[LB953 LB999 CONFIRMATION]

The Committee on Health and Human Services met at 1:30 p.m. on Wednesday, February 24, 2010, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB953, LB999, and a gubernatorial appointment. Senators present: Tim Gay, Chairperson; Dave Pankonin, Vice Chairperson; Kathy Campbell; Mike Gloor; Gwen Howard; Arnie Stuthman; and Norman Wallman. Senators absent: None. []

SENATOR GAY: All right, we'll get started. Thank you for joining us today, the Health and Human Services Committee. We've got two bills and one appointment to get through today, and I know it's usually busy days, but even though we have two bills I think, you know, it's still will require some time. We have a light system here; it's a time system. The reason we do that is many days we'll have five and six bills going on or fairly controversial bills, and what that does, it allows the people who are testifying at 1:30 to get the same kind of...you know, we want to get the person here at 4:30 or 5:00 the same interest as we're giving somebody at 1:30. So for the attention of the senators and those participants in the process, we want it to be fair, and the light system does that, we feel. How that works is five minutes--the opener on the bill can get as long as they want, but if you're a testifier proponent, opponent, or neutral you get five minutes. And the green light will be on for four minutes. When the yellow light goes on, you're at four minutes, and when the red light is on, your five minutes has expired, and if you can wrap it up, we try not to cut off anybody right in between. But if that red light is on and you need to be wrapping it up if you can. So that means, don't be repetitive of what somebody right before you may have said. That's helpful testimony as well, so also if you have a cell phone, if you could silence that we'd appreciate it out of the respect for the committee and the process. Other than that, we have testifier sheets on each end of the room, and I don't see any on the desk. But if you're going to come up and testify, please fill that out and then give it to the clerk because...and then when you come up, state your name and spell it out. It's very helpful because these are transcribed several months down the road from now, and a lot of times that keeps her on track to understand where we're at in the process when she's transcribing that in the future. This is being broadcast throughout the Capitol on closed circuit TV and on the Web, so you're on camera here if you're testifying. If a senator has a question for you, though, if you get to testify and there's a question from a senator, that doesn't count against your time at all, so you may receive questions; you may not. We will see how that goes. So with that, we'll introduce ourselves. I'm Senator Tim Gay from Papillion-La Vista. I'll start at my right. []

MICHELLE CHAFFEE: I'm Michelle Chaffee, legal counsel to the committee. []

SENATOR GLOOR: Mike Gloor, District 35, Grand Island. []

SENATOR CAMPBELL: I'm Kathy Campbell, District 25, Lincoln. []

SENATOR PANKONIN: I'm Dave Pankonin, District 2; I live in Louisville. []

SENATOR STUTHMAN: Arnie Stuthman, District 22. I am from Platte Center, the Columbus area. []

SENATOR HOWARD: Senator Gwen Howard, District 9 in Omaha. []

SENATOR WALLMAN: Senator Norm Wallman, District 30. []

ERIN MACK: Erin Mack, committee clerk. []

SENATOR GAY: Thank you. And our pages are here to assist you in any way if you have anything to hand out or any handouts for the committee. Hopefully, you have about ten copies that our clerk and all our committee members can get that. If you want to hand something out, though, they can also make copies. We'd appreciate if you had them made, but they can also help you out and assist you in any way there too. I would say today, by the way, I've been chairman of the committee, but if I do anything wrong I learned it all from Senator Joel Johnson (laughter) who I see is here. He trained me, so if you don't like what you're seeing, you can blame it on Senator Johnson so (laughter). But welcome, Senator Johnson...you're back there. Thanks for coming. All right, with that, we have an appointment, Bernard Kanger is...is he here? [CONFIRMATION]

BERNARD KANGER: Yes...yes, sir. [CONFIRMATION]

SENATOR GAY: Do you want to come on up? And it's for the Board of Emergency Medical Services. Welcome. Do you want to just go ahead and tell us a little bit about yourself and your (inaudible)? [CONFIRMATION]

BERNARD KANGER: My name is Bernie Kanger. I'm a battalion chief with the Omaha Fire Department. I put in a request to be selected for the Nebraska Board of Emergency Medical Services. I have approximately 22 years of public service work, both with the municipal city of Omaha and the military as well. I was an Air Force firefighter for 20 years in addition to my time with the city of Omaha. I'm a state certified emergency medical technician, intermediate, and I've been providing emergency medical services in many different capacities, not only with the private sector. I worked for a couple of years with the private EMS provider. Then I began working with municipal government, and in addition to that, federal government. So I believe that gives me a very...a well-rounded approach to bringing my knowledge and experience to the Board of Emergency Medical Services with the state. [CONFIRMATION]

SENATOR GAY: Very good. Senator Pankonin. [CONFIRMATION]

SENATOR PANKONIN: Thank you, Senator Gay. Mr. Kanger, thanks for coming and thanks for putting your name forward for this, and we appreciate that service because we're obviously looking for people that are interested and have the background which seems obvious that you do. Specifically, did...your knowledge of this organization...this is the first time, correct, that you will be serving? [CONFIRMATION]

BERNARD KANGER: Yes, sir. Yes. [CONFIRMATION]

SENATOR PANKONIN: You said you put your name forward. Specifically, why? [CONFIRMATION]

BERNARD KANGER: I was actually approached by a gentleman in my organization. The position that I'm filling or hoping to fill, if I do get confirmed here, became vacant. So it wasn't a posted position or one that would come up through a normal process. So I was approached by an individual that was aware of this vacancy and asked to educate myself about the process and to see if I would be willing to engage in this type of work. And I was very anxious and excited to take part in it and, hopefully, be able to serve for a number of years. [CONFIRMATION]

SENATOR PANKONIN: Good. Well, we appreciate your past public service in this dimension as well and being willing to serve is obviously a huge part of it, so thank you. [CONFIRMATION]

SENATOR GAY: Senator Gloor. [CONFIRMATION]

SENATOR GLOOR: Thank you, Chairman Gay and, again, I echo what Senator Pankonin has said. Thank you for taking the time and effort to make application. Do you still maintain an active EMT certification? [CONFIRMATION]

BERNARD KANGER: Yes, sir, I do. I'm an EMT intermediate. [CONFIRMATION]

SENATOR GLOOR: Okay. Would it be your plan that at least for the immediate future, and I understand people make career changes, but would it be your plan to maintain that certification as we look to the future? [CONFIRMATION]

BERNARD KANGER: Absolutely, sir. I've held that license since approximately 1994, so going on about 15 years, and it's a condition of employment for the city of Omaha Fire Department to maintain an EMT license. So as long as I'm employed there and probably beyond that point, I will maintain that certification. [CONFIRMATION]

SENATOR GLOOR: Thank you. [CONFIRMATION]

SENATOR GAY: Okay. I've got a question for you here. Omaha Fire, but this deals with statewide...many smaller agencies as well, are you...I mean, is that something you...how do you handle that? Or where are you from originally? [CONFIRMATION]

BERNARD KANGER: I was born and raised in Omaha. I've lived about the last 12, 13 years in Elkhorn, Nebraska, just outside of Omaha. To answer your question, Senator, I began my career working as a volunteer fireman with the Boys Town Fire Department which is a very, very small organization. With my 21 years in the military, I had the opportunity to work in many different states, many different municipalities, different Air Force bases, so the fact that I'm currently employed with Omaha just adds to the experience level that I have. I've worked with very small volunteer departments. I worked with the Millard Fire Department before transitioning to Omaha which was a combination department, and I also worked as a private EMS provider with some private ambulance companies at the very beginning of my career. [CONFIRMATION]

SENATOR GAY: Well, I think that will suit you very well because it's so diverse, as you know, and many of the volunteers make up the majority of what's done in the state. So that's very good that...are there any other questions? Well, thanks for coming...part of the reason we have these where you come down here, and appreciate you coming today is so you get a view of who is on the committee, but feel free to...if you ever need anything or you got some suggestions, don't hesitate to call your senators just...we look forward to hearing from people and appreciate your service. But part of that is so we can...so you have a part of that, so you can contact us too and don't feel that you can't because I think that's important too. If you see something going on and you think someone else should know, feel free to call, so no more questions from us. One thing, just so you know what happens here. We'll take this, and then we'll vote on it here the next couple of days and then forward that to the full Legislature for confirmations. It takes, you know, I shouldn't see any problem, but usually will take a week or two and then they'll notify you so. Well, thanks for coming down today, appreciate it. [CONFIRMATION]

BERNARD KANGER: Thank you very much. Thank you. [CONFIRMATION]

SENATOR GAY: Thanks. This is a public hearing. Is there anyone else who would like to speak on this issue? All right, we'll close the public hearing on the appointment. Senator Coash is here to introduce LB953. Welcome, Senator Coash. [CONFIRMATION]

SENATOR COASH: Thank you, Chairman Gay, members of the HHS Committee. For the record, I'm Colby Coash, C-o-a-s-h, and I represent the 27th district here in Lincoln, and today I'm here to present LB953 for your consideration. This is probably the perfect committee to introduce this particular piece of legislation and besides your unparalleled wisdom in the body, we have three county board...previous county board members and

a hospital administrator who will understand this issue very well. LB953...just to give you an idea where this came from. Last year I started to talk with some local county officials here in Lancaster County. I began to ask a question, what can the state do or how can the state participate in lowering local property taxes? And their answer was, help us as counties reduce our expenses, and then that led into, what kind of expenses can we assist you with? And the answer came, our payments for medical services for inmates and people who were in emergency protective custody. It is not lost on me that while we may reduce expenses, somebody still has to pay that, and I'll speak to that in a moment. Under current Nebraska law, counties are obligated to pay the unreimbursed medical expenses of county inmates. Similarly, counties are responsible for the provision of medical care for individuals in emergency protective custody or EPC patients. These medical expenses are unpredictable and can be fiscally devastating to counties who must utilize their general funds that are made up of property taxes to pay these expenses. In an era of increasing fiscal constraints, I believe it's important for all of us including state and political subdivisions to find a way to be careful custodians of the public's dollars. When I examined this issue after the concept was brought to me by Lancaster County Board of Commissioners, I thought it was important enough to bring this legislation because of its implication not just in my county, but because of its applicability statewide. I'm of the opinion that the Legislature should have a discussion on the establishment of a statewide policy on these costs. As I weighed this issue, I've discovered that there are many subparts to the question of how much a county should pay to a hospital for providing services to an inmate or a person in emergency protective custody. One of those subparts is to...not only how much should be paid, but also who should pay. And the day before we convened this January, I hosted a meeting of interested parties, and one of those concerns, as you previous county board members are aware of these issues, is the question of which county is responsible for payment of services? In some cases, the arguments over which county is responsible for payments go way back to where the individual resides or plans to reside, so you can see, this issue gets very complex. So it's my hope that this committee could favorably consider LB953 and because I believe it has warrant in a discussion. If the advancement is not possible, I hope that today starts a discussion and a discussion that will involve political subdivisions at all levels, healthcare providers, and other interested parties so that we can find a way to provide stability to the cost of care in these circumstances all across our state. In doing this, if we can find clear answers to the question of which counties are responsible for payment as well, that would be a great achievement. I understand the concern of hospitals across the state that provide an invaluable service to our counties. They're great members to our local communities, and I know that LB953 can pose a burden to them. My intent is to come up with a plan that will provide maximum predictability of both hospitals and counties. I think predictability is a word I think everybody can agree on. In the unpredictable nature of medical billings to counties across the state and therefore to the property taxpayers throughout Nebraska, that has me most interested in doing something about these costs. So with that, Mr. Chairman and members of the committee, I'll end my opening remarks and following me

will be Larry Dix from NACO who's going to...who's familiar with these kinds of billings, and he may be able to answer some questions about how counties deal with this particular issue. [LB953]

SENATOR GAY: Thank you, Senator Coash. Is there any questions for Senator Coash? I don't see any. Thank you. How many speakers will there be? How many proponents in this bill? Two. How many opponents? All right. [LB953]

LARRY DIX: (Exhibit 1) Good afternoon, Senator Gay and members of the Health and Human Services Committee. My name is Larry Dix spelled L-a-r-r-y, last name Dix spelled D-i-x. I am here today in support of LB953. I have with me two letters that I would ask the pages to hand out. Those are letters of support from the Richardson County Board and from the Nebraska Sheriffs' Association. Let me start out--certainly when we have...when NACO takes a look at a bill, examines a bill, we certainly represent all 93 counties across the state, and this is an issue that we have had numerous discussions on over the years. This year we certainly want to thank Senator Coash for bringing this forward, but I've got to tell you this isn't just the first time we've ever had these types of discussions. Back in 2003, there was LB377; in 2005, I think Senator Thompson may have introduced a bill--back then it was LB204. And so, certainly, we understand there are two sides to this story. There's no question about that. We've understood that for years. We've looked at it. We felt it is of vital importance to our counties just in the last couple of months at the county board workshop in which all 93 counties had representatives there. We had some folks from the state of Kansas come up and talk to us about what was going on in their state and some legislation that they recently had passed in that state. I know from sitting in the chair I sit in and seeing not only our neighboring states of Kansas, I've had conversations with other executive directors from other states around the United States that have looked at similar legislation and have come to some agreements on legislation like that. Now, I'm sure that there will be opposition that will say, you know, will this model work? So this model doesn't work, and we understand that, and I would be the first to tell you from NACO's point of view, we understand that. We understand that there has to be a partnership, and I've got to tell you, over the years the partnership that the counties have had with numerous hospitals around the state of Nebraska has been very, very good. I want to make sure that continues. I don't want anybody to walk away thinking, you know, we just have to forge down this path. We know it has to be a partnership, and at the end of the day, that's the direction we want to go. I would tell you that inmate medical care makes up a tremendous share of the costs in county facilities. When we have the inmates in there, we know that the medical costs continue to rise. We all see that every day in our own health insurance. We understand that, but from the county's point of view, we house a pretty significant number of prisoners across the state of Nebraska. And when that happens, it's very, very interesting. A number of those folks will come into our facilities, and it's amazing how quickly a number of the folks are asking for medical care. They're wanting to have something taken care of. A lot of times dental is

just one that right off the top, all of a sudden, we've got a toothache. I've got to get to a dentist. I've got to get to a dentist. And people work the system, let's face it. We understand that. They do. A little bit of...Senator Coash was talking about who pays? And let me give you just a couple of examples of, you know, where this breaks down. If I happen to be...if I have someone who's driving through a county and there's a warrant...and we'll use myself. Say, I'm from Buffalo County. There's a warrant out for my arrest in Buffalo County, and I happen to be driving through Hall County. I get arrested in Hall County, picked up, go to the Hall County facility, lodged in jail. At that point in time, if I have medical requests, Hall County pays. That's sort of the rule of thumb. Nothing hard, written, anything like that. But I may have a contract. I may have another county that contracts. Howard County may contract with Hall County to house their prisoners. Then, if while I'm in Hall County's care, I require medical care then Howard County pays, and so it goes back to the billing. And we can get into that more with the questions given the time. There are all kinds of examples of what happens. Folks get into jail. They do have strokes; they have heart attacks; they have some major medical conditions that we have to address. Certainly, at the end of the day, wherever this bill goes, and we all know we're at the end of the session. We know the bill isn't prioritized. I would certainly hope at the end of the day that over the summer, we can look at an interim session. We can look at sitting down together with hospital administrators, with their association, so that both sides really, really do understand both sides of the story. I don't know that we've ever really sat down at a table like that. I think we've always brought it forth in the form of a bill. We've had the supporters; we've had the opponents. We go home; we come back in a couple of years later. But this has addressed an issue for the best of the taxpayers in the state of Nebraska that does need to be addressed. I'd be happy to answer any questions anybody would have. [LB953]

SENATOR GAY: Thanks, Larry. Any questions? Senator Gloor. [LB953]

SENATOR GLOOR: Thank you, Chairman Gay. And Mr. Dix, if you were to be incarcerated in Hall County, it's a brand new facility; you'd get the best of care I'm sure during that brief stay (laughter), but we hope it doesn't ever come to that. [LB953]

LARRY DIX: Well, and Senator Gloor, I've toured the facility and, as you know, in my examples, I came from Buffalo County. They just opened a new facility, and they would tell you, they have the finest accommodations for me also (laughter). [LB953]

SENATOR GLOOR: I don't think there's a race on, but let me ask you this. One of the challenges, obviously, when we make laws that we know we also set precedent. And so, we're talking about requiring an acute care facility to take the lowest charge, lowest reimbursement when it comes to providing the service. Not a big jump for me to say that what's to stop someone from coming back next year with a bill that says, and that lowest reimbursement ought to be for food service or for the cost of natural gas to heat and

cool those facilities? I understand the dollars involved in healthcare, obviously, but I also think why not lowest cost for anything and everything that's provided to...why hospitals? And why would we not be talking about this as a jumping off point for a pretty expanded look at this issue? [LB953]

LARRY DIX: Well, one of the things I think that...I wouldn't say it is just hospitals. I...you know, have bounced around county government enough to know that a lot of organizations offer government rates, and so I don't think it is only just a hospital that would offer a government rate. I think phone companies offer government rates. I think...I know when I have county officials sometimes have lodging at different facilities and motels and things like that, they offer government rates. So I don't want anybody to get the point that we're picking on hospitals, and that just simply is not the case. But I think there is precedent already that there are governmental rates--discounts, if you will, that are offered on certain services for governmental entities simply because there is a good partnership within communities that offer those different rates. [LB953]

SENATOR GLOOR: Thank you. [LB953]

LARRY DIX: Um-hum. [LB953]

SENATOR GAY: Senator Stuthman. [LB953]

SENATOR STUTHMAN: Thank you, Senator Gay. Mr. Dix, I want to give you a scenario of if an individual is a resident of one county, and he is in another county, and he's EPC'd in that other county, who is responsible for his medical care? [LB953]

LARRY DIX: I think that goes back to the county who actually houses...if they house that person in which they are arrested in or picked up in...not arrested in this situation but picked up in. And that's something that it isn't really, really clear because you'll have counties that will start down this path, and then we have counties and counties arguing. And one county says, well, I had to pay the bill, and they will bill the other county. And the other county will say, no, no, no, I'm not going to pay that bill because it didn't happen in my...didn't happen in my county even though it was one of my county's residents. It almost goes back to indigent care, and then we get into that debate, and we've had bills before in here about indigent care when we have an indigent person that it's hard to determine what the residency of a person is in this very mobile society. So it isn't clear cut. It just isn't, and I think that's something that, you know, I don't know that the hospitals necessarily might care about, you know,...they certainly care about who pays. They want somebody to pay. But I don't know if they want to get involved in the argument between the counties, and that's something that probably should be looked at and try to define also. [LB953]

SENATOR STUTHMAN: Yes, I will also agree with you. I think there needs to be a

definition on that as far as residents and who picks them up and where the billing should go to, so...but thank you, Larry Dix. [LB953]

LARRY DIX: Yeah. Sure. [LB953]

SENATOR GAY: Senator Wallman. [LB953]

SENATOR WALLMAN: Thank you, Chairman Gay. Yeah, thanks for being here. As you probably read awhile back, we had a person trying to break in our jail (laughter). [LB953]

SENATOR HOWARD: Hard times, huh? [LB953]

SENATOR WALLMAN: Yeah (laughter). And...and, you know, like if our county contracts with say Saline County, does Saline County take care of everything then, medical costs and everything, or does that drop back to my county? [LB953]

LARRY DIX: It...a lot of it, counties will sign their local agreements and sometimes it's spelled out in the interlocal agreements. A lot of times I have heard from counties that will say, and we'll use this scenario here of Gage County and Saline County. If the person is housed in Saline County, and it's a Gage County resident that they've contracted to house in Saline County, internal medication--aspirins, ibuprofen, those types of things, most of the times the county that's housing the prisoner, in this instance Saline County, just sort of picks up that cost as a matter of process. But in the event that that person is in Saline County and is out on the exercise and breaks a leg, and has to be taken to a hospital, then I believe that that bill then would go back to Gage County. I think that's the way most of these agreements are written. [LB953]

SENATOR WALLMAN: Thank you. [LB953]

SENATOR GAY: Any other questions? I've got a question for you, Larry. Has NACO done any studies recently on this issue, though, because it's been a perennial issue? But what's the latest study you've done or? [LB953]

LARRY DIX: It's...you know, it's hard to study because there are some...we go across the state, and we have some counties where it is a county hospital, so then you have a county board sort of in overseeing some of the aspects of the hospital. I think the study probably more so the National Association of Counties typically will look at this from a national point of view. I don't know the last time that they have enacted a study to determine how this is being done all across the United States. But right now, in Nebraska, I think most of the counties are talking to the hospitals and trying to negotiate with individual hospitals or in their region at least. [LB953]

SENATOR GAY: Well, I guess if we're trying to steer this towards an interim study, you would obviously be invited to help with that. What I'd say in the interest of time and to make sure we get that done is kind of look into it, give us a recommendation possibly of what...well, of course, Senator Coash's input of who maybe should be invited to this because this is an issue that many of us have heard many times. But if we're going to do that, let's at least sit down and do some groundwork before we come in and get some members of NACO, and maybe we'll look at some hospitals and things like that. But I'd rather have that proposal brought to us than us just dreaming this up and going from there. But I think...I think it's something to look at, and you're right--this late in the game, we'll see what happens but. [LB953]

LARRY DIX: And Senator Gay, I couldn't agree more. Many of you have known me for years and know how we operate. I know since I have been here in 2002, I know I have never been able to sit down at a table with the hospital association and have this discussion. And I think, you know, it's crazy that we bring this back year after year, and there are two sides to the story. We need to sit down and have that conversation, and I would think an interim study would be great. I would think...I would want the hospital association and their lobbyists to say, here's who we think should be at the table. I think it's an excellent idea. [LB953]

SENATOR GAY: Yeah, because if we don't get it done that way then probably it's just our point of view again and... [LB953]

LARRY DIX: Absolutely. [LB953]

SENATOR GAY: And you know, we'll go from there so. Any other questions? I don't see any. Thank you. [LB953]

LARRY DIX: Thank you. [LB953]

SENATOR GAY: Other proponents? [LB953]

MARSHALL LUX: Good afternoon, Senators. My name is Marshall Lux, L-u-x. I am the ombudsman for the state of Nebraska, and I'm here this afternoon to testify in support of LB953. The ombudsman's office has been around now for about 40 years, but it's only been within the last year and a half or so that our office has had jurisdiction over complaints that come from local jail facilities. So this is something that we've just started working on in the last...roughly the last year and a half. In working in that area, our office and our staff has a lot to learn, but one of the first things we learned was how important this issue is to the local jail facilities, to the counties, and to the jail administrators. This is a critical issue, and I wanted to come here today and stress that and express my support for this idea. Over the years, there have been expressions of criticism of the quality of medical care that's been provided in some of our jails. In 2005, for example,

the Nebraska Civil Liberties Union issued a report that was critical of medical care being provided to inmates in some facilities. We worked on a number of cases, and the complaints that we've handled over the last year and a half that have dealt with medical care issues and complaints from inmates dealing with the medical care that they were receiving. And my general observation from looking at those cases is that the problem if there is one, is not a matter of deliberate indifference by the administrators. I think they're good people; they're good managers, and they want to do a good job. The problem is this problem--the budget problem. And so I wanted to make it clear to you today that while this is coming at you from a direction of budget and dollars and cents, there's also a quality of care issue that's at stake here because I think that a measure like this is very much needed in order to remove a disincentive that jail administrators might have for providing the best possible care to inmates. And it's not just inmates. It's inmates and their loved ones, their families. They can't be here to speak, but I think if they were here and had a collective voice, they would encourage the committee to look favorably on this bill and would stress as I'm trying to do today that this is a very important issue, not just from a budgetary standpoint but from a quality of care standpoint in the jails. [LB953]

SENATOR GAY: Thank you. Any questions? I don't see any. Thank you. [LB953]

MARSHALL LUX: Thank you. [LB953]

SENATOR GAY: Any other proponents? Can we hear from opponents? [LB953]

ED HOFFMAN: Mr. Chairman, my name is Ed Hoffman. I'm an attorney with the law firm of Cada, Froscheiser, Cada, and Hoffman here in Lincoln. I am appearing on behalf of Bryan LGH Health System in opposition to LB953, and I understand I have a limited amount of time, but I wanted to just go over the two pieces of legislation that LB953 would amend. The first is 47-701 which is the Medical Services Act, and the second is 71-901 which is the Mental Health Commitment Act. Under the Medical Services Act, which really codifies Nebraska case law, facilities such as jails and police officers or police forces are required to pay for medical services provided to individuals, but the medical providers are first required to see if the inmate or patient has the ability through private health insurance or other coverage to pay. If that's unavailable, then those governmental entities are required to pay for those services. Under the Mental Health Commitment Act, the Legislature required that each judicial district create a mental health board. The mental health board typically meets once a week, and it also provided, though, that if individuals are deemed to be a danger to themselves or others, that they could be placed in what we call emergency protective custody until the mental health board can convene. So if an individual is deemed to be EPC or need to be in emergency protective custody on a Monday, they can be held until the hearing by the board on a Friday. That individual will have to be placed, though, in a medical facility. The statute provides that they cannot be placed in a jail. They have to be placed in a

medical facility. And so what we have is that under that act, there was a question with regard to who is required to pay. Under the Mental Health Commitment Act, the county of residence is required to pay for the services that are being rendered. If there is a debate between a couple of counties, say if there's an interlocal agreement, the counties are the entities to make a determination. But the statute provides that the county of residence is to pay for those services. In reviewing LB953, initially my first opinion in talking to other attorneys with regard to this issue is I believe that it is likely constitutionally suspect both under the due process clause and under the equal protection clause. And let me just elaborate a little bit on that. In the eighties, there were two cases out of Omaha that the city of Omaha was sued by Lutheran Medical, and the Nebraska Supreme Court held that under due process clause, the city of Omaha was required to pay for those medical services and under common law, they were required to treat and under the common law they were required to pay for those services. And so, as I say, there's merely codification. Under federal law, under EMTALA, the Emergency Medical Treatment and Labor Act, hospitals are required to provide care to individuals without issue as to their ability to pay for those services. And so what we have is, we have state law requiring that governmental entities provide medical care to EPC individuals, and that they provide medical care to people that are incarcerated. And we have federal law that's requiring hospitals to provide that care. Under the due process clause, what we have would be similar if a county had an agreement with a company such as maybe any of yours. Let's say your company provided road salt or grading services or equipment. And if I took from the county and I represent the county, and I took ten trucks and had the road salt company fill those trucks with salt and then took the trucks back, and the bill was sent by your company to the county, and the county six months later sent back a payment for half of that bill. Under this legislative bill, the requirement is under federal law, the hospital is required to treat or the medical provider is required to treat. Under the statute, they're required to take a rate of pay that is limited by state law, so we're required to treat, but at the same time we're required to take it...there's no difference between that and the question I believe was asked for any other types of services. This is...would be similar as another entity trying to get that sort of service. The other issue under the Equal Protection Clause would be the hospital is a critical access under the critical access rule, county hospitals receive a different rate of pay than city hospitals. And so the question is, the majority of these individuals that are brought to the hospital are not qualified to receive Medicaid. It's very difficult for a male to receive Medicaid or to be eligible to receive Medicaid that's under a certain age. But what we're saying is, the hospital is required to accept Medicaid payment, but that same individual does not qualify under state standards to be eligible for that Medicaid. And so I feel that there's an issue with regard to Equal Protection Clause as well. I see that my time is up. There were a couple of other issues, but at this point, if there are any questions, I'd be happy to... [LB953]

SENATOR GAY: Are there any questions? Senator Gloor. [LB953]

SENATOR GLOOR: Thank you, Chairman Gay. To use your metaphor, all EMTALA requires is a degree of stabilization. It doesn't require all of the salt for all of the trucks to be spread on the road. At some point in time, you can stop spreading salt if I still remember EMTALA correctly. Isn't that correct? [LB953]

ED HOFFMAN: I think that's right, but I also think that once an individual is brought to a facility, they do have to stabilize before they can forward for treatment, and if there are no other facilities that are available to receive the individual, they then have to continue to provide treatment. [LB953]

SENATOR GLOOR: I think the challenge has always been define stabilize and I think, from the standpoint of malpractice most... [LB953]

ED HOFFMAN: Right. [LB953]

SENATOR GLOOR: ...most healthcare providers err on the side of being very conservative. But interesting argument, when you talk about Medicaid payment versus not being eligible for Medicaid, but my assumption through all this is the only reason Medicaid was picked is because it's clearly the lowest payer. [LB953]

ED HOFFMAN: I think that's right. [LB953]

SENATOR GLOOR: I mean, I'd like...no one has talked about it, but to me if Blue Cross were the lowest payer, not likely, but if Blue Cross were the lowest payer, we'd be talking about Blue Cross, not Medicaid. [LB953]

ED HOFFMAN: And the fact of the matter is, is that for predictability, the hospital is already contracting with Lancaster County. In fact, I was involved, and it's been working for a number of years. If the counties want to have predictability with regard to the rates. It would be with contracting with those facilities like any other business, but right now Medicaid rates do not meet the costs of a hospital with regard to emergency treatment and with regard to mental health treatment. They do not meet the costs, and so this law mandates, under federal law we're required to treat. This law mandates that we take a certain rate that is below costs. If predictability is the goal, I would suggest that contracting with providers as any other business would have to do is the appropriate means of effectuating that. [LB953]

SENATOR GAY: Senator Wallman. [LB953]

SENATOR WALLMAN: Thank you, Chairman. Yeah, thanks for being here. As a hospital rate, as you get a client in, say with grade...step five cancer, are you required under Medicaid to treat that person for cancer in your hospital if he's a prisoner? [LB953]

ED HOFFMAN: It's not under...it would be under Medicare under federal law and actually it's under EMTALA. But what would happen is we would be required to stabilize and treat the individual, and it gets complicated because you have facilities that have a limited number of beds. Some of the information that I brought, for example, we have seen between...in 2006, we saw that the rate of ERs being utilized climbed by 25 percent over the previous ten-year period, but the number of emergency rooms had declined by 10 percent between...and that's under the Institute of Medicine. The American Hospital Association published between...in '88 and '98 a thousand emergency rooms had closed throughout the United States. It's very clear that emergency room treatment and mental health treatment which are rated under Medicaid rates under the DRGs and bundle rate charges are below cost for these types of facilities. I understand it's a tempting issue with regard to controlling budget, but why...you know, again, you could make that with regard to any issue. The way that we traditionally have done that with any other provider that we work with or any other client that we work with is through contracting. And that has worked very well, by the way, with Lancaster County. [LB953]

SENATOR GAY: Well, I think counties, though, when they're dealing with these things it's not always budgets. They got liability issues as well, so they want to make sure the patient is well taken care of. So it's...I mean, I know that's been mentioned several times, but, of course, it's important, but it's not the sole decision when they're making these decisions. [LB953]

ED HOFFMAN: And it's tough. What we have is, for example, in Lancaster County we have a tier of providers with regard to EPC. Some providers...when a provider has a certain level of facility and machinery and equipment, they are required to provide that level of care to all patients that are brought into their facility. That's part of the problem with the Medicaid rate that we're talking about. To me, a significant issue, again, a male under a certain age in the state of Nebraska...it's very difficult for them to qualify for Medicaid. Why would we want to enact a law...again, I think it's suspect constitutionally...that would require facilities to treat them as if they were qualified, but the state itself is not. [LB953]

SENATOR GAY: All right. Any other questions? Well, you had heard earlier, you know, this is probably a good example of an interim study that, I assume, after testimony you'd be interested in that. But this is exactly why it's been going on for so long. It's a complex issue. There's still a certain point, though, to get to it. Maybe we could find some ways that it could work better, so I don't know if it's always a legislative solution here, but I think that's one of the benefits probably of going that route is discussions will be had and maybe best practices could be because it's been an ongoing concern. So thanks for coming and sharing that with us. We appreciate it. If you have a...if you want to submit anything else, though, on something you didn't cover, feel free to just send it to us, and

we'll get that. [LB953]

ED HOFFMAN: Thanks so much. Thank you for your time. [LB953]

SENATOR GAY: Thank you. Yeah. Any other opponents? Anyone neutral? [LB953]

BRUCE RIEKER: (Exhibit 2) Chairman Gay, members of the committee, my name is Bruce Rieker. It's R-i-e-k-e-r, Vice President of Advocacy for the Nebraska Hospital Association, appearing on behalf of our 85-member hospitals in a neutral capacity on LB953. We appreciate the fact that it was brought forward. This is a very critical issue to behavioral health, mental health psychiatric services in the state. We are probably more focused on the EPC side of the bill, but nonetheless, each one deserves merit and our attention. We recommend that this would be an interim study. I appreciate what the other testifiers have said about the need for an interim study. When I joined the Hospital Association a little over three years ago, during the first year that I was here, Department of Health and Human Services had a summit on the complexity of these EPC issues trying to sort through things. It was held out in Aurora. It was sponsored by, like I said, the Division of Behavioral Health as well as it was assisted by the federal Health Resources Service Administration. They issued a report on January 7, 2008. I had the report on my desk this morning as I was preparing my testimony. I can provide that report to all of you, but in a nutshell, I mean, it was definitely longer than this. But it said that the system...or the state needs to create an efficient system that is responsive to all parties--consumers, counties, taxpayers, providers. We need to develop a statewide plan that eliminates regional disparities. We need uniform roles and responsibilities, and I think a lot of that goes into these intercounty agreements. It's almost impossible. I totally appreciate the perspective of where the counties and law enforcement are coming from because when we start crossing borders--county borders, state borders, it get so complex that it's hard for them to determine who actually has the legal responsibility to pay. Where was the warrant issued? Where was the person arrested? Where were they incarcerated? Where were they delivered to a hospital for EPC treatment? And in some cases, you know, another issue that we want to bring forward as a hospital association is the fact that sometimes these patients, they're not taken into legal custody. They are taken into physical custody, brought to our emergency room, and then we must provide care subject to EMTALA. No one has taken legal responsibility for them. I have heard county officials say, well, we didn't cause their healthcare problems. True...neither did our hospital. However, federal government says that since you have this emergency room, you will provide the necessary medical screening as well as whatever treatment it takes to stabilize them and, in addition, specifically, with psychiatric patients we cannot discharge them until we have a place for them to go, a suitable place. So we can't...we as hospitals can also not dump them. We can't just stabilize them and then just put them back out on the street, so we have commitments that are long and drawn out in providing that care, sometimes waiting a long time, if ever, to be compensated for providing that care. So we are definitely

supportive of an interim study. I think that the study that was done three years ago can be dusted off and that we could take it from there. As far as I know, the division never did anything with that once the study was done. We think that there's some merit in several portions of it, working with the regions, Department of Health and Human Services, and other stakeholders, I think we could help you. [LB953]

SENATOR GAY: Thank you. Bruce, I'm just going to ask you a question. Was there a solution in there? (Laughter) Oh, but you'll get us down the road then. [LB953]

BRUCE RIEKER: No (laughter). The solution...I enjoyed the solution...the solution said that the plan has to be more than visionary and just looking out into the future, that we need to, you know, really work on what the roles and responsibilities are for the behavioral health regions, counties, hospitals, everyone that's involved in it. [LB953]

SENATOR GAY: All right. So I guess we'd be interested in seeing that, and I'm sure Senator Coash would as well, so if you can get that to us, we'd appreciate it. Any questions for Mr. Rieker? I don't see any. Thank you. [LB953]

BRUCE RIEKER: Um-hum. [LB953]

SENATOR GAY: Anyone else neutral? Senator Coash, do you want to close on this? [LB953]

SENATOR COASH: Briefly close here. Thank you again to the committee, and I want to thank everybody who came to testify. I think they've helped us...helped me and, hopefully, helped the committee understand this issue a little bit better. As Larry Dix pointed out in his testimony, that there are models out there, and I'm committed to finding a model that works. He also mentioned a partnership, and I couldn't agree more, and I want to thank the Hospital Association for coming and saying that we want to be part of this, and I've already engaged them and been great to work with. Key words here, I think, that I will continue to keep in front of me as we look at this issue is predictability and clarity, and that applies to all parties who...what can we predict and how clear is it? I'm not sure if we have either one of those yet, but that's what I'll be working towards because without some predictability and clarity, I think the end loser here is the taxpayer who...somebody has to pick up the bill, and I'm an optimist, and I believe that there is a win-win situation and a solution out there. And I just would ask in closing for the committee's help and thank you for assisting me and getting this discussion started, and I pledge not to let this one go; we'll keep at it. [LB953]

SENATOR GAY: Any questions for Senator Coash? I don't see any. [LB953]

SENATOR COASH: Thank you. [LB953]

SENATOR GAY: Thank you for coming, appreciate it. All right. We'll move on to Senator Campbell, going to introduce LB999. This provides for a two-year moratorium on new hospital licenses. Senator Campbell, while you're getting ready to testify, I was going to state...I know there's a lot of people that want to talk on this, and I described our time limit situation, but the bill is a fairly simple bill. It's a two year--it's a moratorium. I'd like to kind of...we're going to discuss, obviously, other things. But I think in the interest, I'm going to ask testifiers if we could narrow it to what the specifics of the bill are. I know there are different...it's a very emotional issue for the community and those involved in the room. But...and I...you got time to say whatever you want, but the specific bill says a moratorium, so I'm going to kind of steer people towards that, but give them some flexibility, both sides. And I'm sure it will be very civil, so we'll...but if that's okay with you, Senator Campbell, we'll kind of try to limit that, so go ahead and introduce. [LB953]

SENATOR CAMPBELL: Thank you, Chairman Gay and colleagues. I do agree with Senator Gay's parameters, but I do think you are going to hear some issues that relate to far-reaching implications for the entire state. And I became aware of looking at this issue, and that's when I served on the Medicaid Reform Council prior to coming to the Legislature. But then watching the television news story on Kearney all of those ideas that we had talked about at the Medicaid Reform Council, it piques my interest in terms of where are we, and underscored far-reaching implications for public policy for the state of Nebraska. One only needs to look at the headlines regarding national healthcare reform or for all of you that may have read your copy of Governing magazine, which we should all be receiving, the lead article this month is on healthcare burden. States disagree on whether the impact of reform will spark a boom or bust, and much of it has to do with how we will deal with Medicaid. We should be reminded that the Medicaid cost in the state of Nebraska, and if you couple what the state puts in and what the federal government (inaudible), our Medicaid expenses combined in the state of Nebraska were one billion five for the last year or 21 percent of the state's spending. That's a huge issue for us and has implications to come in the future. From 1979 to 1997, Nebraska had a certificate of need process, and Senator Howard and I talked a little bit about this, this morning. To oversee hospital construction, expansion, and significant equipment purchases, its intent was to control the growth of healthcare costs by preventing unnecessary duplication of healthcare services and to conserve limited healthcare resources. In 1997, Senators Crosby, Witek, and McKenzie worked to repeal this process which many had come to believe was costly and frustrating. I want to underline, it is not my intent to return to a CON process, but to my knowledge no study or review has taken place since 1997. Over those years, we've seen changes to community hospitals as well as the entrance of limited service providers such as specialty hospitals, ambulatory surgi-centers, diagnostic imaging centers, and so forth. Perhaps it is time to look at what question should be considered for the future of hospital care in our state. Questions come to mind. Patient access to emergency and trauma care, efficiency of full-service hospitals in relation to their population base, effect on utilization and costs, quality of care, revision of care to low income, and certainly the

implications to Medicaid just to suggest a few. A preliminary review of national data that I started looking at shows that a number of states have enacted regulations or licensure requirements in the following categories: moratorium on new facilities, disclosure of physician ownership, special fees and taxes, charity care minimum, whether to ban or limit physician self-referral, set quality of other standards, or require Medicaid participation. What was interesting to me as I surveyed this, looking at these categories...in each of those categories, Nebraska is silent. It has no regulation nor relation in the licensure area. It is obviously that this is a policy discussion for the entire state. I want to thank the people in Kearney who took time to visit with me regarding their perspective on both sides of the issue as well as other Nebraskans who have provided a broader picture of the issues for our future. In my closing, I will provide additional thoughts and a course to pursue and answer questions, but for now, we have so many people that want to testify, I just prefer to go to the testifiers. [LB999]

SENATOR GAY: No problem. Thank you, Senator Campbell. So you will just hold questions till the end? Sounds good. [LB999]

SENATOR CAMPBELL: Is that okay? [LB999]

SENATOR GAY: Yep, that's great. Thank you. Let's see a show of hands, how many proponents are going to be speaking? About five or six it looks like. And then how many opponents are going to be speaking? Ten. All right. Well, so quite a few on each side, but. Is there anyone going to be neutral on this? Oh, all right, we've got a couple. All right, we'll start out with proponents and go from there. And again, I'd remind testifiers, if you can state your name and spell it out, that's helpful. [LB999]

CINDY MORRISON: Cindy Morrison, C-i-n-d-y M-o-r-r-i-s-o-n. Good afternoon, Senators, and thank you for the opportunity to speak before you today. My name is Cindy Morrison. I'm vice president of health policy for Sanford Health in Sioux Falls, South Dakota. Our health system has facilities in South Dakota, North Dakota, Nebraska, Iowa, Oklahoma, and Minnesota. As you know, South Dakota is a small state by population similar to Nebraska, but we are home to seven physician-owned hospitals, some of which have been in operation for more than a decade. I'm here today as leader of a 17-state strong coalition that was formed in 2003 to illuminate the issue of physician-owned hospitals and their impact on patients, physicians, community hospitals, and on our health system as a whole. As a result of my ten years of experience in South Dakota and 17 similarly affected states, I've been asked to testify in front of the United States Senate Finance Committee and in multiple states on this issue of physician-owned hospitals and their attendant physician self-referral practices. My testimony today will focus on four important points. The first is physician self-referral. There is no greater market force in healthcare than the sole ability of doctors to admit patients to hospitals. Community hospitals cannot compete with this market force which can eliminate a patient's free market choice when physician-owners direct their patients

to hospitals they own. Second, patients, communities, and community hospitals have been negatively impacted by the entrance of physician-owned hospitals in several ways such as weakened financial condition, emergency room crises, access issues, and recruitment challenges. Third, congressional intent and current self-referral laws restrict physicians from owning a number of designated health services such as labs and pharmacies. The underlying assumption was that financial incentives may skew a physician's judgment, increase utilization, and compromise the quality of care the patient receives. A simple example illustrates this congressional concern. If a physician was permitted to own a pharmacy and profited every time he wrote a prescription, common sense tells us that the number of prescriptions would skyrocket, and it would result in overutilization, harm to patients, anticompetitive behavior because doctors are the only ones who can write prescriptions just as they're the only ones who can admit patients to hospitals and increase costs to the health system as a whole. Doctors owning hospitals is not any different than the rules governing doctors owning pharmacies. Fourth, you might wonder if this issue has been studied to determine if these concerns actually happen. The answer is yes, it has been studied, and yes, the concerns are a reality. The issue of physician self-referral has been studied for years and most extensively, the last five years. Current research findings from independent researchers, peer review journals, and government agencies have found that physician-owned hospitals increase utilization and cost; they cherry-pick the most profitable patients; they use doctor-owners to steer patients; and they make exceptionally high profits. Some of the most compelling research has shown dramatic increases in utilization. For example, a peer reviewed study in medical care research and review documents how doctor ownership affects utilization. In Oklahoma. the use rate for back surgery increased from .52 in 2000 to 4.05 in 2004, an increase of 679 percent. Without the doctor-owned hospitals, the use rate in Oklahoma would have been 1.13 which is 21 percent higher than in states where there are no physician-owned hospitals. A similar analysis in South Dakota showed that the use rate in Rapid City was 2.72 in 2000, and it increased to 10.73 in 2004. This use rate was 11.4 times higher than in states where there were no physician-owned hospitals. Community hospitals of all types and sizes have been impacted. Urban and rural hospitals, nonprofit, and for-profit hospitals. Typically, physician-owners come from the community hospital setting, and once their facility is built they drain the community hospital of the profitable services. This scenario has played out in nearly every community where these facilities operate. In Ruston, Louisiana, 65 percent of the community hospital's medical staff became investors. The community hospital lost $8 million. In Rapid City, the community hospital was unable to maintain emergency room coverage when the neurosurgeon-owners built their own facility, stopped taking emergency room call, and, as a result, patients were transported hundreds of miles away when gaps in neurosurgery coverage occurred. This situation created disturbing consequences for patients and families. Today physician-owners in Rapid City are expanding their facilities, and the community hospital expects they will lose additional surgeries. In Sioux City, Iowa, a doctor-owned hospital just over the border in Dakota Dunes had a

similar impact on the community hospital. These are just a few examples, and there are many more that demonstrate the access, recruitment, and emergency room problems. Recently, the United States House and Senate both passed bills that included a provision to ban new physician-owned hospitals. Three congressional leaders who are known for their role in federal health policymaking...Senators Grassley and Baucus and Representative Stark who the self-referral laws are named for...they're called the Stark Laws...have a strong commitment to address this issue and lead the effort in Washington. While the clear path for health reform is not known at this time, legislation to address this issue will continue to be aggressively pursued for the protection of patients and for the health of our entire healthcare system simply because eliminating conflicts of interest is the right thing to do. I would encourage you to support LB999 and place a moratorium on bed expansion, so that Nebraska doesn't follow the same path as South Dakota, Kansas, Texas, Ohio, and other states who have repealed their certificate of need laws, and who have experienced the negative effects of physician ownership of hospitals. I'd be happy to answer any questions. [LB999]

SENATOR GAY: Senator Stuthman. [LB999]

SENATOR STUTHMAN: Thank you, Senator Gay. Cindy, who did you represent? [LB999]

CINDY MORRISON: (Laugh) Good question. I actually work for Sanford Health which is...corporate offices located in Sioux Falls, South Dakota, but I'm the executive director of a national coalition that's been in place since 2003 that includes hospitals in 17 states. [LB999]

SENATOR STUTHMAN: In your opening remarks, I thought I understood you represented the physicians-owned hospital and I thought, oh my gosh. (Laughter) [LB999]

CINDY MORRISON: Oh, no (laugh). No, no. People that know me would say no, that would not be the case (laughter). [LB999]

SENATOR STUTHMAN: So that's my fault, but I just wanted to make it clear on the record, you know, of who you're representing so, okay, thank you for your testimony. You did a wonderful job. [LB999]

CINDY MORRISON: Yeah, yeah. That's correct. Thank you. [LB999]

SENATOR GAY: Senator Gloor. [LB999]

SENATOR GLOOR: Thank you, Chairman Gay. Ms. Morrison, I probably should start out by saying, you and I don't know each other. We've not interacted or discussed...

[LB999]

CINDY MORRISON: Right. [LB999]

SENATOR GLOOR: ...at least that I know, we've not interacted in any way. I want to make sure people know it isn't as if we teed up questions. [LB999]

CINDY MORRISON: Okay (laugh). [LB999]

SENATOR GLOOR: But I will follow up with Senator Stuthman. I thought you also said that you have physician-owned hospitals. [LB999]

CINDY MORRISON: No, we do not have physician-owned hospitals. No. [LB999]

SENATOR GLOOR: No physician-owned hospitals. [LB999]

SENATOR GLOOR: But you're aware of physician-owned hospitals that exist. What kind of models do exist? I mean, we're talking about a proprietary hospital, in this case, but there are other physician-owned models, are there not? [LB999]

CINDY MORRISON: Oh, right, right. The physician-owned hospitals that I'm most familiar with have actually been started from a couple of different perspectives. One, they started as an ambulatory physician-owned ambulatory surgery center, converted to a specialty hospital which simply means they put on beds for overnight stays. But what it also tells you is, there's a significant dollar increase for reimbursement once you convert into a specialty hospital. There is one model. We have those in South Dakota. The one in Dakota Dunes would be that model. There are other models like the Heart Hospital of South Dakota which was started by the heart doctors in South Dakota, didn't start as an ambulatory surgery center, and that one has been in existence since, I believe, about 2003. And there may be others, but those are some that I'm most familiar with. The ones that you see across the country in these states, a lot of them started out as ambulatory surgery centers, and then they converted into specialty hospitals. [LB999]

SENATOR GLOOR: Thank you. [LB999]

SENATOR GAY: Senator Wallman. [LB999]

SENATOR WALLMAN: Thank you, Chairman Gay. And welcome to here. [LB999]

CINDY MORRISON: Thank you. [LB999]

SENATOR WALLMAN: And I know doctors that have surgery centers,... [LB999]

CINDY MORRISON: Um-hum. [LB999]

SENATOR WALLMAN: Why do you...and I have never asked them why they started. But do you think the hospital is charging too much rates for them to operate in? Do you think that's...? [LB999]

CINDY MORRISON: You know, no, I don't think that was the case. I think what happened was, way back when the Stark Laws were put into place in the nineties, they left a small loophole, and the whole idea behind the loophole was...it's called the whole hospital exception, that if you had a whole hospital, you couldn't economically advantage yourself because that was the theory. You own the whole economic model, and if you understand how the hospitals get paid, you have patients that you don't make any money on, and you have some patients that you do. And so, the idea was that if you had the whole spectrum that these types of things would not happen. And so I think that there were some people that were very creative legally and otherwise and figured out a way to open up these hospitals and increase their facility fees and be able to capture that revenue. And if you really take a look at some of the doctor-owned hospitals, and you look at their mix of patients, what you see is they treat more surgical patients which is easily done by their admitting practices on which patients they admit. Well, if you treat more surgical, you make more money. If you treat medical patients, you do not. And so, if you look at community hospitals, typically, they're two-thirds medical patients, and they use those surgical patients then, of course, to help offset the costs of taking care of the medical patients. In the physician-owned hospitals, you would see just the opposite on average. [LB999]

SENATOR WALLMAN: Thank you. [LB999]

SENATOR GAY: Any other questions? I don't see any. Thank you. [LB999]

CINDY MORRISON: Thank you. [LB999]

JODY OLSON: My name is Dr. Jody C. Olson, J-o-d-y, middle initial C, last name Olson, O-l-s-o-n. Thank you, Senators, for allowing me to testify today. I'm a fellow in the Division of Critical Care Medicine at Mayo Clinic in Rochester, Minnesota. My opinions today do not reflect an official position of the Mayo Clinic, and in the interest of full disclosure, I am a former employee of Good Samaritan Hospital in Kearney. I started my medical career there as a paramedic in 1991. My interest in this legislation, instead, is that of a concerned physician who was trained at the University of Nebraska Medical Center, and who has an interest in the preservation of high quality medical care across the state of Nebraska. Today I will speak as a physician as to what I believe are the issues that will affect healthcare quality in Nebraska if physician-owned hospitals are allowed to expand unchecked, and how I believe a moratorium on new hospital

construction could potentially benefit all healthcare delivery in Nebraska by offering a thoughtful review of the process and the potential implications. Unfortunately, much of the data published on the impact of for-profit physician-owned hospitals suggests that they provide better quality at lower cost, does not always tell the whole story. I will not attempt to review all the literature that exists on the topic at this time. Instead, I will try to give an opinion as to what I perceive are the serious problems that physician-owned specialty hospitals pose to existing facilities. The complexities of healthcare delivering healthcare economics are a beast like no other. I'm not telling you anything you don't know. But there has been much discussion about competition improving healthcare and cost, but hospital competition is not the same thing as competing hardware, grocery stores, or restaurants. If that were the case, no hospital would provide care for free nor would they provide services that are nonprofitable. These services such as emergency medical care, mental health services could become scarce. Community and academic medical institutions do provide these services, often at a loss, but done for the betterment of the community as a whole, and that is a testament to the fact that they exist for the greater good. It is because of that mission that the services they provide may deserve special protection and consideration. LB999 could offer this protection in the form of a reasoned analysis of new hospital construction and the potential impact to existing facilities in health systems. This bill could do this by thoughtfully monitoring new hospital construction. You are potentially preserving access to full-service medical care offered by more traditional full-service and community hospitals. In addition, a moratorium could force full disclosure of the range of services that are to be offered by the proposed facilities, and that would perhaps let communities make more educated and informed decisions about supporting or not supporting proposed new hospital construction. As I mentioned at the outset, my concern is an impact of overall quality of healthcare delivery. Opponents of this bill will no doubt point to studies that reflect quality of services provided in specialty hospitals is better than or equal to community hospitals. But, again, these statistics do not always tell the whole story. I do not challenge the fact that specialty hospitals can provide excellent quality care, but I do suggest that the statistics that they report that suggest that they do as good a job or better care at lower cost are obtained by their ability to select out preferred patients. At the Mayo Clinic in Rochester, we are consistently rated number one or number two in all major clinical areas reviewed in U.S. News and World Report. However, this is a subjective criteria that are used to give us these rankings. If you looked at other quality metric data, in certain procedures our quality metrics might suggest that we are not rated as high as number one or number two; in fact, may rank lower in the forties. In this example, our lower rating is not a true measure of the quality of care we deliver, but instead, is a reflection of the complexity of the procedures we perform and the complexity of the patients that we perform these procedures on at an international referral center. Our surgeons perform complicated operations that no other facility would ever consider, and, as a result, we have higher mortality figures. Again, compared to a specialty hospital, this might suggest that we're not doing as good a job. To provide tertiary care and maintain accreditation as a level two trauma center, a hospital must be

able to treat the unexpected, and that requires breadth and depth and availability of differing medical specialties. A competing hospital in a city the size of Kearney or Scottsbluff does not bring in competition in the form of additional services. It instead divides and dilutes existing services. Furthermore, the following correlates with outcomes, there are essentially a finite number of patients that will present to these communities, and if a service that was originally provided by one hospital is now done by two, the quality of nursing skills and etcetera could deteriorate because the volume that they are experiencing is no longer at the level that it used to be. Serious questions exist when a new hospital threatens to divide a health system in a community. LB999 offers a pause to fully analyze the potential ramifications of a new hospital in Nebraska. It is not an impediment to free market competition and, instead, offers a chance to ensure adequate access to a full range of services. Please remember that the statistics you hear do not always tell the whole story, and I like to use a quote from Albert Einstein that says, "Not everything that counts can necessarily be counted, and not everything that can be counted necessarily counts." This statement rings true in the very dynamic nature of healthcare delivery. I urge the committee to advance the bill and would take questions at this time. Thank you. [LB999]

SENATOR GAY: Thank you. Senator Wallman. [LB999]

SENATOR WALLMAN: Thank you, Chairman. Thanks for coming. Are your hospital rates lower than predominantly across the country? That's what I'm told. [LB999]

JODY OLSON: Let me qualify this by saying, I spend most of my time strictly taking care of patients, and I cannot adequately comment on what our costs are. I'm not on the business side of things. My interest is providing medical care. I think we do offer some efficiencies in our system. They do bring our costs down in some metrics, but I'm not qualified to give a full...full answer. [LB999]

SENATOR WALLMAN: I know you diagnosed one of my nephews with a very, very rare disease, and he went to numerous hospitals around the country, and you found what it was. And he was operated on, so I'm impressed with your facility. [LB999]

JODY OLSON: I am too (laughter). [LB999]

SENATOR GAY: Senator Gloor. [LB999]

SENATOR GLOOR: Thank you, Chairman Gay. Dr. Olson, thank you for taking time to testify and, again, we don't know each other in any way that you know of, do you? [LB999]

JODY OLSON: Not that I know of. [LB999]

SENATOR GLOOR: Tell me about the hospital physician model for the Mayo Clinic. [LB999]

JODY OLSON: So, the Mayo Clinic--it is again, not a physician-owned hospital. It's a system that operates that the physicians that are employed there are employed by the system, and they're salaried employees. Often they're employed at salaries much lower than what they would make if they were working in community hospitals or outside. It's an academic medical institution, and by its nature, physicians are paid at lower rates. The physicians are paid, and they have no...they receive no incentive for admissions or for doing procedures at the hospital. The profits that are generated at an academic medical institution like Mayo Clinic go back into developing the system, making research available, training additional physicians, training residents, training fellows. So this is not a physician-owned model of care. [LB999]

SENATOR GLOOR: But you are an employee of that not-for-profit system. [LB999]

JODY OLSON: Correct. [LB999]

SENATOR GLOOR: Thank you. [LB999]

SENATOR GAY: Any other questions? I've got a question for you. You had talked about competition. I'm from Omaha metropolitan area, and there's several hospitals. In a way, wouldn't that be better because if competition brings out the best where you could...is there a certain size that that works and another size it doesn't? Because if I don't like what I'm hearing, I could get a second opinion or...because that happens all the time. [LB999]

JODY OLSON: I believe it is true...I believe your point is correct. In a larger metropolitan area, the impact of competition is probably...it doesn't have the same ramifications as it does in a community the size of say, Kearney or Scottsbluff. And in this particular case, I would like to go back to the issue of the level two trauma center. This is something I continually get...get to put around. In order for a hospital to maintain level two trauma center accreditation, they are required to have on-call or present in the hospital certain types of specialties...medical specialists, etcetera. In a city the size of Kearney...Scottsbluff, Norfolk, perhaps you only have one or two neurosurgeons. If that neurosurgeon is now dedicated to a second hospital, the potential that they would not be available for...at the level two trauma center may affect their accreditation. Because you have a limited number of physicians in a smaller community, I believe that a competition in that form does not necessarily offer more diverse care. I think it dilutes the system instead of making it stronger. [LB999]

SENATOR GAY: So is there data to suggest that...you said probably. Is there anywhere we could look to say that a community of 100,000 it works or 500,000 or 25,000?

[LB999]

JODY OLSON: I cannot give you a number, correct. [LB999]

SENATOR GAY: Have you ever seen anything like that? [LB999]

JODY OLSON: No, sir. [LB999]

SENATOR GAY: Okay. Thank you. Any other questions? I don't see any. Thank you. Other proponents. [LB999]

JANICE WIEBUSCH: Janice Wiebusch, J-a-n-i-c-e W-i-e-b-u-s-c-h. Mr. Chairman and members of the committee, I thank you for the opportunity to speak before you today. My name is Janice Wiebusch, and I have been a long-time resident of Kearney and actually, I've been in the same business--I've been a Kearney realtor for 34 years. I am currently a trustee of Good Samaritan Hospital, and I am here today to represent our organization in support of LB999. Thanks to the unique, long-time collaboration between Good Samaritan Hospital and the dedicated doctors of our medical community, we have built something both special and vital to our region. The scope and breadth of services we have as a result of the close relationship long enjoyed by our talented physicians and Good Samaritan staff is in many respects unique to our nation. Thousands of people throughout central Nebraska and northern Kansas count on Kearney as a regional referral hub and provider of level two trauma care in critical times of need. We provide the greatest number of clinical consults in the state by Telehealth and invaluable time and money savings service for Nebraska's rural patients. We were our state's first certified chest pain center. We offer nationally recognized orthopedics care. Through Richard H. Young Hospital, Good Samaritan provides vital behavior health services that have been so important in the state's reformed behavioral health system. And in fiscal year 2009, Good Samaritan Hospital provided $19 million in community benefit in the form of charity care, the unreimbursed cost of Medicaid, medical education, health services, donation, and great programs like Safe Kids and Teen Net. The $19 million does not count the Medicare shortfalls or bad debt. Such a special and vital healthcare system only can be accomplished through collaboration between gifted physicians and the leadership and the staff of the hospital. Hospitals and physicians need each other to deliver care and services necessary for our patients. This relationship in any hospital can be strained, creating a healthy tension that often leads to improved services and greater trust. Good Samaritan recognizes that our relationship with some physicians are fragile, and I believe that a great deal of this conflict is based on misunderstanding, but readily acknowledge that we have made mistakes. A second hospital, however, is not the solution. Duplicating hospital services in Kearney threatens to tear apart that which has been decades to build. A Kearney Hub editorial used an analogy to describe the conflict as much like a divorce, noting that in a divorce it is often the children or, in this case, the community that is harmed. Duplicating hospital services

will limit our community's access to vital specialty services, drive up cost, and weaken the quality of care. You may wonder, what is Good Samaritan doing to address the concerns of the physician community who we consider our friends, neighbors, and trusted colleagues? Today we are collaborating with many doctors to develop a new model that gives the physicians a stronger voice in the hospital's operations. The four key tenants of this model include physician leadership, allocation of capital and local resources, physician recruitment, and local ownership opportunities for certain clinical service lines. The changes we are proposing are dramatic; they are progressive; and they give our physicians greater ownership. Outside investment groups and companies have targeted Kearney and targeted Nebraska to exploit the tensions we are experiencing today. Outside investors have entered our community and presented a physician-owned hospital as a panacea that promises a high return on investment and an illusion of complete control for doctors. What this means for Nebraska is that Good Samaritan's level two trauma and regional referral services, the only one along a 450-mile stretch of road from Scottsbluff to Lincoln, will be threatened. Good Samaritan Hospital's trauma center is a leader in the state's trauma system, a role we embrace with pride but also with great responsibility. These are expensive and often less reimbursed services. Better reimbursed procedures subsidize those services that actually lose money, but are nonetheless needed and I am out of time. [LB999]

SENATOR GAY: Thank you. Senator Stuthman. [LB999]

SENATOR STUTHMAN: Thank you, Senator Gay. Janice, thank you for your testimony. How long have you been at this hospital, did you state? [LB999]

JANICE WIEBUSCH: I've been a trustee for five years, I believe it is. [LB999]

SENATOR STUTHMAN: For five years. [LB999]

JANICE WIEBUSCH: Um-hum. [LB999]

SENATOR STUTHMAN: The management team at the hospital, how long has that management team been there? [LB999]

JANICE WIEBUSCH: Now, are you referring to...? [LB999]

SENATOR STUTHMAN: To the Good Samaritan Hospital...the ones in charge...the CEO. [LB999]

JANICE WIEBUSCH: Well, the CEO...when...we are in an interim CEO status right at the moment. [LB999]

SENATOR STUTHMAN: Okay. Thank you, because...then, in other words, in other

words, one has left and you're searching for a new CEO. [LB999]

JANICE WIEBUSCH: Yes. [LB999]

SENATOR STUTHMAN: Okay, thank you. [LB999]

JANICE WIEBUSCH: Yes. [LB999]

SENATOR GAY: How long have you been at an interim basis then? [LB999]

JANICE WIEBUSCH: Oh, five...well, the CEO who was in place when the physician-owned hospital became public decided that it was probably of the best interest for Good Samaritan that he step down. So that would have been four or five months ago, whenever that was. Four months ago. [LB999]

SENATOR GAY: So this issue is four or five months old then? Is this when it became...you said when it became public? I mean for us, it became public a month ago, but...so about four or five months this has been going on? I guess when the proposal was... [LB999]

JANICE WIEBUSCH: Time passes quickly. I hope I'm in the right time frame. [LB999]

SENATOR GAY: ...no, it's okay, just ballpark is probably good. I'm just trying to get a...it's been a two-year process or five-year... [LB999]

JANICE WIEBUSCH: Well, from the standpoint of...well, from the standpoint of addressing a physician-owned hospital and how that will impact on Good Samaritan, and that's how long we have been addressing that issue, yes. [LB999]

SENATOR GAY: Okay. That's good enough. Senator Wallman. [LB999]

SENATOR WALLMAN: Thank you, Chairman. Yes, we're looking for an interim CEO, I...you know, have been through the superintendent, the elevator stuff and everything. Do you include your doctors in this search too and your nurses? [LB999]

JANICE WIEBUSCH: Yes. Yes. [LB999]

SENATOR WALLMAN: Okay, thanks. [LB999]

JANICE WIEBUSCH: They're an integral part of the hospital, so, yes. [LB999]

SENATOR GAY: Any other questions? I don't see any. Thank you. [LB999]

JANICE WIEBUSCH: Okay. Thank you. [LB999]

SENATOR GAY: We're still on proponents. [LB999]

AHMED KUTTY: I'm Ahmed Kutty, M.D., A-h-m-e-d K-u-t-t-y. Senator Gay, thank you for giving the opportunity to be here. I'm a cardiologist, practicing in Kearney since 1992. I do not work for Good Samaritan Hospital. I have only privileges there. I'm representing the general good of the community that I have come to love and work for. That includes the 18-county service area that we have been providing primarily heart care for that was not available prior to that, especially the acute heart attack care and so on that became a reality since about 1994 when a heart program...full-blown heart service program was offered in development, but offered at Good Samaritan Hospital. And I believe that is still a work in progress, and the full capacity of...especially cardiac program...heart surgery, cardiac cath, intervention type of procedures are still underutilized at Good Samaritan Hospital roughly 10 to 15 years in the works. And, therefore, a physician practicing in that community since its inception of the heart program in 1992, I fail to see from a patient's point of view or from a physician's point of view or from the general perspective of our service area, need for another hospital because they are still underutilized and not full capacity utilization of, for example, cardiac surgery numbers speaks for underfilling. Medicare, for example, requires a hospital of our size, at least recommends roughly 300 procedures to be done, open heart procedures a year. And Good Samaritan has barely met that requirement. One of its best years was about 260 procedures. So in that sense, in terms of program development, the hospital...Good Samaritan, is still struggling to meet the numbers. And so, therefore, I see no need for another hospital, and I'm speaking not as an investor in the new proposed hospital nor as an employee of the current hospital, but an independent sole practitioner practicing cardiology at Kearney, dedicated to the concept that nonprofit setup is the best way and is the ethical way, and is the only overall model that we should try to promote. And that I do not support any credible data in published literature, especially in peer review journals such as I have one here, Journal of American Medical Association, New England Journal of Medicine, and so on...prestigious journals have no published data showing that for-profit systems of healthcare delivery provided any better care, caused efficiency complications, or quality. In fact, several of them tend towards pointing to a negative impact if it is a for-profit setup, primarily because it tends to drain healthcare dollars to satisfy the investors and to pay for the enormous executive salaries and other overhead that for-profits have to deal with which nonprofits do not because they don't have investors or owners to financially meet their requirements. And, therefore, I see the general good of our community being harmed by a proposed physician-owned for-profit system entity coming in to essentially take away what Good Samaritan or one of our 80 years of initially owned by nuns, St. Francis Sisters, and so forth built up and created as a valuable asset and treasure for our community, and I see that being endangered. [LB999]

SENATOR GAY: Thank you. Senator Pankonin. [LB999]

SENATOR PANKONIN: Thank you, Senator Gay. Doctor, thanks for being with us today. As I'm...this is my first question to ask because I've been observing and listening, but our job up here is as policymakers for the entire state. And I'm interested in what happens in Kearney, but I'm more interested in what happens to the state of Nebraska, and, obviously, this situation is maybe indicative of other situations that could or have happened. So, besides knowing what your local situation is, do you think this is a good policy, this bill, this moratorium for the entire state while we look at this situation, and we should study it in this two-year period to come up with a better policy about how this should work? Is that your opinion? [LB999]

AHMED KUTTY: Yes, I think it is for the state of Nebraska. Statewide, there should be a moratorium. For example, in the state of Nebraska, there are 82 hospitals. Out of that, six are for profit, and to put it in context, nationwide U.S. has about 5,800 hospitals--registered hospitals, and about 980 are for profit. So 18 percent nationwide and less than 1 percent in Nebraska are for profit. [LB999]

SENATOR PANKONIN: Thank you. [LB999]

SENATOR GAY: Senator Stuthman. [LB999]

SENATOR STUTHMAN: Thank you, Senator Gay. Doctor, as you have been granted privileges at this hospital, do you see that this hospital could provide more service or can that hospital, you know, attract more patients to the hospital, or is that hospital filled up and can't handle any more patients? [LB999]

AHMED KUTTY: Good Samaritan Hospital? [LB999]

SENATOR STUTHMAN: Yes. [LB999]

AHMED KUTTY: It can handle...it is not fully utilized, so it can take in more patients in any... [LB999]

SENATOR STUTHMAN: So it could be...it could be utilized more yet. [LB999]

AHMED KUTTY: Yes. [LB999]

SENATOR STUTHMAN: It could handle more patients so... [LB999]

AHMED KUTTY: Uh-hum, uh-hum. Its capacity is not fully utilized. [LB999]

SENATOR STUTHMAN: Okay, okay. That's what I wanted to hear. I mean, so that...the establishment that you got could be utilized more. [LB999]

AHMED KUTTY: Yes. [LB999]

SENATOR STUTHMAN: Okay. Thank you. [LB999]

SENATOR GAY: I've got a question for you. That...those figures you just gave, where did you get those from? [LB999]

AHMED KUTTY: This is from...the figures? [LB999]

SENATOR GAY: Yeah, about the for-profits in Nebraska verse nationwide. [LB999]

AHMED KUTTY: Nebraska Hospital Association and American Hospital Association. [LB999]

SENATOR GAY: Okay. Thank you. Senator Gloor. [LB999]

SENATOR GLOOR: Thank you, Chairman Gay and Dr. Kutty. We do know each other. [LB999]

AHMED KUTTY: Yes, we do. [LB999]

SENATOR GLOOR: It's good to see you. It's been a number of years since we've talked, though, clearly. Help me and Senator Stuthman asked a question that got me to thinking. If I go back and look at CEOs at Good Samaritan since the year 2000, we have Bill Hendrickson, Ken Tomlin, Art...and I forget Art's last name. [LB999]

AHMED KUTTY: John Allen. [LB999]

SENATOR GLOOR: And then John Allen. And then currently, Steve Loveless who would be the fifth... [LB999]

AHMED KUTTY: Interim. [LB999]

SENATOR GLOOR: ...and Steve would serve as the interim. Is that correct? We're talking about five CEOs who have served over the past ten years in my...? [LB999]

AHMED KUTTY: Past 18 years. Out of which three were permanent, Bill Hendrickson since I've been there. Bill Hendrickson followed by Ken Tomlin, and there was an interim in between. [LB999]

SENATOR GLOOR: Art somebody or other. [LB999]

AHMED KUTTY: Yeah, but he was interim. Ken Tomlin and now John Allen for five years. And John Allen just stepped down in September. [LB999]

SENATOR GLOOR: When did Bill Hendrickson leave exactly? Do you remember, was it 2000? [LB999]

AHMED KUTTY: 2000. [LB999]

SENATOR GLOOR: Okay, thank you. [LB999]

SENATOR GAY: Any other questions? I don't see any. Thank you. [LB999]

NICKI BOHL: Good afternoon, Chairman Gay, members of the committee. My name is Nicki Bohl. It's spelled N-i-c-k-i B-o-h-l. And I apologize because probably going to tear up but I'm going to work through it and get through my whole testimony in the five minutes allotted. I'm here to encourage you to support LB999. I'm a pharmacist. I am the director of pharmacy at Good Samaritan Hospital. My degree is that of a doctor of pharmacy. I work with 15 other doctor of pharmacies at Good Samaritan Hospital. I'm telling you this to explain, you know, where I come from. A doctor of pharmacy, to get that degree nowadays, it requires seven or eight years of school, so it's a pretty good dedication, pretty good amount of dedication in order to get through school and a commitment to really want to take care of patients and help other healthcare professionals take care of patients. I'm here representing Good Samaritan Hospital. More importantly, I'm here to represent the people of the outstate Nebraska where healthcare access and services is a concern. I don't live in Kearney. I live about an hour away. I live outside of a small town called Litchfield, Nebraska. It is in Sherman County. I make the 45-minute drive to and from Kearney every day. It is the closest hospital to where I live. It is the hospital where I or my family would seek care, and we do use Good Samaritan Hospital. As you know, this bill would place a two-year moratorium on any hospital licenses in the state. This two-year period would allow us in the community and you Legislatures time to study the policy implications of other physician-owned hospitals such as the one proposed in Kearney. I hope you realize this is a statewide concern. This same issue can come up in Norfolk, Grand Island, Scottsbluff, wherever there is a community hospital that provides a lot of services. Kearney is the closest hospital to where I live. I have a particular concern. You've heard about the level two trauma center. I have a 40-some year-old husband who truly believes he has a 20-year-old body, and there are many times where he acts before he thinks. And he has managed to survive two instances where he put his hand in an auger, and, yes, he still has all of his fingers by the grace of God. So I'm concerned because this is a service that I desperately need for my family. My parents farm; I grew up on a farm; I still live on that farm. This would also be true for cardiac care, psych care, and stuff like that. Those

are the real concerns...access to that care is very important, and those truly are the services that are in jeopardy if we would have a second hospital come into town. Some other concerns that I have relate to what I've heard from my peers in talking to them. I've had an opportunity to talk to directors of pharmacy and pharmacists who work in community hospitals where other physician-owned hospitals have come into town, and I'm truly shocked by some of the stories that they tell me. And I hope you have the opportunity to talk to others and verify some of the stories that are out there. It speaks to quality of care, and how do you provide quality of care in two hospitals especially when you run the risk of decreasing services in one? Some of the questions that I have: Will a second hospital be able to provide, you know, all the key services, all of the quality services? Will they have, you know, emergency rooms? Will they have physicians trained in emergency care to provide services? Will they be joint commission accredited? Will they have certain standards by which they're met? Some of the pharmacists that I've talked to...yeah, those other physician-owned facilities don't have joint commission accreditation. And so there's a quality concern in that regards. Most of my time is spent on quality initiatives, policies, processes, improving care, benchmarking, doing best practice...stealing, begging, borrowing from hospitals in Lincoln and Omaha and other facilities that have a best practice in place. As a pharmacist, I think it's very important to have pharmacists in the hospital. We go through a lot of training. My pharmacists are very dedicated to what they do. They tell me that they're in the hospital because that's what they choose to do. As a pharmacist, I could make more money doing retail pharmacy. We choose to work in a hospital. I have 15 other pharmacists. My biggest fear is that if we have...we could end up with two hospitals in Kearney, but not enough patients to have 24-hour pharmacy coverage for either one of the hospitals, so you may go for 8 or 10 or 12 hours during evenings, nights, weekends where there's no pharmacist on call...no pharmacist in the facilities, and I think that speaks to decreased level and quality of care for our patients. And I just urge you to support LB999, and I'd be happy to take any questions. [LB999]

SENATOR GAY: Thanks. Senator Gloor. [LB999]

SENATOR GLOOR: Thank you, Chairman Gay. You did a very nice job. I want to show you something. (Laugh) Your husband's not the only person who thinks he's a 20-year-old (laughter). [LB999]

NICKI BOHL: You know, he needs one of those sometimes, but he is...you know, he's too proud...that farmer-rancher, they're too proud to say and admit that... [LB999]

SENATOR GLOOR: Yeah, well, I'm a hospital CEO...once upon a time, I'm not too proud. I know (inaudible)(Laughter). [LB999]

NICKI BOHL: Good for you. [LB999]

SENATOR GLOOR: Serious question for you. Where did you go to school? Where did you get your undergraduate degree and where did you get your pharmacy degree? [LB999]

NICKI BOHL: Against the best advice of my parents (laugh), I got my degree from Creighton. Nothing against Creighton. I absolutely love Creighton. That was the place that I wanted to go ever since I was old enough to know that I wanted to go to school. I did not grow up on the most profitable family farm (laugh), and so they made it very clear to me that if I wanted to go to school I could go anywhere I wanted to as long as I paid for it. So I went undergrad and pharmacy school at Creighton, and I paid for it all myself. [LB999]

SENATOR GLOOR: Did you get any state assistance that you can think of...special scholarships that were out there, programs, loan forgiveness when you moved back to Kearney? [LB999]

NICKI BOHL: Very little. Very little. [LB999]

SENATOR GLOOR: So most of it was on your own. [LB999]

NICKI BOHL: And when I moved back to Kearney, did I get any assistance? Did I get some sort of...? [LB999]

SENATOR GLOOR: Yes. Relocation bonus, something? [LB999]

NICKI BOHL: No. They paid for my trip. When I got done with pharmacy school, I opted to do a year residency in Denver, and so the hospital...Good Samaritan, when I finished my residency, I agreed to take the only position available at Good Samaritan which was one of the night positions. We were just opening night positions 14 years ago, and I opted to take that position. When I actually got back to Kearney, they paid $500 to move me back to Kearney, and at that time, one of the day positions opened up, and so I took...I was a staff pharmacist, and then I was the clinical manager, and now I'm the director. [LB999]

SENATOR GLOOR: How many of your pharmacists would you guess were educated in the state of Nebraska? And I'll be specific...at the university as an example or state colleges for undergrad as pre-pharm majors. [LB999]

NICKI BOHL: All of them except one. [LB999]

SENATOR GLOOR: Which would be roughly how many people? [LB999]

NICKI BOHL: 14 out of 15. [LB999]

SENATOR GLOOR: Senator Pankonin is helping remind my memory, but he also reminds everyone, I think, that our issue here really is not a Kearney issue. It's trying to think in a broader aspect... [LB999]

NICKI BOHL: Exactly. [LB999]

SENATOR GLOOR: ...and one of the concerns we have is, as this committee can attest to, we're approached all the time with bills or the request to introduce bills that has to do with training healthcare professionals. [LB999]

NICKI BOHL: Um-hum, exactly. [LB999]

SENATOR GLOOR: And that means an allocation of state dollars... [LB999]

NICKI BOHL: Exactly. [LB999]

SENATOR GLOOR: ...either to programs that relate to expansion of classes at the university, loan forgiveness, special programs through high schools that have to do with medical career tracks,... [LB999]

NICKI BOHL: Exactly. [LB999]

SENATOR GLOOR: ...all of those things, and so the concern here, I think, is in part when we talk about this moratorium...what does it mean in terms of statewide staffing needs that might eventually come up if we're seeing an additional demand for those healthcare professionals above and beyond the huge demand that's already out there, so I appreciate your response. Thank you. [LB999]

NICKI BOHL: Exactly. [LB999]

SENATOR GAY: Senator Stuthman. [LB999]

SENATOR STUTHMAN: Thank you, Senator Gay. Thank you for your testimony. I just wanted to make a comment, you know, I feel like I'm similar to your husband, you know, but I (laughter)...I have survived many of these...I've been pinned under... [LB999]

NICKI BOHL: (Laugh) I think there are probably a lot of stories like that, you know. [LB999]

SENATOR STUTHMAN: ...pinned under a tractor, but the worst situation, I was pinned under a large animal in a squeeze chute and couldn't breathe with nobody around there, so but I was very fortunate to make it, so. Thank you. [LB999]

NICKI BOHL: Uh-hum, uh-hum. Congratulations. That's a good thing. (Laughter) [LB999]

SENATOR GAY: All right. Any other questions? I don't see any. Thank you. [LB999]

JULIE ERICKSON: (Exhibit 1) Chairman Gay, members of the Health and Human Services Committee, my name is Julie Erickson, J-u-l-i-e E-r-i-c-k-s-o-n, and I am here as the registered lobbyist for the Nebraska Society of Respiratory Care to testify in support of LB999. There are 1,340 respiratory care practitioners in the state of Nebraska, primarily working in hospitals. Respiratory therapists work in critical care areas serving patients who are unable to breathe sufficiently enough to support life by using various means of mechanical support. They also work in all areas of the hospital testing lung function and working with pulmonary patients as well as many post surgical patients to assure them a speedy recovery without complications. To help cut costs, in many hospitals, respiratory therapists work in areas where they have been cross trained, such as helping perfusionists in surgery. If this bill is not passed, it would potentially decrease an already limited work force and put an additional strain on hospitals in rural areas. It is critical to safeguard patient care, and by enacting a two-year moratorium on applications and licenses for new hospitals, Nebraska will still be able to step back and review the current situation. With possible changes at the national level relating to health care delivery, and our economic situation, we believe this legislation is in the best interests of current hospitals in Nebraska. The Nebraska Society of Respiratory Care urges the committee to advance LB999 to General File for full debate. Thank you. [LB999]

SENATOR GAY: Thank you. Any questions? I don't see any. Thank you. [LB999]

BRUCE RIEKER: (Exhibit 2) Good afternoon, Chairman Gay, members of the committee. Again, my name is Bruce Rieker. It's R-i-e-k-e-r, vice president of advocacy for the Nebraska Hospital Association. The pages are passing out three different documents, but what I would like to do is definitely not go over any of the things that have already been talked about. But I want to assure you that this is not only a state issue; it's a national issue. Congress has been dealing with this for ten years to some avail, but in other cases, they have lacked the political courage to handle this particular issue or it gets dumped out of various packages that have been before both the House and the Senate in the last few years. What I'd like to try and do is boil down a few things that, as from a hospital association, and we do support LB999 with a study associated with it. That in healthcare, physicians are the gatekeeper. Hospitals do not admit patients; physicians admit patients. So they have all the control, the ability, and when they own for-profit hospitals, the financial incentive to direct patients to or away the facilities that they may own. Something that I haven't heard talked about so far in the testimony is emergency care. According to the Department of Health and Human

Services Office of the Inspector General and a 2008 federal study, they found that most physician-owned limited service hospitals are not equipped to handle medical emergencies. Two-thirds of those physician-owned hospitals use 911 as part of their emergency response procedure including 34 percent that use 911 for medical assistance to stabilize a patient. According to the Medicare regulations, 911 may not be used as a substitute for the hospital's own ability to provide an adequate initial response to the emergency needs of patients. About one-quarter of the physician-owned hospitals, as of 2008, lack policies regarding the management of medical emergencies while less than one-third have physicians on-site 24 hours a day seven days a week. What types of patients are seen by community hospitals versus physician-owned hospitals? Unlike community hospitals, which typically treat a diverse group of patients, physician-owned hospitals tend to treat only a small share of Medicaid patients and rarely treat patients who cannot pay for their care. Medicaid beneficiaries comprise 13 percent of the community hospital's patients across the nation. It's 14.5 percent for here in Nebraska, but only 2 to 3 percent of those limited service hospital patients are Medicaid patients. Why does the NHA support the moratorium? It gives the Legislature and the state time to lay the groundwork and establish the rules and policies that need to be in place so that as healthcare moves forward in a state where we have limited dollars like almost every other state where we need to make sure that our dollars go the farthest, we need to make sure that we are not doing things that will increase the cost of healthcare, that we are utilizing our resources to the greatest degree possible. We've talked about the study a little bit. Hopefully, through the course of the other people that were testifying, they have shared with you some of the concerns. But as we see the study, or what we should do for the Legislature is look at the whole spectrum, and I would say that that spectrum exists from doing something like what Montana did which was a complete moratorium on physician-owned hospitals to what some other states have done such as Nevada or New Jersey. Nevada requires a certain payer mix. They say that these physician-owned hospitals have to have at least 30 percent Medicare and Medicaid patients. New Jersey charges a fee, a half a percent fee on revenues. They use that money to support federally qualified health centers to take the burden off of community hospital emergency rooms. Other things that should be examined in this study should be, to what level should an emergency department be maintained? How many beds should be in that emergency department? Who's going to provide the on-call service? Transparency issues...I mean I...transparency issues. We've talked about that. I visited with several senators. Transparency issues that apply to both for-profit hospitals owned by physicians as well as community hospitals. One of the issues that some senators have asked me about is, where is the community hospital's responsibility to reinvest in the community as well as in the facilities? And those are things that we have agreed as a hospital association to say, let's take a look at that, you know. What I think should happen is we should have representatives from the Legislature, equal representatives from the physicians' groups, from the hospital association, a few others that are healthcare experts, and that we put together a study group that makes a recommendation to the Legislature that you can deliberate and debate in the next

session or two to come. [LB999]

SENATOR GAY: Thanks, Bruce. Senator Pankonin. [LB999]

SENATOR PANKONIN: Thank you, Chairman Gay. Mr. Rieker, thanks for your testimony. I think it's important testimony, and I've got two questions along this line. For your association to formulate this position out of the 85 hospitals that you represent, what was the process in coming to this decision to support LB999 with the study associated with it afterwards as you've described? Was it a board of directors or did you take a poll or how did you come to this decision to support this legislation? [LB999]

BRUCE RIEKER: Yes, yes, and yes. Our policy development process...the Hospital Association has had a longstanding position, board-approved position against physician self-referral to facilities that they have an ownership interest. We have policy briefs on that. We have tracked that legislation in Washington for years, so we have a longstanding position along those lines. What our formal process is in the association, as you know, we have 85 members. We have a policy development committee that consists of 30 of those members represented by either a hospital CEO or administrator or a designated hospital representative. So we...across the state, we have roughly one-third of our hospitals represented in that process. They study these issues. This was presented to them. We had...we presented the possibility of this issue coming up in December. Again, we had another meeting in January where we talked about it in more detail. It was a very good discussion, a debate about the issue. I would say that I am not aware of any one of our members that is opposed to this particular initiative. Some are very cautious about how far they're going to go out in front because of situations with hospital physician relationships that, if they have good ones they don't want to ruffle the feathers. If they have tenuous situations, they don't want to make matters worse. So I understand the political sensitivity of their position. That's why we have associations sometimes to build a little bit of that buffer, but I'm not aware of any hospital that we represent that opposes this legislation, and it was a consensus of our policy development committee and board approval on January 27. [LB999]

SENATOR PANKONIN: Thank you. That's helpful. My second question would be without delving into the details that...in the community of Kearney, that there was apparently some kind of breakdown in communication, in intent, and maybe leadership. Senator Gloor may have alluded to that by asking how many CEOs over a certain period of time. But when these situations arise and you...in the first answer you indicated that sometimes there is tension, conflict between doctors and hospitals over these sort of issues. What should be the mechanism that fosters discussion and resolution versus a situation that developed in Kearney? [LB999]

BRUCE RIEKER: Well, we have some very successful joint ventures across the state, and we as an association have been discussing that. Last week we traveled the state to

meet with our CEOs across the state to talk about this issue and many others. But where we're going in healthcare, and I think it really grew to a head in Kearney, and I'm not familiar with all the details. But we have several hospitals, large and small, that have developed joint ventures with their physicians, so that there is more of a...I don't want to say collegial, but a collaborative effort to understand what it takes to run a community hospital, the financial pressures of, you know, funding something that you're undercompensated for as well as handling personnel issues, things like that. We have several cases in Omaha where the relationships between the physicians and the hospitals are good because they did these things. And the way, wherever federal healthcare reform is going, when we hear about bundling payments, accountable care organizations, things like that, part of the model is already telling us to go that way because, to some extent, Congress will probably mandate it somewhere down the road. But there's a balance, and that's where some of the states have looked at this, and I think that that's part of why we need to have legislative guidance or authority to say, okay, within these bounds we can allow these things to exist. It's in the public's best interest to do this. Some states allow physician ownership up to 49 percent of a hospital. Some go 50-50. I'm not aware of any state that...well, I should say New Jersey...they allow whatever percentage of physician ownership you want, but then they're going to charge that fee. And I know that New Jersey is a lot bigger than Nebraska, but they cap that fee or that fund at 40 million a year, and they use that to support their federally qualified health centers. We're intrigued by that idea, not for the sake of charging physician-owned hospitals a fee, but we are very...as a hospital association, we're very supportive of federally qualified health centers and public health clinics because they take a tremendous pressure off our emergency room, and it's more effective, more cost effective care. [LB999]

SENATOR PANKONIN: Thank you for your testimony. It was real important today to have that...those policies discussed. Thank you. [LB999]

SENATOR GAY: Any other questions? I've got one for you, Bruce. [LB999]

BRUCE RIEKER: Uh-hum. [LB999]

SENATOR GAY: That statistic, that less than 1 percent of Nebraska...hospitals in Nebraska are for profit versus 18 percent nationwide. Is that correct? [LB999]

BRUCE RIEKER: It is. [LB999]

SENATOR GAY: So, it's a smaller problem, obviously, but I guess when we say a two-year moratorium, that's what I'm saying, and I know this is a little broader than what the bill says sometimes. But is it two years, is it something else? And then I've heard many times, now we're talking physician-owned hospital...bad; certificate of need, we've been there, repealed it. Are we going back to there? I mean, where does it end and

which are we looking at? And then...because there's so many issues, and now you're asking...public policy on healthcare obviously hasn't been very good. I don't think we're watching what's going on nationwide. Then you're saying to us, well, go ahead and take care of this problem. Is it two years to take care of the problem? Is it one year, six months? I mean, I don't know. I mean, that's what I'm saying. If we go and do these things you suggest, we're holding people up. We're...and I can see, you know, it's a difficult situation or none of us would be here. But at what point...is it a two-year thing? When would this be done because earlier, before, we were talking...we've been working on that issue for 14 years. I mean, at what point do we...which model do we use? I just kind of wonder if we're just kicking the can down the road a little bit here if we did that, or would there be a time limit that you'd suggest? [LB999]

BRUCE RIEKER: Absolutely. [LB999]

SENATOR GAY: What? [LB999]

BRUCE RIEKER: And this was part of our policy development committee discussion as we were going through this and discussing what sort of moratorium or...I mean, we looked at several examples. We were not convinced that just a study would do it because there's...there's not a stick out there to hold both sides to the table and say you got to talk on this thing. I mean, if we look just at Kearney. But in a conversation that I had with Senator Flood, and we were talking about this, I shared this with him, and these were my comments. We wanted to structure something that was responsive to the physicians as well. Okay? If we could get this study done by December of this year, and the Legislature could act on it, whatever you choose to do. I mean, obviously, we're going to lobby that particular process as well, but if the study were required to be done by December 31 of this year, and the Legislature acted on it--next year you have a long session. Theoretically speaking, you could lay the groundwork or say here's the rules of participation, and this is how we're going to go forward. Then if the physicians...I mean, based upon whatever you decide, then if the physicians want to go forward with their particular hospital, they know the ground rules, and then we move forward. If we don't think we're capable of getting the study done to the need that we're...to the level we need to...and I don't want to drag it out. You know, the gentleman that I used to work for said, you know, if you give somebody a month to figure it out or you give them a year, they'll get it done in a month or they'll get it done in a year. Okay? I want to have the appropriate people at the table, and I think that it's going to be some of you so that we have a systematic or, you know, it's a seamless hand-off from this group to the Health and Human Services Committee and then to the Legislature. But I think the critical question is, how long do we need to do this study? I truly think that if we put our nose to it, to the grindstone, we could have it done by the end of this year, and then the Legislature could act on it next year. And if there are still things that you...or we can't agree on, then that's something that we'll have to continue to work on, but I see no reason to delay this. But I see a great need to lay the groundwork so we all know what

rules we're going to play by. Did that...I...I...? [LB999]

SENATOR GAY: Yeah, that is fine. Any other questions? Senator Gloor. [LB999]

SENATOR GLOOR: Thank you, Chairman Gay. Different question to you, but it goes back to the testimony from the pharmacist, and my concern about, in fact, statewide. With your knowledge of reimbursement and how reimbursement is worked out, both through Medicare rates, Medicaid rates, negotiations with insurance company, if the competition to fill positions in another hospital drives up the overall salaries, great think the professionals, but if it drives up the salaries and, therefore, drives up the costs, how does that come back to the payers and, specifically, our concern would be Medicaid. [LB999]

BRUCE RIEKER: Okay. Do you want my dissertation on work force shortage? [LB999]

SENATOR GLOOR: No, I would...(Laughter) I think...I think we all do, I think, understand there's a work force shortage, and that's obviously part of the concern of the other angle on this. [LB999]

BRUCE RIEKER: Okay. Yeah, yeah. Very quickly, our hospitals did a study...we do this every year, human resources need, and based upon the demand that is growing, we estimate that over the next six years we need to hire about 8,000 people to meet the demand because of the aging baby boomers. Okay? As well as the retiring baby boomers. So we already have a work force shortage. We are only able to recruit back to the state 3 percent of those people who leave. We have not figured out how to bring any more back, so we have almost a static work force, and we actually have a deficit in work force in the ages between 19 and 44 to fill some of those needs. Okay. Why I share that with you is because in healthcare...I mean, we have a shortage of work force. Okay, hypothetically if this hospital were built in Kearney, they're going to be competing over the same work force. So we start...and like you said, nobody begrudges better wages, but what happens is one hospital starts paying better and then you get incentives going back and forth. Pretty soon one or both of them have work force shortages, so then they go out to our critical access hospitals and offer them a hiring bonus or some sort of incentive to leave Litchfield or wherever it may be and come to Kearney. Okay. Well, then our critical access hospitals, which we have 65 of them, need to find people to replace those individuals, and they have to pay more to get them there. We all pay for that through Medicaid because our critical access hospitals are reimbursed at cost through their cost reports. So it will eventually...I mean, there's a few steps in this equation, but it will drive up the cost of Medicaid because of those increased salaries and that competition. We only have so many workers. [LB999]

SENATOR GAY: Thank you. [LB999]

SENATOR GLOOR: Thank you. [LB999]

SENATOR GAY: Any other questions? I don't see any. Thank you. [LB999]

BRUCE RIEKER: You bet. [LB999]

SENATOR GAY: How many more proponents do we have? How many more proponents after this do we have? We're going to do this. We'll go ahead and then we'll wrap up the proponents, take about a 15-minute...10-minute break probably. We'll see where we're at, and then I want to give the opponents equal time too and let us stretch our legs, use the restroom, whatever we got to do. And then we'll come back and go from there, so we can give them the same attention. Go ahead. [LB999]

JIM CUNNINGHAM: (Exhibit 3) Senator Gay, members of the committee, good afternoon. My name is Jim Cunningham, C-u-n-n-i-n-g-h-a-m. I'm the executive director of the Nebraska Catholic Bishops Conference representing the mutual interests and concerns of the three Catholic bishops serving in Nebraska. In anticipation of a conflict with a hearing in another committee, I submitted our testimony prior to the start of the hearing and therefore I won't go through that entire testimony. But I appreciate the opportunity to be on your committee's record. The Catholic Bishops Conference supports LB999 because it proposes what we believe is a conscientious, responsible, and justified response to issues that threaten the common good of providing access to medical care for many Nebraskans, especially the vulnerable, disadvantaged, and impoverished. Maintaining the status quo on hospital licenses for the period proposed by LB999 will enable the Legislature to thoroughly and adequately examine and respond to issues created by physician-owned for-profit hospitals, issues such as cost, competition, community benefits, and health system needs. Putting at risk the ability of Catholic and other community hospitals to provide essential high quality, comprehensive medical care, especially to the uninsured and underinsured truly would threaten the common good. Given this reality, a legislative response designed to provide time and opportunity for a thorough consideration of all relevant factors and issues is necessary and justified. LB999 reasonably facilitates just such a response and, therefore, we urge the committee to advance the bill to the full Legislature for debate on a matter of great significance for the communities and citizens of Nebraska. Thank you for your attention and consideration. [LB999]

SENATOR GAY: Thank you. Are there any questions? I don't see any. Thank you, Jim. [LB999]

JIM CUNNINGHAM: Great. Thank you. [LB999]

SENATOR GAY: All right, with that, let's say about 10 to 4 we'll get back here. That's about 10, 15 minutes to check your office, do whatever. [LB999]

BREAK []

SENATOR GAY: We'll get you to take your seats and we'll get rolling again here. We will get started and we'll get going, hear from opponents, so come on up and... [LB999]

SEAN DENNEY: (Exhibit 4) Hello, my name is Sean Denney, S-e-a-n D-e-n-n-e-y. I have a couple of things. I'm going to speak in opposition to LB999 today, and I also have to hand off a letter of opposition from the Nebraska Medical Association as well. Mr. Chairman, members of the committee, thank you for allowing me the opportunity to speak to you here today. My name is Sean Denney; I'm from McCook, Nebraska. I graduated from McCook High School and then, ultimately, Hastings College, and Creighton University is where I did all my medical training, pretty much through fellowship, medical school, and otherwise. I'm a physician there in Kearney and also the chair of the board for the new Kearney Regional Medical Center. It's been aptly said that our hospital in Kearney is no more a local hospital than Walmart is the local hardware store and, indeed, this is one of only five hospitals in our state that's run by an out-of-state corporation. Our local CEO earns a half million dollars a year which is more than double any of the family physicians in our town, and the national CEO earned $2.5 million for his work last year, based on the form 990 returns. All this, while our 35-year-old operating rooms deteriorate, a nearby small town clinic was abandoned last year and anesthesia equipment which had become outdated was not replaced, but was instead left in circulation, thus compromising patient care. Our most recent building campaign which was started several years ago, but was soon abandoned thereafter due to a perceived lack of finances has only half the floors finished at the present point in time. Our hospital is fabulously profitable, but when corporate mandated an across-the-board reduction in staffing by 3 percent, we were still hit with around 40 nursing and patient care job losses two weeks before Christmas in 2008. In 2009, we watched CHI strategize to gain statewide market share. By leveraging the cardiac services of Kearney into a proposed purchase of the Nebraska Heart Hospital here in town, the proposed combination would prove a financial windfall for the corporate entity by sending cardiac care east, but would endanger lives by eliminating the only full-service cardiac program between Lincoln and Denver. Last year we also watched our hospital hire two new gastroenterologists at the 90th percentile of pay in the nation to compete against the two existing private practice GI docs in town who don't earn anywhere near that amount of money. Competing with physicians in town is very easy for our hospital system, but working with them is a completely foreign concept, and has made negotiations to this point absolutely impossible. For all these reasons and probably a thousand more, 40 of the busiest physicians in town, half of whom are primary care physicians, decided to do something about this finally. We raised money by draining our retirement and savings accounts, took out loans, borrowed money from family members, and scraped together enough money to secure funding for a $20 million general community hospital project on our own. This is why this legislation is

such an affront to our healthcare community. This bill targets our Kearney Regional Medical Center project. Ours is the only project affected by the proposed moratorium time line, which by the way, has been in development for more than a year at this point. If this is not your intent, I would suggest you change the time line for the moratorium to either come after this project is completed and not in the midst of the...our construction. The only other project that's currently under construction is the joint UNMC and Bellevue Physician Hospital project that I'm aware of. I just can't understand why that project gets special consideration from LB999 while the Kearney project is torpedoed in the process. Most people I talk to don't think it's good public policy to target one project, spare another, and cost small town Nebraskans millions of invested dollars. If the intent of LB999 is to study the impact of for-profit hospitals on the community they serve, why don't we look currently at the Creighton University Medical Center, how it's affected North Omaha's medical care as the only other for-profit general hospital around. I'd also offer that we look at the Kearney project as an ideal test case to see how a general for-profit hospital such as our own will impact our region. Ours is going to be a small general hospital with an excellent emergency room trained by ER trained staff physicians, will offer an array of services from general medicine through gynecologic procedures, orthopedics, neurosurgery. We hope to expand it once we prove profitability to every procedure medical treatment we can to give care to all of the 400,000 patients in our region. There is some obvious hypocrisy present when nonprofit hospitals claim cherry-picking is the case, but hire physicians, and thus guarantee self-referrals to their own facility. They buy into for-profit ambulatory surgery centers such as the case both in Kearney as well as elsewhere and purchase specialty hospitals as CHI has done nationally for years and tried to do last year here in Lincoln. We'll take on charity care just as we do in our own private practices and surgery centers which amounts to more than $12 million a year in the largest clinics. We'll ensure our community will not lose service lines and trauma services, emergency services. Please remember that the physicians are the service lines, and we aren't going anywhere. We're all in practice in both hospitals, and we've never said we would be anything other than that. If the current hospital in town decides to eliminate service lines that aren't as profitable as we'd like, we'd roll those into the...our current project. In closing, please look with skepticism at the for-profit versus not-for-profit argument in medicine as it applies to Kearney, Nebraska. Please don't target this project alone with this bill as it's presently written, and please let the taxpaying citizens of Kearney decide what is best for Kearney, and let free market system play itself out in Kearney, Nebraska. Please don't legislate, but allow us to create a for-profit hospital that will pay at least $3.5 million in taxes annually and still provide better care than the competing nonprofit in town. Resist the temptation to legislate for national big business in a $12 billion national hospital system, and lastly, please help a local town regain local control of its local healthcare. Thank you very much for your time, and if you have any questions, I'd be more than happy to answer those as best as I can. [LB999]

SENATOR GAY: Thank you, Doctor. I've got a question for you. You said this has been

going on for about a year then of private investors... [LB999]

SEAN DENNEY: Yes, it has. Um-hum. [LB999]

SENATOR GAY: ...because I asked the other lady, and she thought when it became public was a few months...five months ago. So it's been about... [LB999]

SEAN DENNEY: About nine months ago actually. [LB999]

SENATOR GAY: ...okay, so somewhere in there. And then as far as investment goes, and you don't need to get into all the personal finances, of course, but...so when we talk about investors, is it a group...and for the record, I'm in Papillion, and I've helped, and I'm excited about the new hospital in Bellevue. And that to me is a physician-owned, the med center, and a...I think a private company with them. I don't know all the details, but it's a joint thing. But I guess on that, do you have a joint partner with this or is that the...down the road? [LB999]

SEAN DENNEY: At the present point in time, the funds have come, all but about 10 to 15 percent of the funds have come from the physician base in town, and so we've raised a significant amount of funding through the physician base in town. Our plan, ultimately, you know, until this came along was to start to extend that out to the local community and fully fund the rest of the project. Obviously, that's become about impossible with pending state legislation. We have 10 to 15 percent of the funded project is from our developers who are from Kansas. [LB999]

SENATOR GAY: Okay. Then another question I was interested then because I think in the process of the Bellevue Community...I think it's called the Bellevue Community Hospital...in that process, there was a federal...they had some issues where they...I think they had to go to Senator Nelson and get a waiver of this physician-owned...were you familiar with that? [LB999]

SEAN DENNEY: Certainly. The legislation that, you know, this comes around on an annual basis with regards to physician-owned hospital legislation. And, here again, this is a doc in Kearney trying to spin what I think is going on in Washington, but, in essence, the August deadline was what was negotiated by Senator Nelson for that project with the thought in mind that they'd certainly be done with their project at that point, and they would have their Medicare Medicaid licensure. The proposed moratorium and perhaps some other folks that are going to come after me can speak some more adequately to this. The proposed legislature at the federal level was targeting physician ownership dating back to say February of last year, and that would have completely annihilated that project with any kind of a physician-owned component to it. And so that's why the August...I think it was August 1st or something like that, deadline this year was chosen and negotiated in by Senator Nelson at one point in time

when the healthcare legislation was moving along. [LB999]

SENATOR GAY: So is that off the table now then as far as you understand to get a license...? [LB999]

SEAN DENNEY: It's tough...I think it changes on a daily basis, yeah. [LB999]

SENATOR GAY: So, and if you don't know, don't answer then... [LB999]

SEAN DENNEY: Yeah. [LB999]

SENATOR GAY: All right, thank you. Senator Gloor. [LB999]

SENATOR GLOOR: Thank you, Chairman Gay. Dr. Denney, this may surprise you, maybe in a positive way, but I'm certainly empathetic with the physicians and their frustration over dealing with a bigger entity, although I think if we're going to characterize CHI as Walmart, all the physicians would be employees by now. That would be, I think, a Walmart approach (laughter). And maybe that would be preferable to what's going on in some ways. [LB999]

SEAN DENNEY: In deference, I think we're moving towards that (laugh). [LB999]

SENATOR GLOOR: It may be as a country. And my frustration, we're losing a degree of autonomy of running the hospital in Grand Island. I tell you, that entered into my thoughts about trying to find something else to do with my life, and in all fairness to CHI, any place I looked to larger institutions, I realized some of that loss of autonomy seemed to be where healthcare was headed nationally. And so I...although I understand your frustration, I also think there's an inevitability here that's part of the national healthcare debate that we put out there. But I want you to understand, I certainly understand the degree of frustration that physicians feel about not having absolute local control over things. But my surprise in this came up is that the physicians brought this forward as a proprietary entity when there is a Mayo model, you know, an employed model. There are other models that are out there. Why is it that you decided on a for-profit model rather than perhaps something that might have been better received by a broader community whether it's not for profit or whether it's just an employed approach? [LB999]

SEAN DENNEY: Well, with the fabulous success that we've had with talking to our hospital thus far in regards to helping us out with this project or negotiating some kind of a common ground, we certainly did not think there was any option for a 501C-3 type of a model at play, number one. Number two, where would that funding come from would be option number two. Number three, with as much city in-growth as well as what I certainly wonder is some degree of statewide in-growth into the political system that the

current...our current hospital has. I really don't think we'd have been successful in garnishing support for that in a rapid fashion, and most likely, those kind of attempts would have died off. The most rapid way to do it is, I write a check; my buddy writes a check, and we ask everybody we know that is a close friend of ours to write a check...secure debt that direction and get the ball rolling. And certainly for us, we felt like that was something we needed to do because as I alluded to before, there is a lot of folks in our medical community that thought that we were losing control in a very rapid fashion, and that it was going to be only a matter of time before we did lose things like trauma services or cardiac services or things like that, and we just won't stand for it. [LB999]

SENATOR GLOOR: Can I ask a follow-up question? One of the testifiers, Mr. Rieker, talked about the transparency issues in healthcare, and although he didn't mention my name, he would tell you that I have talked to him for the past couple of years even before coming down here about the need for greater transparency, I thought, with hospitals across the state both for-profit and not-for-profit, sharing information that shows to the community that they've earned the right to not-for-profit status or if they're proprietary. Where does the money go? Does that legislation...regardless of what happens with your initiative, does that legislation concern you at all or would it bother you? [LB999]

SEAN DENNEY: Certainly. I think that would be an excellent step in regards to solving a lot of this for-profit versus not-for-profit issues. You know, in my own kind of searching for that kind of information, you know, I'm at a loss for why we can't find that easier, you know. I've got to pay $1,500 to, I think it was Guiding Star.com or something like that to get the...what's supposed to be provided at a required level on form 990's for something like Catholic Health Initiatives. Most of the people on our board have never seen a return for the local corporation, you know, and so, certainly, I think that people need to know if you have a nonprofit healthcare system, where does that money go? Is it spent in your local community? Does it go ultimately to an offshore account in the Cayman Islands of $140 million? You know, does it go to a CEO in Denver that gets paid a lot of money that we've never met before, and those are all things that I need to know, you know, in order for me to feel happy that I'm doing the work that I'm doing in the local community and not having equipment that I need as long as I know absolutely every penny that's left over is going to my grandma or my dad who walks through the door who may not have insurance. I'd be more than happy to do that, but when I start digging and I start finding that that isn't the case, certainly my frustration level rises, and there's no level of trust there with the healthcare organization that's in our community. [LB999]

SENATOR GLOOR: Okay. Thank you. [LB999]

SENATOR GAY: On that issue, I know Senator Grassley has been, for years, trying to figure that out, so it's a challenge. [LB999]

SENATOR GLOOR: Well, we'll give another senator with a G a chance (inaudible)(laughter). [LB999]

SENATOR GAY: Yeah, there you go (laugh). It's a challenge. On that then, Senator...on Senator Gloor's...just follow-up to that then, so the easiest and quickest route was your own money was certainly...that's my own money, and I'm not...as a business model, I don't want to put it in nonprofit model... [LB999]

SEAN DENNEY: Um-hum. [LB999]

SENATOR GAY: ...so that was...that clarifies that. [LB999]

SEAN DENNEY: Well, certainly that's to play as well. You know, if I'm going to put that kind of money up, I'd certainly like to see some kind of a return on it too, for that matter. Absolutely. But at the end of the day, to be absolutely honest, the spin side of that question is, is, you know, we talked about this before with federal legislation potentially coming down the pipe. You know, it seems crazy to a lot of our physician colleagues. Well, why would you guys jump in on this right now at this point in time when so much is at stake federal wise, you may not ever end up with any kind of a return on your investment. And that speaks to the reasons why the physicians in this project did what they did, you know, is is that we very well may need to sell every single penny of that to someone else or roll it ultimately over into a nonprofit at the end of the day, but it is very important for us to have another alternative place to practice in this community without doubt. [LB999]

SENATOR GAY: So you're answering my question earlier about the time frame because that to me...when we were talking on...I think when the hospital association was talking how long do you wait on these things, and I don't know. But that's why I asked him, and you're kind of covering that ground. This is your own money. One, two years, or whatever, this could go on for awhile, so you clarified that for me. [LB999]

SEAN DENNEY: Yeah, as this...as this legislation is presently written, this will certainly do in this project that we have constructed at the present point in time. [LB999]

SENATOR GAY: Okay, thanks. Any other questions? Senator Wallman. [LB999]

SENATOR WALLMAN: Do you feel like there's a danger of self-referral that was mentioned earlier, you know, if you get in financial trouble to increase your business? Do you see where I'm coming from? [LB999]

SEAN DENNEY: Well, you know, that's something that keeps being brought up, but I'm going to ask an alternate question is, is that when a hospital hires physicians to work for

them which is a model that's employed by nonprofits across the nation in a lot of different places. Where do those patients end up ultimately? They end up right in that hospital, and so, you know, the flip side of that is, is that you still end up having an issue of potential self-referral. But I think if you look at, you know, traditionally, what has happened as far as other physician-owned facilities, ambulatory surgery centers, you know, there's a lot of different things that physicians have owned traditionally that haven't been issues really as far as that is concerned. I just don't think that argument holds a lot of water, you know. The consumer, you know, if I say, oh well, you know, you need to come in, and you need to have an open heart surgery procedure, and you don't need an open heart surgery procedure, I think you're going to be the first one who says, wait a minute, what in the world is going on here, you know? And so, certainly, I think that, you know, is there potential? Yes. Is there potential on the other side of the coin? Absolutely, you know. And so I don't think you'll ever completely get away with any kind of legislation that targets necessarily self-referral. It's something that's going to be indigenous to the entire medical population no matter what model you have. [LB999]

SENATOR GAY: All right, thanks. Any other questions? I don't see any. Thank you. [LB999]

SEAN DENNEY: Thank you. [LB999]

JOHN SCHULTE: Senator Gay, members of the committee, my name is John Schulte, J-o-h-n S-c-h-u-l-t-e. I'm a member of the physician investment group who is hoping to provide an option in hospital care for our community. I'm also a longstanding member of the Kearney community. I'm here to express my opposition to LB999. This bill appears to be targeted directly at our hospital. You don't need a moratorium to do a study. In Kearney, they sometimes call me a local yokel. I grew up 15 miles from town. I went to high school at Pleasanton, Nebraska, 18 in my graduating class. I went to pre-med, undergraduate, University of Nebraska in Kearney, and I went to medical school at the University of Nebraska Medical Center. I went there for my residency training as well, and I'm very grateful for the educational opportunities that were given to me by the state of Nebraska. I'm in obstetrics and gynecology. I've been in practice in Kearney for approximately 30 years. I came in June of 1981. With my training and education, I could have gone anywhere in the world, but I chose to come to Kearney. Kearney is my community; it's my home. I now have two partners and a third one on the way. We have 18 full-time employees. I'm a businessman too. We buy their health insurance. We see Medicare; we see Medicaid, and the uninsured. We write off charges of nearly $2 million annually through my office. I say this not to brag, but just to make you aware that I believe it's my duty as sort of a payback to the citizens of Nebraska who subsidized my education. You may be wondering why a physician my age...I'm 58...would be involved in investing in a community hospital in Kearney. Why would I be willing to borrow money, mortgage what I own, and put myself at financial risk in order to compete with a huge powerful out-of-state corporation which is Catholic Health Initiatives? Let me

assure you, it's not for personal gain. I've invested in this hospital because I believe it's in the best interests of my community. I would not have become involved if I thought it would be harmful to my community or to those we serve. In my practice, I've been closely involved with Good Samaritan Hospital. Over 30 years I've served on almost every committee at the hospital, and I've chaired most of those committees. I've been the chief-of-staff and served on the hospital board. I have lived and worked with Good Samaritan Hospital for the last 30 years, and I want you to know I know what I'm talking about. Good Samaritan Hospital is not the problem. This institution has a fine reputation as a medical center serving our local community and our region estimated at 450,000 people. Maybe there's room for another hospital. Our hospital is frequently in contingency. What this means is that before we can admit a patient to the hospital, we need to contact the nursing supervisor so she can coordinate a patient being discharged, and we've got a room to put that patient in. Most of us think of Good Samaritan Hospital as our hospital, our community hospital. Sadly, it's not. It's owned and operated by CHI based in Denver, Colorado. Most decisions are made in Denver, not locally. Our hospital board is not the problem. They're well-intentioned, civic-minded individuals with only limited input. They get their information from our administrator who represents CHI. Significant decisions are guided by the administrator. The only information the board receives is from CHI. The outcome is always predetermined and always what CHI wants. I know, I sat on that board for years. Our administrator is not the problem. He works for CHI, not the local community. The administrators are hired by CHI, paid by CHI, moved around from community to community by CHI. They're told what to do and given goals to meet. They come and they go; they do their jobs. When I was on the hospital board, we didn't even know our administrator's salary. Our employees are not the problem. The dedication and hard work of the Poor Sisters of St. Francis lives on today, and the labors of our nurses support personnel and volunteers. The work ethic is strong in central Nebraska; these people make it all work. Our community is not the problem. Kearney is a progressive, forward looking city. Many have contributed much in time and money to help establish and maintain quality healthcare for our region. The physicians are not the problem. We work hard for those we serve. We live here; we raise our families; we pay taxes; we provide many jobs. We're honored by those who put their trust and their lives in our hands, and it's a privilege to be a physician in our community. CHI is the problem. They own 75 hospitals and 40 long-term care facilities in 19 states. A recent visit to their Web site revealed a $12 billion business; 2009 revenues were in excess of $8 billion in the midst of a recession. They showed $5.3 billion unencumbered assets; $3.8 billion unencumbered investments; over $700 million in cash, and third quarter of 2009, revenues in excess of expenses of $449 million. I'll finish up here quickly. I know they are listed as a nonprofit, but that sounds like profit to me. I don't know how you can have those kinds of assets and investments if you're putting everything back into the communities you serve. If they choose to decrease services such as trauma in Kearney, Nebraska, it's not due to a lack of resources. The citizens of Kearney deserve an option in hospital care. We did not come here to the state to ask you to help us accomplish this task. I do believe CHI

came here to try to stop us. We took this upon ourselves as physicians as our responsibility to our patients and our community. All I ask of you is not to get in our way. Let us prove to you what we can do. Do not take away our right as citizens of the state of Nebraska to engage in free enterprise and compete with the out-of-state money managers. Thank you for your time and please vote against LB999. [LB999]

SENATOR GAY: Thank you. Senator Stuthman. [LB999]

SENATOR STUTHMAN: Thank you, Senator Gay. Doctor, thank you for your testimony. In other words, this nonprofit hospital, what is currently there, correct? [LB999]

JOHN SCHULTE: Yes, sir. [LB999]

SENATOR STUTHMAN: The profit from it in which there is, according to your figures,... [LB999]

JOHN SCHULTE: Yes, sir. [LB999]

SENATOR STUTHMAN: ...from that is not being...is it being returned to the community or is it being reinvested in that hospital? [LB999]

JOHN SCHULTE: I wish I had some way to trace that down. I have no idea...well, I can't say I have no idea...I, in my estimates alone and with people I've talked to, they take somewhere around $20 million out of our community on a yearly basis. Now they say they're going to invest $65 million into our hospital. Well, they've been there since around 2000. They've had other projects, and, yes, I'm sure a lot of that money comes back, but I don't know. I don't know how to trace that down. [LB999]

SENATOR STUTHMAN: So, in other words, there's a possibility those dollars in a nonprofit organization establishment could leave the state? [LB999]

JOHN SCHULTE: I'm sure they're out of our state. [LB999]

SENATOR STUTHMAN: Okay. Okay, thank you. [LB999]

SENATOR GAY: I've got a question for you. You mentioned 450,000 residents. Is that that 19-county area or...? [LB999]

JOHN SCHULTE: It's the general service area, yes, extending down into the northern tier of counties in Kansas. [LB999]

SENATOR GAY: And then I guess on that, then the proponents were talking about the 18...we're talking the same market area pretty much. [LB999]

JOHN SCHULTE: Yes, yes. [LB999]

SENATOR GAY: So you're going west and south? [LB999]

JOHN SCHULTE: Oh, certainly. [LB999]

SENATOR GAY: Because if you're coming east, you're running into...is it the same market area as Grand Island? [LB999]

JOHN SCHULTE: Grand Island is east of us, and... [LB999]

SENATOR GAY: Yeah, but... [LB999]

JOHN SCHULTE: ...and they're 45 miles east, and we overlap a little bit with Grand Island to the east. [LB999]

SENATOR GAY: But you're mainly looking past... [LB999]

JOHN SCHULTE: But to the west and to the north and to the south, we extend to very large areas. Grand Island and Kearney overlap somewhat to the north in communities such as Ord and Loup City, but it's not uncommon for us to have patients that come from 150 miles to the west and hundreds of miles to the north and south. [LB999]

SENATOR GAY: Yeah, and I'm trying to relate that back to what is the number of service per hospital. The prior gentleman was talking about in a small community. Well, if you're talking 450,000 is a lot different than what's the size of Kearney? [LB999]

JOHN SCHULTE: Kearney's population is around 30,000. [LB999]

SENATOR GAY: And with the students and things? [LB999]

JOHN SCHULTE: Yes. [LB999]

SENATOR GAY: Yeah, so we're talking a much larger area than just the community of... [LB999]

JOHN SCHULTE: Oh, it's a much larger area and... [LB999]

SENATOR GAY: ...I mean, not that I've never been to Kearney, believe me, I just didn't know that (laughter). [LB999]

JOHN SCHULTE: But I really think that many of your hospitals in Lincoln and Omaha

would not serve the... [LB999]

SENATOR GAY: Yeah. [LB999]

JOHN SCHULTE: ...numbers of people that we're trying to serve there in Kearney, Nebraska. [LB999]

SENATOR GAY: That's something we could check into as well, so. All right, any other questions? Senator Gloor. [LB999]

SENATOR GLOOR: Thank you, Chairman Gay. Dr. Schulte, you had mentioned the fact that you had received some sort of benefit from the state, and that's one of the reasons, admirably, you decided to stay in the state and practice. Is that correct? [LB999]

JOHN SCHULTE: That's part of the reason, yes, plus I've got roots in Kearney. My parents, my grandparents, my wife's parents. Kearney is a great town to raise your family, raise your kids. [LB999]

SENATOR GLOOR: But did you get loan forgiveness or...I mean, did the state invest in some way, shape, or form in your education? [LB999]

JOHN SCHULTE: I got no loan forgiveness. I...I credit the state with their contributions towards maintaining the higher education level system. You know, they...they kept my tuition much lower than it would have been had I needed to have gone to a private school. I think the state gave me wonderful opportunities. [LB999]

SENATOR GLOOR: Well, and, you know, this isn't an issue of who's right and who's wrong. It's an issue of the broader issue for the Legislature is, when we're approached by the state schools to make sure we provide adequate funding, all that is part and parcel of the challenge we have about where the healthcare dollars go and how do they get spent. Do you have concern about being able to have the staffing necessary to provide the services that you expect in your new hospital? [LB999]

JOHN SCHULTE: I'm sorry. I'm not sure I follow your question. In our new hospital, having enough staff? [LB999]

SENATOR GLOOR: Yeah, having enough staff to be able to come up with the pharmacist that you expect and the lab and...and what you would expect for quality service for your patients. [LB999]

JOHN SCHULTE: I don't think there's going to be any problem coming up with pharmacists or having lab work available. I'm... [LB999]

SENATOR GLOOR: Do you expect to do 24/7 for some of those key services like pharmacy and lab imaging department? [LB999]

JOHN SCHULTE: I don't really know. I've not been involved in the nuts and bolts of that part of the operation. [LB999]

SENATOR GLOOR: But it would be...but your hope I'm sure would be...if that's what you're used to, that's what you hope to be able to have. [LB999]

JOHN SCHULTE: And I do know that we're going to have 24-hour emergency room availability, yes. [LB999]

SENATOR GLOOR: Okay. Thank you. [LB999]

SENATOR GAY: Senator Stuthman. [LB999]

SENATOR STUTHMAN: Thank you, Senator Gay. Doctor, in your comments when I made the question to you, would you feel more comfortable if the not-for-profit status and the profit generated from that would be identified as to going back to the community or back to that operation? Is that where the gray area is? [LB999]

JOHN SCHULTE: Well, that's one area, and it's not just the money. It's more local control. I don't feel like our local community has any control in our hospital anymore. I don't feel like the monies, the revenues that are generated there are being put back into the community. They may be held in accounts in Denver with Good Samaritan Hospital's name on them, but we can't access them, not without their permission. I just feel like it's...we need a community hospital where we have some input; where we have some control. Yes, it'd be...it would be helpful if we at least knew where the money was going and knowing that it was all coming back. That would make us feel better about things. But if we still have no say in the control of how those funds are spent, if we have no say in whether to do a major investment or to finish up, you know, the last $45 million project, half of which is sitting empty while we're on contingency plans, you know, we don't have beds. You know, we'd like to have some input, and we're just not getting through to CHI. They're too big; they're too powerful. They don't listen. I don't think they're interested in our community. [LB999]

SENATOR STUTHMAN: So Doctor, your biggest concern is, you know, where the profits be, where the profit's ending up at, and more concerned with the local control. [LB999]

JOHN SCHULTE: I would put local control first. [LB999]

SENATOR STUTHMAN: Okay, okay. Thank you. [LB999]

JOHN SCHULTE: Yes, sir. [LB999]

SENATOR GAY: I don't see any other questions. Thank you. [LB999]

JOHN SCHULTE: Thank you. [LB999]

LARRY SPEICHER: Mr. Chairman, members, my name is Larry Speicher, S-p-e-i-c-h-e-r. And Larry is spelled L-a-r-r-y. Thank you for your time today to listen to us discuss these issues. I'm the administrator of Platte Valley Medical Group in Kearney. I was raised in Kearney. I graduated from Kearney State College. I went to work at St. Elizabeth Community Health Center in Lincoln for four years. Then I went on to receive my graduate degree in health administration from the University of Missouri in Columbia, and then I made my way back to Kearney through a...working at a health insurance organization in the managed care operations division where I helped develop health plans in various markets throughout the United States. So I've spent my entire career on the business side of healthcare, learning about the economics and how it impacts patient care services through various healthcare delivery models. Platte Valley Medical Group, we're a multi-specialty physician organization. We have 28 providers. We have 150 employees. As an employer, we provide health insurance through a self-funded plan, and that requires constant attention to the monthly claims that are paid. It's a very anxious time to look at our healthcare costs, and Kearney is a very expensive market for purchasing hospital services, and I just want to talk a little bit about transparency regarding hospital services. Our hospital expenditures each year ranges from 50 to 55 percent of total claims paid. According to a Kaiser Family Foundation study, healthcare expenditures for hospital care in Nebraska range from 40 to 43 percent during the years 1991 to 2004. I couldn't find any more recent data than that, and a national average for hospital expenditures equaled 38 percent. All right? And based on our average of 53 percent compared with the state's average of 40 percent, this amounts to nearly 33 percent more in costs for hospital services in Kearney and nearly 40 percent higher than the national average. And the uninsured are no better off in this market. According to the 2005 Nebraska Center for Rural Health Research Study, costs are as much as three times higher in central compared to eastern Nebraska. To further illustrate pricing discrepancies, a local independent cath lab charges, on average, $5,500 for an outpatient diagnostic cath and receives a total reimbursement...an average reimbursement from all payers of about $2,000. Good Samaritan charges approximately $9,000 for the same service and receives approximately $5,000 in average reimbursement from all payers. This is 125 percent higher reimbursement. In a recent phone call...so as an employer, I don't know what to do. I don't know where...you know, and I'm concerned about the local pricing. I called an eastern Nebraska hospital and learned that I could send one of our employees in need of cardiac care to this hospital to have a single vessel, single stent placement with an

overnight stay of a cost ranging from $12,000 to $15,000. In Kearney, that cost for that same procedure would cost us $30,000 to $35,000. This is double the cost for a self-funded health plan, and we can't afford this. Employers in the market can't afford that. The employees can't afford because they're paying their high deductibles; they can't afford that in central Nebraska. And we're all looking for better solutions; we're looking for transparency. The CHI Hospital in Kearney is a tertiary care hospital in a rural market, and they have a monopoly on the hospital services market. Cost savings for the citizens of central Nebraska will be difficult to achieve if LB999 is enacted, and physicians recognize more than ever the need to organize and work together in a unified constituency for the purpose of improving service, access, cost, and quality measures. And physicians know what is best for patients they serve in terms of resource commitment and health management. In federal and state governments, you're looking for solutions to control costs without sacrificing quality, and if this law is enacted, you'll be eliminating the most suitable stakeholder in healthcare that will guarantee access for patients, reduce costs, and respond to any quality benchmark measures that is required from purchases of healthcare. I think an unintended consequence for your consideration with LB999 is by preventing physicians from organizing and implementing new healthcare delivery models, you'll be preserving the existing pricing models and the monopoly for hospital services in our region, and this would eliminate the opportunities for physicians and hospital...any hospitals to pursue negotiations in a meaningful way. So, thank you very much for your time. [LB999]

SENATOR GAY: Thank you. Senator Gloor. [LB999]

SENATOR GLOOR: Thank you, Chairman Gay. Mr. Speicher, for the board's benefit is...then I go back a ways...yes, I'm sorry...not far enough, obviously. (Laughter) He's a good (inaudible) and does know his business, but let me ask you a question. [LB999]

LARRY SPEICHER: Okay. [LB999]

SENATOR GLOOR: Do you know, when you look at the numbers, are the charges of Kearney...for Kearney's acute care. I won't look at the physician...I'll just look at the hospital's (inaudible)...higher than metropolitan Omaha's or Lincoln. Have you seen any numbers there? [LB999]

LARRY SPEICHER: The limit...I haven't done a comprehensive study, but based on what I've seen, EES...their charge masters are higher. The insurance, the pricing models are different. They're higher in central Nebraska, I believe that based on my limited research. [LB999]

SENATOR GLOOR: Of course, the charging is one thing; reimbursement is another... [LB999]

LARRY SPEICHER: That's exactly... [LB999]

SENATOR GLOOR: ...what's your experience with Platte Valley Medical Group? [LB999]

LARRY SPEICHER: That's a very good point. My experience as a purchaser of healthcare is that the local hospital has a different reimbursement structure than Omaha and Lincoln hospitals, in particular, with certain health plans. A lot of self-funded employers have a rental network like Midlands Choice or Coventry. They might rent to Coventry Network. Those contracts typically...rural hospitals and tertiary care hospitals in rural markets like to negotiate a percent of discount off of bill charges instead of per diems or case rates, and so they can bill us as high as they want. If it's a 20 percent or a 15 percent discount off of bill charges, they have the ability to...you're talking about self-referral. I would talk about self-regulating price increases in markets where there is a monopoly. [LB999]

SENATOR GLOOR: Of course... [LB999]

LARRY SPEICHER: With private insurance, I'm not referring to Medicare and Medicaid. I'm just referring to private insurance, and I don't know what Blue Cross has for a contract. [LB999]

SENATOR GLOOR: The problem in most cases with the competitive model is, other than Good Samaritan, apparently, from what you're saying, in most cases the most expensive hospitals in the state have been in the only communities that still have multiple hospitals...Omaha and Lincoln markets, and communities that did consolidate have stayed sizably under whether it's Norfolk most recently, Grand Island, Scottsbluff, even years ago, Columbus, North Platte, and there were other communities that had multiple hospitals. [LB999]

LARRY SPEICHER: And...and those communities had multiple hospitals, but those models were different than they are today because these are physician-driven models, and I would like to see more cooperation and ways to integrate to control costs, but I...you know, working on the business side, physicians know what resources are needed for patients. They're very good at going into an OR and say here's what we need to do. They're very efficient, and they need to...we need to enable them to have that control and designing delivery systems when it comes to patient care because they understand the work flow and the work design and the work processes that goes into the input and output of dollars. And when you talk to them about this, it's amazing what they understand, and I very much enjoy working with physicians. [LB999]

SENATOR GLOOR: Is the only solution here then ownership or can there be potential for gain-sharing models, and I understand there's some federal regulations that

occasionally get in the way. But above and beyond... [LB999]

LARRY SPEICHER: Yeah, and that's the frustration is that, you know, when you depend on a regulation it may be phased out...under arrangements have been phased out in metropolitan markets, and these under arrangements that see...that Good Samaritan CHI is potentially looking at, we don't know what's going to happen, and we're not...you know, we're not sure that there's going to be a favorable outcome to continue that control that the physicians would need. [LB999]

SENATOR GLOOR: Okay. Thank you. [LB999]

LARRY SPEICHER: Thank you all very much. Thank you. [LB999]

SENATOR GAY: I've got a question for you. Hold on. [LB999]

LARRY SPEICHER: I'm sorry. [LB999]

SENATOR GAY: So I grew up in Columbus, Nebraska, and Senator Stuthman claims he's from Platte Center, but he spends a lot of his time in Columbus. But on this...so Columbus we're 85 miles from...or my mother is still here, and family...they're 85 miles from Omaha and all the resources there. You're talking about central Nebraska, but you have Grand Island. Would those models then...and I just want your general because I know you haven't done a detailed study so...but then the resident in a Columbus or Norfolk or somebody like that, who Columbus has a brand new...newer hospital. They may be running the case too, the better services they're getting just because they didn't go to Omaha could be quite a bit higher than is what you're kind of...or not necessarily. [LB999]

LARRY SPEICHER: Well, they're a community hospital and what I've observed is that community hospitals with strong leadership work very well with physicians and try to look at different delivery models. And it depends on what services are provided. As they add services, some of the more expensive services...cardiac, orthopedic, trauma...if those services stay competitive from a pricing perspective, they're going to capture the market share and keep...the physicians are going to be very busy. The patients are going to want to go to those physicians because Columbus, I'm sure, would have done a good job of recruiting high quality physicians. [LB999]

SENATOR GAY: Yeah, and I know you don't want to speak of...but the problem we have here, I think, a little bit is I toured...Norfolk is expanding their hospital. I was up there touring that with Speaker Flood and been to the Columbus one because my mother had some knee surgery done there, and they have a relationship where they're going back and forth. And they will send patients based on their specialties. See, and I think that's a little bit of what we're trying to do a global view here that we know...know

all, and I'm a little bit worried about that when we say we're going to do some more studying. But I guess what you brought up...how would I find out information, though, about some of those fees? Is it just...it's probably not easy to get. It sounds like you put a lot of time into it. [LB999]

LARRY SPEICHER: You know, I guess the best...there's some national data out there that individuals after the meeting can reference. I don't know specifically. There's information you can buy from various healthcare organizations... [LB999]

SENATOR GAY: By regions...but would it be...? [LB999]

LARRY SPEICHER: ...that sell, but, you know, you don't know exactly what hospital or what market you're talking about. I go off of claims, explanation of benefits, and I've accumulated a number of those throughout the years, so... [LB999]

SENATOR GAY: But to be accurate it would have to be pretty well detailed. [LB999]

LARRY SPEICHER: ...and there's nothing better than an explanation of payment from an insurance company or from Medicare that show what the charges are and what's been allowed for reimbursement. [LB999]

SENATOR GAY: All right. Thank you. Any other questions? I don't see any. Thank you. [LB999]

LARRY SPEICHER: Thank you, everyone. [LB999]

MOLLY SANDVIG: Good afternoon, Senator Gay and other senators on the committee. Thank you for your time today. My name is Molly Sandvig, M-o-l-l-y S-a-n-d-v-i-g. I am the executive director of the national trade association that represents doctor-owned hospitals in the country. It's called Physician Hospitals of America, and I'm here today to provide some national perspective on really what's going on in Nebraska and in Kearney specifically. I've seen this personally, this issue, this scenario played out at other communities, other states around the country. This is not a new story, circumstances are not different. And really everything comes down to the real issue behind all this is doctors really wanting to provide the best possible care they can for their patients. And the way that they found to do that is through personal governance. So I know...I'm happy to comment on a number of things that have already been brought up today. But I'll give you a little bit of background on who we are nationally, who physician-owned hospitals are. From historical perspective, up until about 1946 there was no differentiation between doctor-owned hospitals or any other type of hospitals. Everything was doctor-owned or county-owned until 1946 when Hill-Burton basically created the system, and everything since there has skyrocketed. So you can see the real reemergence of doctor ownership starting in the early nineties. And

everything behind doctor ownership has come again from the need for doctors to govern their own hospitals. In a MedPAC study that was done back in 2005, MedPAC stated that physicians wanted to control decisions made about the patient care areas of hospitals so they can improve quality care provided, improve productivity, and make the hospitals more convenient to them and their patients. MedPAC and CMS both found that this is the number one reason doctors want to own hospitals. Who we are nationally right now: There are about 260 physician-owned hospitals in the country that are in existence right now, another 100 under development. We are made up of every type of hospital you can imagine: general hospitals, specialty hospitals which have actually been referenced on a number of occasions this afternoon so far. Women's, children's, rehab, LTACH, anything you can imagine is a doctor-owned hospital nowadays. The most interesting trend we see nationally is that the general hospital model is the biggest growing model nationally. That's because of two reasons. First, everything that is being done at the community level doctors can do at their hospitals, and they're doing it very well. Second, there's an economic need, frankly, in a number of communities for doctors to step up to the plate and rescue hospitals that are going bankrupt, and that's happening at a number of communities across the country. One of the, I think, most interesting trends that we've seen at physician hospitals across the country is that on average 5.3 percent of charity care and bad debt and patient write-offs basically is the national average of charity care, bad debt that's done at physician-owned hospitals. That's actually higher than nonprofit hospitals across the country. And when CMS looked at the net community benefit that physician-owned hospitals provide across the board to the communities in which they operate, they found that considering taxes paid, considering charity care and bad debt write-off the net community benefit of a physician-owned hospital is eight times higher than that of a nonprofit hospital. With that said, we found across the country, as one of the previous testifiers has mentioned, that quality care at physician-owned hospitals is incomparable. Consumer Reports came out in August of 2009 with a study that declared basically in every state that a physician-owned hospital is located, they are almost number one or number two, including the state of Nebraska, the top-ranked hospitals in the state of Nebraska by Consumer Reports are both physician-owned. There have been a number of arguments made today. I'd love to address each of them. I'm afraid I don't have time to do all of that, but cherry-picking. Doctor hospitals do not cherry-pick patients based on whether they can pay or not. Doctor-owned hospitals take Medicare, they take Medicaid. On a national level, over 30 percent of the net revenue gained by physician-owned hospitals is because of Medicare/Medicaid. Like I said, they do charity care also. There has been a number of folks have addressed a couple of issues regarding self-referral. Let me just touch on that briefly. There's a great deal of talk about self-referral nationally, but to understand the concept of self-referral, you have to understand that everything that a doctor does is a self-referral, whether they're employed, whether they're not employed. Now most of the monies that doctors make actually come from the private, the actual fund that you pay when you are a patient you pay your doctor. You pay the hospital, you pay your doctor. If there was a motive to self-refer, it would be because of that money. It

wouldn't be because of the additional monies made through hospital ownership. That's a very, very small percentage of what physicians actually make on a procedure. In addition, there are a number of issues that have been raised, of course, on employed physicians, hospitals that have their own insurance plan and only refer to those plans as well. So any time that that occurs, that's the ultimate form of self-referral really. I see that my time is up, and there's a lot more I'd love to cover. I'm happy to take any questions you might have. [LB999]

SENATOR GAY: Thank you. Senator Gloor. [LB999]

SENATOR GLOOR: Thank you, Chairman Gay. I don't doubt a lot of your numbers. But one of the numbers that I've asked for and no one has ever been able to get me is, are there any numbers that relate to utilization within population bases where proprietary entities go in? Obviously, you can do a lot of wonderful, good things, provide a lot of charity care and services and reach out to the community and buy balloons for United Way celebrations if the utilization goes up such that you're generating enough revenue to do all those good things. I have been told that that's a problem in communities where there's proprietary entities in healthcare, whether it's an imaging center or ASC or proprietary hospital. Is there information like that that's out there that...because we're a payer. I mean as we sit here... [LB999]

MOLLY SANDVIG: Yes, absolutely, absolutely. [LB999]

SENATOR GLOOR: ...the state's a payer of those services. [LB999]

MOLLY SANDVIG: There is information but here's the thing--it's on both sides. There's information that says there's no overutilization, that numbers do not increase, and there's information that says hospitals that have ownership and ASCs that have ownership do increase. So it goes both ways. The CBO, Congressional Budget Office, has been dealing with this issue with no success, frankly, for two years. And we have looked at it a number of times, as have other entities. Frankly, it's inconclusive. What we find happens oftentimes when a doctor-owned hospital comes into a community is that they're able to grow the market because it becomes a center for healthcare excellence. Patients who were otherwise leaving and leaving the catchment area basically now stay. So there's increase capacity because of that, and that capacity is typically met by patients coming in, patients staying. And in rural areas such as Kearney, oftentimes they're much better able to recruit doctors, specialists, people who may not otherwise see the value of living in Kearney, although I would. I'm from Sioux Falls, South Dakota, so that's, you know, I understand those sorts of things. It's just a matter, frankly, of looking at the numbers in each area, and typically there's numbers on both sides. [LB999]

SENATOR GLOOR: But I believe part of the concern here with utilization and do I

believe you can make the pie bigger, I do. But our responsibility would be to those additional pie...does that pie growth come at the expense of the Lexingtons and the Holdreges and the McCooks and some of the smaller communities around there that are already subsidized cost? And so that's where I think some of the cost shifting and is the state going to be picking up a larger share of a market share growth in Kearney community with a subsidization of that lost market share in the surrounding critical access hospitals? [LB999]

MOLLY SANDVIG: I can tell you I'm not as familiar with geographically with Kearney as I am other areas, but where I've seen this sort of thing happen in the Sioux City area, Sioux City, Iowa, which was mentioned earlier, all of the doctors that own parts of the hospitals practice in those communities too. And so what they do is they keep their patients there. They still practice at those hospitals. They don't drop their privileges at all these smaller places. They keep their privileges. They keep their patients there. And when they need to bring them in, they bring them in. But it doesn't tend to harm that hospital because those doctors continue to practice at all those facilities if that helps. [LB999]

SENATOR GLOOR: Okay. Thank you. [LB999]

SENATOR GAY: Thank you. Anything else? I don't see any. I guess one thing I was going to ask and Senator Gloor kind of covered it as well, but the information we were handed out, why the Hospital Association, obviously you have the same...could get to us that we could pour through that as well. [LB999]

MOLLY SANDVIG: Yes. Absolutely. [LB999]

SENATOR GAY: And if you would want to give some in the interest of fairness, feel free to turn it in and we'll put it in...get it distributed if you (inaudible). [LB999]

MOLLY SANDVIG: Certainly. I have all of the studies that have been done here under the federal moratorium. I was there in D.C. when then CMS director Mark McClellan said, you know what? We've studies these hospitals. We think they're good. No more moratoriums. So I think that might be helpful for you as well, and I will certainly enter that if you'd like. [LB999]

SENATOR GAY: All right, thank you. Thank you. [LB999]

MOLLY SANDVIG: Thank you. [LB999]

ROBERT MESSBARGER: Chairman Gay, members of the committee, I appreciate the opportunity to speak today. My name is Robert Messbarger, R-o-b-e-r-t M-e-s-s-b-a-r-g-e-r. I'm a family physician from Kearney. I was born in Kearney at Good

Samaritan Hospital. I grew up in Kearney and graduated from Kearney State College. I attended University of Nebraska Medical Center and then completed my family practice residency here in Lincoln. I returned to Kearney to join Family Practice Associates, currently comprised of seven family physicians. I've been in practice in Kearney for 17 years, and I'm also the associate program director of the family practice residency program, Rural Training Track, in Kearney. I believe this background is relevant to help you understand just how important the regional community of Kearney is to me and how committed I am to the delivery of high-quality healthcare to my patients. As a primary care physician, I feel I'm the strongest advocate for my patients in regards to their healthcare. Good Samaritan Hospital is an excellent medical facility. It has an outstanding staff of caregivers ranging from the nurses and pharmacists to the ward secretaries and volunteer services. There are many wonderful and dedicated people at Good Samaritan Hospital, and that is the true reason for the high-quality of care delivered there. I, as well as all of the other physician investors, fully intend to continue to provide care for our patients at Good Samaritan Hospital with a second hospital in town. We are committed to continue to work with Good Samaritan and provide all of the services that are currently offered. The problem, as you've heard, is that there's no local control to assure that decisions made regarding healthcare delivery at our hospital is in the best interest of our local community. Catholic Health Initiatives is a very large corporate entity. I respect their mission, and I'm sure there are some communities that are greatly helped by their presence. From my perspective, the root of the problem in Kearney is that when decisions are made, they are made based on a corporate agenda and not a local or regional agenda. Specifically under CHI governance, there's no real local control of capital reinvestment, which is impacted on the quality of our facilities. Also there's been consideration for consolidation of service lines by CHI Nebraska that's posed a threat to our community. In our present situation, if CHI decides to remove the service line from our community, we have no recourse to respond to that threat. As a physician who was born and raised in Kearney, I care deeply about our community and the patients we serve. I care deeply about Good Samaritan and its staff. Through a tremendous amount of soul searching, I have come to believe that the best thing for Kearney regional community is a hospital that has local control and governance. CHI just does not allow this to happen, thus the need for a new Kearney regional medical center that truly represents our community. I believe a community hospital with local control and governance will also make CHI more accountable to the healthcare needs of our community. I stand before you today as one primary care provider from Kearney who's passionate about the delivery of healthcare for my patients. But I believe it's important to realize that of the 40 physician investors involved in this mission for a true community hospital, 19 are primary care providers. It's also important to realize that we have agreed to reengage in negotiations with Good Samaritan Hospital to try and solve this issue locally. In closing, I ask this committee please do not allow this bill to take away the only meaningful way we have to effect positive change for our community's healthcare needs. And I thank you for your time and consideration. [LB999]

SENATOR GAY: Thank you. Any questions? I don't see any. Thank you. [LB999]

DOUG NUTTER: My name is Doug Nutter from Kearney, Nebraska, spelled D-o-u-g N-u-t-t-e-r. I come as a consumer. I am what is probably referred to by Catholic Health Initiatives as a cash cow because I have a file about the thickness of an arm. I've been very satisfied with the performance of the staff and the doctors. I've been less than satisfied with some of the policies of CHI specifically. A lot of those concerns have been specifically because of the things that have already been addressed. I can tell you that I started out with a whole page that has been redacted as information comes out, and I still have some, so I'm going to share some of that with you. Part of this, I wish that this hearing had happened a year ago. It would have been very helpful so that we don't have the acrimony that we have in Kearney, Nebraska, right now. We have an awful lot of people that see CHI as the 500-pound canary that sits wherever it wants. And there's a lot of us that feel like we need to designate a perch now because there is a place. There are some people who have feelings that when the doctors announced that they were going to build a hospital that all of a sudden things started happening and the timing stinks, quite frankly. The first thing that happened was immediately we had an announcement from CHI that they were going to invest $64 to $65 million in our hospital, and this was immediately after it had been making cutbacks, which was referred to a number of people just before Christmas. Didn't do public relations a bit of good. There are a number of people who have problems with special privileges that the charitable organizations get because we have a longstanding policy of separation of church and state. And there's a perception, maybe not accurate, but there is a perception amongst a lot of the people that I know in Kearney that CHI is using the Legislature to do their dirty work, quite frankly. Now there's a lot of people here that are a lot more gentlemanly than I am, but I'm more likely to call a spade a spade as I see it. There's been on two occasions in the Hub letters from people in the medical community referring to some decisions that I don't know for sure if they were discussed or not, but the second letter had a lot of credibility with me. And that is that there was some discussions, some serious discussions on the part of CHI to pull some of their services out of Kearney if we go ahead with LB999. And that were to happen, we would have a serious problem on our hands because we have no alternative to pursue. We have no way of building another facility, you know, if we have a moratorium in place. Our physicians are doing everything in their power to provide a great service--I'm going back to script here--at reasonable prices in our community. They have made a tremendous investment in their education. As taxpayers, we have a tremendous investment in their education. We invest nearly $100,000 in every high school graduate alone in this state and a lot more in every one of the graduates that are licensed to practice. These physicians live in our community. They work in our community. They raise their children in our community. They have a stake in our community. And they're not going to follow business practices that are counter, you know, to the best interests of the community. Their interest and the interest of the community are intertwined. That's not true of a corporation that's several hundred miles away. They look at their bottom line and that's

it. That's a lot of what most of the problems are in this country right now in a lot of areas, including healthcare. I ask you as legislators to refrain from hobbling the workings of free enterprise. This great country was founded on the principles of free and fair enterprise, and the function of government is to ensure both freedom and fairness to all parties. And I think that's where a lot of your work right now is headed is to ensure that you have both the freedom to operate in business and fairness to all parties involved and as consumers, investors, employees, everybody. LB999 is designed to do neither. All it is, is just a roadblock. I ask you to defeat it. And from your perspective as you're looking at your pieces of paper there, when you look at LB999, and I look at it from my perspective, I see 666. (Laugh) [LB999]

SENATOR GAY: Thank you. Senator Gloor. Hold on, we got a question for you. [LB999]

DOUG NUTTER: Okay. [LB999]

SENATOR GLOOR: I'm going to give you an opportunity to be not gentlemanly if you want to. [LB999]

DOUG NUTTER: Okay. [LB999]

SENATOR GLOOR: Do you think I'm one of the CHI conspiracy folks that are out there? You understand, I used to work for the CEO of St. Francis Medical Center (laughter). I mean, you're not under oath. You can say what you want, but... [LB999]

DOUG NUTTER: I think that CHI is so far removed from the needs of Kearney, Nebraska, that they cannot relate, and I think that's probably a foundation of what most of the problems are that we have in Kearney right now. [LB999]

SENATOR GLOOR: Well, I'm sorry, but that's not an answer to the question. [LB999]

DOUG NUTTER: Okay, go ahead. [LB999]

SENATOR GLOOR: The...the... [LB999]

DOUG NUTTER: Am I conspiracy? No. [LB999]

SENATOR GLOOR: But do you think that senators like myself are involved in as a result of interaction with CHI, making...throwing up hurdles just on behalf of CHI to make life difficult for the Kearney physicians who are interested in doing this? [LB999]

DOUG NUTTER: Honestly, it occurred to me. [LB999]

SENATOR GLOOR: Okay. Let me share a couple of things to you. First of all, I took

great pleasure in building market share when I was at St. Francis, and I enjoyed taking that market share away from Kearney, and I enjoyed taking it away from Hastings. My peers and friends who were still in the business find it very humorous that I would be charged with trying to shore up Good Samaritan given how many years I worked to take business away from Good Samaritan (laughter) even though it was a sister hospital. But I was evaluated and rewarded based upon building market share, and it didn't make any difference where it came from. [LB999]

DOUG NUTTER: I understand that. [LB999]

SENATOR GLOOR: So understand that I don't have it built in my genes to protect Good Samaritan in any way, shape, or form. The second thing is, no one from CHI...and I appreciate your being candid with me because it gives me an opportunity to respond to the multiple e-mails and letters that I have gotten accusing me of being in CHI's back pocket. I have no relationship with CHI, and, in fact, no one from CHI at either the out-of-state level or Lincoln has been in contact with me except one phone call from Steve Loveless in early January and one phone call from my replacement in Grand Island about two weeks ago...brief conversations that...did they have to do with the subject? Yes, but that's two phone calls over a two-month period of time. I will also tell you this, and it's a personal story. My daughter has been unemployed in Denver for 18 months, and there was a position open at CHI for which she was qualified and went in and applied for that position, and they knew who she was and knew who her father was. She couldn't get an interview. Now if CHI considers me to be in their back pocket, they certainly could have at least given my daughter an interview (laughter). And you think about that a little bit, and I hope we'll understand the fact that what concerns me is that if there's a large cadre of people in Kearney who think that the concerns of the Legislature are built around a conspiracy, that's a bad foundation to build a hospital...a new hospital venture on. I make decisions based upon the business aspects of it, and I'm telling you, this is not an effort to go out and get the Kearney physicians who want to do this. This is a discussion about the broader issues, and what the state may have to pay for as a result of this, and what the ramifications are for other hospitals like this going up across the state. Thank you for giving me the opportunity to voice it. [LB999]

DOUG NUTTER: That's quite all right. May I reply? [LB999]

SENATOR GLOOR: Absolutely. (inaudible) sure. [LB999]

DOUG NUTTER: Since the hearings began, I started out with two pages and half of it has been redacted since we began. Given the mood of the people towards government right now, I think that there's a lot of communication that needs to take place and a lot of transparency that needs to take place. We've been talking about that, and that's great. [LB999]

SENATOR GLOOR: You're welcome to call me. We'll have a cup of coffee over some of those concerns. I'd be glad to talk to you. [LB999]

DOUG NUTTER: All right. [LB999]

SENATOR GAY: Thank you. Any other questions? [LB999]

DOUG NUTTER: Anybody. [LB999]

SENATOR GAY: Thank you very much. Any other opponents? No other opponents? All right. [LB999]

SENATOR HOWARD: Don't encourage them (laughter). [LB999]

SENATOR GAY: I'm not going to ask again (laughter). All right. How many neutral? I know we got one, two, three...a couple. Come on up. [LB999]

ROBIN LINAFELTER: (Exhibit 5) Thank you, Senator Gay, for allowing me to testify. My name is Robin Linafelter, L-i-n-a-f-e-l-t-e-r, and I am the CEO of the Lincoln Surgical Hospital here in Lincoln, Nebraska, which is a 100 percent physician-owned facility. I am here as a neutral party in this debate. While I thoroughly support physician-owned hospitals and what they do and what they provide, it is the opinion of the board of the Lincoln Surgical Hospital that this is not an issue that affects us directly. But I was encouraged to provide you with some numbers that would say, what's going on in Lincoln? In Lincoln, Nebraska, there were two physician-owned surgical hospitals opened in 2003--the Lincoln Surgical Hospital and the Nebraska Heart Hospital. And if you want to take a study of what happens when physician-owned hospitals come into play into a city, Lincoln is where...is a hot bed for that to have the study and where the information should come. So I have just provided you with some information regarding some of the claims that have been made by the Nebraska Hospital Association and certainly the fight that we do with the American Hospital Association on a federal level. And I won't take much of your time because they're there in charts and graphs, and you can look at them. But I will highlight a couple if you give me a few minutes to do that. One of the issues that comes up that we talked about is the cherry-picking, and one of the ways that you can measure people in a hospital is their severity of illness. In Medicare measure, that's through a case mix index, and I've provided that with you in my testimony that when you look at the facilities in Lincoln, certainly the Nebraska Heart Hospital with only being a specialty heart hospital would have a high case mix index, and you see that in the information I've provided. But when you look at Lincoln Surgical Hospital with St. Elizabeth and Bryan, our case mix index which would indicate the severity of illness in the patients is right there with the other facilities. One of the other things...another thing on the next page, we look at doing more profitable cases, will have an impact on the ability for the facilities to grow and expand. I've provided you with

information that I have obtained. All the information that I get is available on the Internet through Medicare cost reports, through 990 forms and through the Medicare Web site. When you look at what's happened in Lincoln since our openings, St. Elizabeth Regional Medical Center's revenues have grown 59 percent from 2004 to 2009. Bryan LGH's have grown 31.1 percent. So we've seen...they've seen a tremendous growth in their activity and their charges. If you also note that the Bryan LGH's expenses have remained relatively flat during that time. I think that's direct...as a result of competition that works in the market. One of the other claims that we receive a lot of times is we don't do Medicare and Medicaid. If you look at your information provided for you, the Heart Hospital--63.6 percent of their discharges are Medicare and Medicaid. Bryan's is 60.5; St. Elizabeth, 49.6. In our facility which is strictly an elective procedure facility, we're 45 percent of our cases are Medicare and Medicaid, and we also are one of the only facilities in the state that provides care to the general population for Medicaid. The other issues regarding emergency rooms, that's already been debated. I was here three or four years ago to debate that. I will let you know that we do fall into the EMTALA laws and provide care to patients that show up at our door. We have to stabilize and transfer just like Senator Gloor stated before. But it is the case in Lincoln, Nebraska, if you want to transfer a patient, you do have to call 911 to make that transfer, so when we fill out that survey as to how you transfer patients, it's a requirement of the Lincoln Fire Department that you call 911 to get a transfer to another facility. The same thing goes on between the hospitals...the other hospitals in the states. The issue that I'd like to point out is that you have a claim that will hurt the rural hospitals and the critical access hospitals, between the clinic that I represent which is Eye Surgical Associates and the Nebraska Heart Institute, we go to over 60 out-of-state clinics. And if we take those patients out of those clinics, guess what? Those referrals dry up. I have a doctor that does close to 200, 300 surgeries in Beatrice every year--could easily drive into Lincoln--chooses not to do so. Finally, I've provided you with information regarding patient satisfaction scores. I think Lincoln patients benefit greatly. The scores of all four hospitals are at the top of the list, and lastly, you had asked a question earlier, Senator Gloor, about charges. There's a site that provides what charges by diagnosis, charges by APC. It also gives what the Medicare reimbursement is for those...it doesn't give the private, but it does give you information in regard to what Medicare reimbursements for each of those procedures. So we could get that information relatively easy in terms of that impact so. My purpose was to provide you with information, not from a global perspective and what's going on potentially nationally. These are hard facts and numbers that come directly from Lincoln, Nebraska. [LB999]

SENATOR GAY: And I got a question for you. What would you...what's the Lincoln market, number of people? [LB999]

ROBIN LINAFELTER: What would we consider our? It's about a 400,000, but Lincoln itself 250...we... [LB999]

SENATOR GAY: Okay, so it's a good...so it may be a good comparison then--400. I think they were talking 450,000. [LB999]

ROBIN LINAFELTER: Um-hum, uh-hum. Right, because we butt up against... [LB999]

SENATOR GAY: Right. I think they both agreed on that market share, so, okay, thank you. [LB999]

ROBIN LINAFELTER: Yeah,... [LB999]

SENATOR GAY: I don't see any questions for you. Thank you. [LB999]

ROBIN LINAFELTER: Okay. Thank you. [LB999]

SENATOR GAY: All right. Doctor Johnson, I think you're the last...and out of senatorial courtesy, we won't run the light system for you (laughter). So...but...I know, yeah. Yeah. However, I know when you're Senator Johnson...you're the last one between Senator Campbell and us being done, so you use your own discretion there. [LB999]

JOEL JOHNSON: All right. Well, let me thank you from the whole audience because this has been a good session this afternoon with a lot of material that's been discussed and so on, so thank you. What I'd like to do is that there has been a small group of us in Kearney that has been endeavoring to settle this dispute, and one of the main people involved is Tom Henning, and I'd like to read his letter of testimony, and then I'll just make a comment or two at the end of his letter. And don't get too worried about the length of this letter. It's in very big print (laugh), so it shouldn't take us very long. At any rate, "Senator Gay, members of the Health and Human Services Committee, my name is Tom Henning. I'm 61 years old and have been a lifelong resident of Kearney, Nebraska. My company is a major employer in Kearney, and during the past 25 years I've been very active in community activities, having served on many advisory boards, community boards, including the hospital, many fund-raisers and leadership positions in the Chamber of Commerce, Economic Development Council, the airport, just to name a few, and I...which (he says) I hope symbolizes my strong interest in the Kearney community." He's being modest. "I am one of many who are a concerned citizen about the issues and differences that exist between the hospital and the medical community in Kearney. I'm also one who believes that one hospital is the best for our area. On the other hand, the fact remains that there are issues that divide a number of physicians and the hospital to a point where approximately one-third of the area physicians have 'jumped ship' to the second hospital bandwagon, and it appears that there are others who are sympathetic to this cause. One can't deny that the physicians are a very important component if not THE most important component of healthcare. However, the fact remains unless these issues are resolved, the medical community is going to be divided and the divisiveness will be a real detriment to this community irrespective of

who one may think is right or wrong. For that reason, a number of concerned citizens in the Kearney area including myself, Joel Johnson, and a former hospital administrator plus a number of retired physicians and community leaders, some of whom are former hospital board members, believe that resolution will only come about if both parties can come together and resolve their differences through negotiation. I might point out that this group of individuals is neutral in their opinions on the issues but united in the goal of resolution. Our group has been having conversations with both parties, the hospital, and the second hospital physicians in an effort to bring both sides to the negotiation table. As of this last week, we are happy to tell you that both parties have agreed to sit down through negotiation, make an attempt to work through these issues that divide them with the goal of developing an understanding that will lead to an agreement that will bring both parties back together. Tomorrow evening, February 25, both parties will be engaging in the first step of this process whereby the framework of negotiation and the rules of this engagement will be determined. One can assume that the meeting will be followed with a number of meetings held on a frequent basis to bring this issue to a meaningful conclusion, hopefully, at the earliest possible date. We strongly believe that a community solution to these issues is the best approach, and we're confident that those who serve in administrative capacity for Good Samaritan Hospital, the Good Samaritan Hospital Board, the second hospital physicians, and other concerned members of our community will concur with this approach is the only one that makes any kind of sense in bringing the medical community together. This brings me to the point of LB999. The community needs to be the entity and the body that finds and brings this to resolution. It was because of the community, doctors, hospital administration, leaders of the community that got our healthcare system to where it is today, and it's going to take it back...the same groups back to put it back together. I truly believe in my heart of hearts like the others that have spent a lot of time on this issue that the solution is in this community of Kearney. And that's where it will be found. Kearney doesn't need the help of the Legislature in dealing with this issue, and we do believe that if LB999 is passed, the hopes of bringing the two parties together will very abruptly end. If that happens, the issues that divide the physicians and the hospital will continue to fester, and that's not good for our community. Added to that is the risk of a great number of physicians leaving our community, the hampering of future recruiting efforts, and the community of Kearney well known as an out-state medical center experiencing a dramatic setback. Most everyone recognizes that our healthcare system in Kearney is a pillar of the city's economy and the ramifications of this issue are significant. The community of Kearney is best served if this legislation doesn't pass, and if we're successful in dealing with the issue through local negotiation, Kearney could become a model for other communities who may experience the same problems that we are at this time. Thank you in regard to this issue." And I might correct that just a bit in saying, see LB999 as stated. Now, just a word or two of my own thoughts, and we'll call it a day. You know, one of the things that we've got to look at is when you have 30 to 40 percent of your physician community looking to break away from the single hospital that is present in our community, I think you need...and CHI needs to look in the

mirror and see what part in this fractured medical community they are the cause because our community isn't the only one that is going to be like this. And so with this, let me say that my personal feelings is that CHI has made mistakes, but personally, I don't feel that the second hospital is the best solution. People have worked for a half a century or longer to get where we're at by all pulling in the same direction, and I think that should continue. Fortunately, there is a silver lining emerging as both sides of this controversy have at least agreed to try negotiations which will lead to creating a single hospital system with a new and improved governance, one that would have a larger measure of local influence and local control and yet allow CHI to maintain and even expand its stated mission. The formula for success is very simple. Do what's best for the patient, and as someone once told me, the next patient may be you (laughter), and someone else long ago said, do unto others as you would have them do unto you. With that, I'd be happy to field any questions. [LB999]

SENATOR GAY: Thank you, thank you. Senator Wallman. [LB999]

SENATOR WALLMAN: Welcome to this committee, Doctor. [LB999]

JOEL JOHNSON: Thank you. [LB999]

SENATOR WALLMAN: And you can't smoke in my house. [LB999]

JOEL JOHNSON: All right (laughter). [LB999]

SENATOR WALLMAN: Do you feel...getting serious here, do you feel like nonprofits, you know, my...a collection agent in town whom I know quite well, trying to look in some nonprofit issues as far as their charges. Do you feel that's transparent enough? [LB999]

JOEL JOHNSON: Well, probably not, and...but I think you can say the same thing with the nonprofits. We've heard quite good testimony here this afternoon that, you know, we don't really know what the profits were for the nonprofit hospital... [LB999]

SENATOR WALLMAN: Yeah. [LB999]

JOEL JOHNSON: ...and where that money went. Was it spent or reinvested in the Kearney area community, or did it go to Denver, never to be seen again? We don't know that, so, yes, I would agree with you. [LB999]

SENATOR WALLMAN: Um-hum, thanks. [LB999]

SENATOR GAY: Any other questions? I don't see any. Thank you. [LB999]

JOEL JOHNSON: You bet. Thank you. [LB999]

SENATOR GAY: All right. No other...we'll close...Senator Campbell, you want to close? [LB999]

SENATOR CAMPBELL: Yes, just briefly. [LB999]

SENATOR WALLMAN: Legal counsel's gone (laughter). [LB999]

SENATOR CAMPBELL: I'm not going to go there (laughter). Thank you, Chairman Gay, and colleagues on the committee. I do want to ask the committee's patience. I have been very fortunate to have conversations with almost all the people who have testified here from the physicians, Good Samaritan, and certainly with Rob and Bruce and Senator Johnson and Mr. Henning. And what I'd like is for your patience for me to continue all of those conversations and bring back an amendment for the committee to look at. But it's apparent to me that there are some broad issues for the state, and we want to make sure that we address those, but on the other hand, we need a little bit more time. [LB999]

SENATOR GAY: All right, thank you, Senator Campbell. Any questions for Senator Campbell? I don't see any. Thank you and thank you all for your patience in coming today to be with us. That will close the public hearing. [LB999]