, evidence that the owner holds title to or permission to construct on the site specified, a general description of the facility, including number of beds, services provided, market and service area, and a proposed construction schedule

expire on July 1, 1995

PHCW 3-23-93 attm #2 pg 2

PHCW 3-23-93 attm #3 pg 2

a continuing care provider under K.S.A. 1992 Supp. 40-2235 and amendments thereto shall be issued for a medical nursing facility which, after the effective date of this act, (1) is constructed, (2) is created by conversion from another licensure category, (3) enlarges the licensed capacity of an existing medical nursing facility, or (4) changes a place which is not a medical nursing facility, including any existing nursing facility that is operated as an intermediate care facility for the mentally retarded, into a medical nursing facility, except nothing in this subsection (a) shall apply to facilities which have commenced construction on the effective date of this act or have permanent financing on a project on the effective date of this act;

(b) no medical nursing facility beds that are for all individuals shall be converted to medical nursing facility beds exclusively for individuals receiving mental health care and treatment; and

(c) no medical nursing facility beds that are exclusively for individuals receiving mental health care and treatment shall be converted to medical nursing facility beds that are for all individuals.

Sec. 3. The secretary of health and environment may adopt rules and regulations, with the concurrence of the secretary of social and rehabilitation services and the secretary on aging, which establish procedures and standards under which the secretary of health and environment may grant a waiver of the limitations on the granting of licenses on an individual, regional, or other geographic categorization, or state-wide basis.

Sec. 4. The provisions of this act shall expire on July 1, 1998.

Sec. 5. This act shall take effect and be in force from and after its publication in the statute book.

Wells Saldern Home

Proposed Amendment

Delete current item (2) lines 3 and 4

(3)

Hall
3-23-93
Attm # 4

My name is Carolyn Exley and I am from Wichita, Kansas. I am the administrator of Surgicare of Wichita. I would like to thank you for the opportunity to provide comment in support of the currently proposed bill change that would allow ASCS in Kansas to provide care to their patients for up to twenty-four hours.

The regulations governing ASCS were developed in the 1970s when surgical technology was not as complex as it is in the 1990s. The patients in this era of innovative surgical technology aren't sicker and do not need to be in the hospital but do require individualized care with all their needs met regarding pain control, safety, nutrition, convenience and cost considerations.

With the capability of keeping patients overnight the surgeons also would be able to work at the ASC facility with a greater level of comfort knowing they have the capability of caring for their patients for an extended period of time should such a stay be warranted.

I truly hope that much consideration will be given to adopting Senate Bill 402 to allow patients to be kept in the ASC facility for up to 24 hours. This could provide one of the answers to the growing need for high quality, cost effective health care in the state of Kansas.

PH+W
3-23-93
Attm# 5

OVERVIEW OF PROPOSED STATUTORY CHANGE

Significant changes in medical technology and demands for cost effective, high quality alternatives to traditional inpatient services have led to the growth and acceptance of freestanding ambulatory surgical programs. Medical technological capabilities, combined with growing physician and consumer preference have also made outpatient surgical care for up to 24 hours a very attractive clinical and economic option. The factors contributing to the growth of ambulatory surgery are outlined in this document, and very recent data are presented which favorably compare surgical services provided in freestanding ambulatory surgery centers (ASCs) with those that are hospital based.

Surgical procedures once performed exclusively in hospital settings can now be safely and efficiently provided outside of the hospital. In fact, third parties in both public and private sectors often demand that certain surgical procedures be performed in an ambulatory setting. Physician and patient satisfaction with ambulatory surgical settings has been high. Several states have recognized the positive contribution which freestanding ambulatory surgical programs offer to the health care system, and have extended care up to 24 hours. Policy makers in public and private sectors have accepted the viability of freestanding ambulatory surgery programs, and the combination of utilization, cost and outcome data available indicate that these programs are highly desirable. Indeed, they represent a natural evolution in the provision and management of health care services.

As a matter of public policy, it is wise and appropriate to recognize the important contributions which ASCs make to health care quality and costs. As a reasonable part of a state's effort to provide quality, cost effective health care and to develop positive, structural changes in the health care system, expanded ASC services to include recovery for up to 24 hours after surgery should be given serious consideration.

P&W
3-23-93
attm# 5-A

lations for patient to stay ~~overnight~~ *more than 24 hours*.

(g) "Recuperation center" means 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 of every day, to provide treatment for patients who require inpatient care but are not in an acute phase of illness, who currently require primary convalescent or restorative services, and who have a variety of medical conditions.

(h) "Medical care facility" means a hospital, ambulatory surgical center or recuperation center.

(i) "Rural primary care hospital" shall have the meaning ascribed to such term under K.S.A. 65-468 and amendments thereto.

(j) "Hospital" means "general hospital," "rural primary care hospital," or "special hospital."

Sec. 2. K.S.A. 65-425 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the Kansas register.

Session of 1993

SENATE BILL No. 402

By Committee on Ways and Means

3-2

AN ACT concerning medical care facilities; relating to ambulatory surgical centers; amending K.S.A. 65-425 and repealing the existing section.

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

Section 1. K.S.A. 65-425 is hereby amended to read as follows: 65-425. As used in this act: (a) "General hospital" means 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 of every day, to provide diagnosis and treatment for patients who have a variety of medical conditions.

(b) "Special hospital" means 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 of every day, to provide diagnosis and treatment for patients who have specified medical conditions.

(c) "Person" means any individual, firm, partnership, corporation, company, association, or joint stock association, and the legal successor thereof.

(d) "Governmental unit" means the state, or any county, municipality, or other political subdivision thereof; or any department, division, board or other agency of any of the foregoing.

(e) "Licensing agency" means the department of health and environment.

(f) "Ambulatory surgical center" means an establishment with an organized medical staff of physicians; with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; with continuous physician services and *during surgical procedures and until the patient has recovered from the obvious effects of anesthetic and at all other times with physician services available whenever a patient is in the facility; with continuous* registered professional nursing services whenever a patient is in the facility; and which does not provide services or other accom-

24 HOUR CARE

What is 24 hour care?

This is the level of service provided to patients who require continuing medical intervention following a surgical procedure, but who do not warrant acute hospitalization. Many states, such as Alabama, Georgia, North Carolina, Tennessee and Texas, permit a stay of up to 24 hours in the ASCs, allowing the patients to receive care in an appropriate setting to meet their needs following a surgical procedure.

What patient needs are met?

The typical patient being cared for in a 24 hour unit would receive one or more of the following services:

* Management of pain
* Additional monitoring/observation
* Replacement of fluids with infusion therapy
* Administration of intravenous medications

What cost savings could be expected?

As with ASCs, it is anticipated that significant cost savings could be realized. In a recent study done by Lewin/ICF, an independent economics research firm in Washington, D.C., a comparison was done between the total costs of surgery and recovery services for traditional, inpatient care and surgeries performed which utilized overnight or recovery care services. The findings of this study revealed that:

* over 90% of patients were discharged home without complications, with no cases of mortality or emergency hospital readmissions.
* an average savings of between $ 750.00 to $ 1000.00 per patient could be expected by utilizing overnight or recovery care services rather than traditional acute hospitalization.

PNRW
3-23-93
Attm #5-A
pg 3 of 7

EXECUTIVE SUMMARY

* **"Ambulatory Surgery Center (ASC)"**- a health care facility which provides surgery that does not require an inpatient admission to a hospital.

  - **"Freestanding ASC"** is not generally located in a hospital

* **ASCs provide high quality, convenient, cost-effective services**, thereby enhancing patient access to care.

  - Range of procedures performed in ASCs has expanded dramatically. **(Medicare has currently approved 2100 procedures for ASCs).**

  - Greater growth in ASC services is expected in the 1990's as medical technology and anesthetic agents are developed.

* ASCs in Kansas are regulated by the Department of Health and Environment in accordance with KSA 65-425 through 65-441, Kansas Statutes. This licensing agency has been mandated to establish rules, regulations and minimum standards for the operation of ASCs.

  - These rules establish strict standards for ASCs with regards to medical, surgical, nursing, anesthesia, laboratory and radiological services, as well as fire and physical plant safety.

* Kansas ASCs which provide services to Medicare patients are subject to additional federal standards enforced by the U.S. Department of Health and Human Services.

  - In addition, the Joint Commission on the Accreditation of Health Organizations and the Accreditation Association for Ambulatory Health Care establishes even broader standards for ASCs which seek national accreditation.

PH&W
3-23-93
Attm #5-A
pg 477

* Freestanding ASC services have proven to be extremely cost effective.

  - Recent data released by Blue Cross/Blue Shield of North Carolina and Florida show that freestanding ASCs are far less expensive than hospital-based outpatient facilities.

  - North Carolina: charges 44% lower in freestanding ASCs. Florida: charges 25% lower in freestanding ASCs.

  - North Carolina has authorized ASCs to keep patients up to 24 hours if deemed medically necessary.

* Freestanding ASC services have been studied and shown to be cost-effective, offer comparable quality to inpatient surgical services and provide equally safe environments to hospital-based outpatient facilities.

* It is the national public policy to deliver services in the least costly environment.

  - The federal government and private insurers alike recognize the cost effectiveness, quality and convenience of ASCs.

* While freestanding ASCs provide high quality, cost-effective and convenient services, Kansas currently has a costly and inefficient gap in freestanding ASC services relative to hospitals.

  - Hospital-based outpatient units can provide up to 24 hours of post-operative care and/or observation, but freestanding ASCs are restricted by law from providing "services or other accommodations for patients to stay overnight." This effectively prevents freestanding ASCs from providing a number of services which are highly suited to their setting, but which may require post-operative care and/or observation for up to 24 hours.

PH&W
3-23-93
attm #5-A
pg 5 of 7

- In at least 11 other states, freestanding ASCs are permitted to recover their patients for up to 24 hours.

  Alabama
  California
  North Carolina
  Georgia
  Kentucky
  Texas
  Missouri
  Nevada
  Iowa
  Arizona
  Oklahoma
  Colorado

* By defining an "Ambulatory Surgery Center" as proposed in this bill, this costly, inefficient gap in ASC services would be closed, authorizing both hospital-based and freestanding ASCs to admit and discharge patient within 24 hours after surgery.

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FREESTANDING AMBULATORY SURGERY CENTERS
ADDITIONAL DATA

What is a Freestanding Ambulatory Surgery Center (ASC)?

There are approximately 17 ASCs in the state of Kansas, with 10 being multi-specialty facilities (more than 2 operating suites, offering more than one type of surgical service). The average caseload for a multi-specialty ASC is about 3000 patients per year. These facilities are usually participants in both the state Medicaid program and the federal Medicare program, with many also providing services at a substantially reduced cost to other programs for medically indigent persons.

ASCs are fully equipped with instrumentation and equipment required to perform a wide range of surgical procedures. The average four (4) room multi-specialty ASC has about a million dollars invested in equipment and instrumentation and has an annual budget of $150,000 for replacement and/or new items.

These facilities are staffed by professional nurses and other allied health care professionals who assist surgeons in the provision of patient care. Favorable working conditions in ASCs promote staff stability and minimize employee turnover. As a result, surgeons can depend on consistent, quality support from an experienced nursing team.

Surgeons working at the facilities are not employed, but elect to bring patients to the centers because of quality, convenience and cost-effectiveness.

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My name is Margaret Orman. I am a Regional Director for Medical Care International which is the General Partner and Managing Partner at Surgicare of Wichita and Surgicenter of Johnson County. Our company has ninety one surgery centers in twenty five states. Thirty of these facilities currently have the capability of offering their patients post-operative observation for at least twenty four hours. Over 2500 patients were cared for in this manner in 1992 and there were no serious complications.

I would like to ask you to support Senate Bill 402. This bill would allow Ambulatory Surgery Centers in Kansas to keep patients in the center for observation for up to twenty four hours. Currently, we may not keep patients past midnight. By allowing ASCs to keep patients for up to twenty four hours, we would be able to provide better continuity of care for our patients for pain management, additional monitoring or observation, replacement of fluids with infusion therapy, and administration of intravenous medications.

I personally have been involved with ambulatory surgical centers since 1974 when the first ASC in Kansas (in Wichita) was licensed. I have seen that ASCs provide high quality patient care. In the State of Kansas, ASCs must meet strict State regulations as well as Medicare regulations. The Surgicenter of Johnson County is accredited by the Accreditation Association of Ambulatory Health Care (AAA/HC) and Surgicare of Wichita has been accredited with

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commendation by the Joint Commission for Accreditation of Health Care Organizations (JCAHO). Each of these accrediting bodies sets high standards for quality of care and many ASCs voluntarily seek accreditation.

Ambulatory surgical centers are also cost effective. Recent data released by Blue Cross/Blue Shield of North Carolina and Florida show that freestanding ASCs are far less expensive than hospital-based outpatient facilities. In North Carolina charges were 44% lower in freestanding ASCs and in Florida charges were 25% lower in freestanding ASCs.

Ambulatory surgical centers care for Medicare patients and Medicaid patients. We also provide free or very low cost services to unemployed, uninsured or indigent persons.

The original ASC rules were adopted almost twenty years ago. Perhaps at that time a restrictive length of stay might have been appropriate; there was no history - the surgery center in Wichita was not only the first in the state but also among the first ten to open in the United States. We now have a track record of quality and safety. Given the advances in technology and anesthesia care, we feel that it is essential that our patients and the residents of the State of Kansas be afforded the continuity of care that observation in an ASC for up to twenty four hours will provide.

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KANSAS HOUSE; COMMITTEE ON HEALTH AND WELFARE

TESTIMONY RE: S.B. 402

MARCH 23, 1993

MARVIN M. FAIRBANK, TOPEKA

My name is Marvin Fairbank. I am a resident of rural Topeka, Kansas, and the executive director of Topeka Single Day Surgery a licensed ambulatory surgery center in Topeka, Kansas.

My purpose for speaking to you today is to support the passage of S.B.402. The bill, if passed will amend the present language of KSA 65-425, the licensing law covering Ambulatory Surgery Centers (ASC's) to allow patients to be kept up to 24 hours.

While the ASC licensing law has served the public of the State reasonably well over the past twenty years, the delivery of ambulatory surgery has changed radically in that period. Procedures that only a few years ago required hospital stays of up to a week, are now done in freestanding ambulatory surgery centers, where the patients are safely sent home the evening of the procedure. When the law was written no one anticipated the widespread use of televideoscopic surgery that would revolutionize orthopedics, gynecology, and most recently general surgery. Developments in the field of anesthesia have also contributed greatly to the growth of the out patient surgery concept. In today's ASC, complicated procedures like laparoscopic cholecystectomy, endometrial ablation, and anterior cruciate ligament repair are successfully carried out on a regular basis. Though the need for overnight stays after these procedures is fairly rare (less than .5% in 1992 in Topeka ASC), it occasionally happens that patients' conditions require observation overnight. Rather than experience an expensive transfer and overnight admission, patients would be better served if ASC's were allowed to care for them on site.

The State of Kansas and Medicare inspect these facilities annually. The requirements for ASC's are at least as stringent as those for hospital operating services. At present hospitals may monitor outpatients overnight without "admitting" them. There is no reason to believe that ASC's would offer less safety for the patients requiring post operative observation overnight than they receive in hospitals.

I ask you to pass the amending language in S.B. 402.

Thank you

P H&W
3-23-93
Attm # 7

Surgicenter of Kansas City

1800 East Meyer Boulevard
Kansas City, Missouri 64132
816-523-0100

An Affiliate of Medical Care International

March 23, 1993

Room 4235
Committee Hearing on Senate Bill 402

Presented by Robert L. Goolsbee, M.D.
Medical Director of Surgicenter of Kansas City
A unit of Medical Care International , Dallas Texas

Surgicenters were not uncommon in the 1930's, 1940's and 1950's. Health insurance became widespread in the 50's and would only pay for procedures preformed in a hospital so Surgicenters disappeared. The "New" wave of Surgicenters started in Phoenix, AZ in 1970, Wichita, KS 1974 and Kansas City, MO 1978.

We started very conservatively and preformed limited procedures on basically healthypatients only. We have expanded our procedures dramatically and preformed these on sicker and sicker patients with excellent results and high patient satisfaction. Procedures done in Surgicenters today include bilateral hernia repairs, gallbladder removal, hysterectomy, mastoidectomy and knee ligament repair. Probably 60% of all surgies that used to be inpatient are now frequently done outpatient (home the same day).

Factors restricting use of one day surgery include pain not controlled by oral medications, no one at home to stay with a patient the first post-op night, excessive blood loss, severe heart or lung or other diseases requiring speical care.

Today pain can be managed better with use of long lasting local anestheics (not available in the 70's), long lasting medications such as Toradol, and even patient controlled I.V. medications such as demeral and monphine.

Blood loss for many procedures has been minimized by use of the cautery and laser. Blood volume expanders, use of self-donated blood and better understanding of the physiology of blood loss has broadly expanded the procedures that can be performed on an outpatient basis.

The next logical step is to adopt the hospital oriented 23 hour observation mode and further expand the use of the low-cost, high quality, high patient satisfaction outpatient surgicenter.

P&HCW
3-23-93
attm # 8

State of Kansas
Joan Finney, *Governor*

Department of Health and Environment
[redacted]
Robert C. Harder, Secretary
Reply to:

TESTIMONY PRESENTED TO

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

BY

THE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

Senate Bill 402

Introduction

Senate bill 402 would amend the licensing statute for ambulatory surgical centers at KSA 65-425(f). If passed, this bill would make two changes, neither of which would substantially affect current licensure regulations. Those changes would: (1) allow patients to remain in an ambulatory surgical center overnight but not to exceed 24 hours, and (2) allow physicians to leave the surgical center when patients have "recovered from the obvious effects of anesthetic."

Background

In recent years, some owners of ambulatory surgical centers, and physicians staffing those centers, have argued that patients should be allowed to remain in the facility overnight. This would allow centers to schedule surgery later in the day and still assure that patients would not be discharged before they were ready. However, since the original concept of ambulatory surgery was something which could be completed without an overnight stay, surgical centers have been required to dismiss patients before midnight on the day of surgery. This interpretation was based on provisions of the current licensing statute which prohibits facilities from providing "services or accommodations (for the patient) to stay **overnight."**

P. Hall
3-23-93
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The amendment which would authorize physicians to leave the facility after patients had recovered from the obvious effects of anesthesia would still require that physicians be "available" whenever a patient is in the facility. Moreover, the law would continue to provide for registered professional nursing services whenever a patient is in the facility. During testimony before the Senate Public Health and Welfare Committee, the Department pointed out that Medicare regulations, 42 CFR 416.42 (a), require each patient to be evaluated by a physician for proper anesthesia recovery "before discharge." Therefore, KDHE staff assisted with the development of new language found at line 2 through 4 on page 2.

Issues

The desire of center owners and staff physicians to provide surgery later in the day, thus necessitating that facilities remain open during evening and nighttime hours, may change the original concept of "same day" surgery. However, the ability to provide more surgical procedures in an ambulatory setting may reduce health care costs.

Recommendations

The Kansas Department of Health and Environment (KDHE) recognizes that changing technology and expanded hours may provide greater options for patients to obtain surgical services in an ambulatory setting. Earlier concerns related to anesthesia recovery "before discharge" have been addressed in Senate Bill No. 402, as amended and therefore, KDHE supports passage of the bill.

Thank you for the opportunity to present testimony. I would be happy to answer any questions you may have.

Presented by: Greg L. Reser, Medical Facilities
Certification Administrator
Bureau of Adult and Child Care
Kansas Department of Health and Environment
March 23, 1993

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