

COMMONWEALTH OF KENTUCKY  
CABINET FOR HEALTH AND FAMILY SERVICES

RE: 900 KAR 5:020  
State Health Plan for Facilities and Services

907 KAR 1:055  
Payments for Primary Care Center, Federally-Qualified  
Health Center, Federally-Qualified Health Center  
Look-alike, and Rural Health Clinic Services

PUBLIC HEARING

\* \* \* \* \*

June 22, 2015  
9:00 A.M.  
Health Services Building  
Conference Suite B  
275 East Main Street  
Frankfort, Kentucky

\* \* \* \* \*

APPEARANCES

Hon. Jennifer Wolsing  
MODERATOR

Tricia Orme  
CABINET FOR HEALTH & FAMILY SERVICES

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INDEX

Opening Comments by Jennifer Wolsing	3 - 7
Wade Stone	7 - 10
Charles Papp	11 - 13
Jennifer Rae	13
Tim Herber	14 - 15
Rob Rothenburger	16 - 18
Brian Lebanion	18 - 31
Kip McNally	31 - 36
Randy Strause	36 - 38
Mark Leach	38
Terry Music	39 - 40
Ben Johnson	40 - 41
Mark Leach	41 - 45
Dave Hoffman	46 - 53
Steve Hale	53 - 56

1 MS. WOLSING: Good morning, ladies and  
2 gentleman. My name is Jennifer Wolsing. I am one of the  
3 Assistant Counsels with the Cabinet for Health and Family  
4 Services. We are calling this meeting to order on June  
5 the 22nd, 2015 at approximately 9:18 a.m. We thank you  
6 for your patience as we did have a delayed start today.  
7 There was some confusion about specifically where we were  
8 holding this meeting. Thank you very much for finding the  
9 right spot. Looks like we have a lot of people here  
10 today. So, I'll do my best to keep it moving along.

11 We have several Cabinet  
12 representatives here today. First of all, Rita Moore, who  
13 is not with the Cabinet, is our stenographer. As you guys  
14 can tell, we all have microphones; but I'm projecting here  
15 so everybody can hear me. This doesn't amplify your  
16 voice. It just goes to Ms. Moore's recording device. So,  
17 when I ask you to come up and talk, you get to come up to  
18 that podium right there and speak into the microphone. If  
19 you want to make sure that the gentleman in the blue shirt  
20 with the red tie way in the back here hears you, then, you  
21 need to speak up as best you can. But your comments will  
22 be recorded even if you speak quietly.

23 This meeting is being convened  
24 pursuant to KRS 13A.270 which authorizes an administrative  
25 body to hold a public hearing to receive comments

1       pertaining to Administrative Regulations. Today, we are  
2       looking at two particular Administrative Regulations. One  
3       of them is 900 KAR 5:020, State Health Plan for Facilities  
4       and Services. The other one is 907 KAR 1:055, Payments  
5       for Primary Care Center, Federally-Qualified Health  
6       Centers, and Rural Health Clinic Services.

7                       I understand that a lot of people here  
8       today are here to talk about the State Health Plan. Is  
9       anyone here for the other reg; Payments for Primary Care  
10      Centers, Federally-Qualified Health Centers, and Rural  
11      Health Clinic Services? Please raise your hands. Very  
12      good. I see there are no people here for that regulation.  
13      I will try not to tell people in that area of the Cabinet  
14      so that they are not sad that there's not as much  
15      interest.

16                      So, what we're going to do is I'm  
17      going to go through this sign-in sheet here; and I'm just  
18      going to call people's names. The people who have said  
19      yes, they're going to testify, at that time, you can come  
20      on up and make your statements. But I should also let you  
21      know that the public comment period for these regulations  
22      -- or this regulation since we're only going to talk about  
23      one today -- goes through the close of business on June  
24      the 30th, 2015.

25                      Anyone wishing to submit additional

1 comments in writing regarding these regulations may do so  
2 by June the 30th, 2015. These comments should be  
3 addressed to Tricia Orme, who is right here. Raise your  
4 hand, Tricia, so everybody sees you. And you can do that  
5 in writing to her.

6 As noted in the Notice of Public  
7 Hearing and Comment Period with the regulations, KRS  
8 13A.280 provides that the administrative body shall file  
9 an official agency response in consideration of the  
10 comments received today at this public hearing and at the  
11 conclusion of the public comment period. If you would  
12 like to receive a copy of our Statement of Consideration,  
13 the Department will mail you a copy once it has been filed  
14 with the Legislative Research Commission.

15 Everybody who has signed up on the  
16 sign-in sheet will receive a copy. If you want a copy and  
17 you have not signed up, there are some extra sign-in  
18 sheets. So, you guys can get to that whenever you have  
19 the opportunity.

20 The Department is not required to  
21 change or amend a regulation, but it is required to  
22 consider all comments that it receives. Therefore, the  
23 Department will address your comments in writing.

24 Before we begin, I would like to ask  
25 everyone here to please make sure your phones are turned

1 off or silenced. Anybody who has only written comments to  
2 submit, please raise your hand. All right. Bring them up  
3 here to me, and I will make sure that they are forwarded  
4 to the agency.

5 AUDIENCE: Not yet.

6 MS. WOLSING: Not yet? Okay. If you  
7 feel like you want to do that later on, you can. And you  
8 can also hand-write comments during this period. I have a  
9 notebook here. If anybody needs paper and a pen, I'm  
10 happy to loan mine out. You can write down your comments  
11 and submit them to me at any time as long as we're having  
12 this hearing.

13 So, when you are called to speak,  
14 please come forward and speak into the microphone at the  
15 podium right there, as I have said. Please state your  
16 name and identify if you are representing a group or an  
17 individual. So, remember that these comments are being  
18 recorded; so, speak up for the microphone. These comments  
19 are not being amplified. So, speak up so that everybody  
20 can hear you.

21 I will now open up the hearing for  
22 comments on the first regulation, which is 900 KAR 5:020,  
23 State Health Plan for Facilities and Services. I will  
24 only be hearing comments on this specific regulation at  
25 this time. So, please confine any comments only to that

1 regulation. After all comments have been given on this  
2 regulation, I'll open up the floor for any comments on the  
3 next regulation if somebody thinks of any, I guess. So,  
4 let's start with the first person on the list we have. It  
5 looks like Marie A. Cull.

6 MS. CULL: I'm not going to -- I'm  
7 going to submit comments on the 30th.

8 MS. WOLSING: Very good. Ms. Cull has  
9 stated she will submit comments. The next person listed  
10 is Eddie Slone.

11 MR. SLONE: I'll submit comments.

12 MS. WOLSING: He will submit comments.  
13 Wade Stone. Mr. Stone, come on right up here.

14 MR. STONE: Good morning. My name is  
15 Wade Stone. I'm representing Medical Center EMS which is  
16 part of The Medical Center, Bowling Green, Kentucky. I'm  
17 an Executive Vice President with the organization, and I  
18 want to point out that Randy Fathrockner, our Director of  
19 EMS, is also with me here today.

20 The Medical Center respectfully, yet  
21 adamantly, opposes removing ambulance service from the  
22 State Health Plan. Our organization owns and operates the  
23 ambulance service in Warren County. We believe  
24 Certificate of Need as a whole is good for Kentucky in  
25 that it prevents the needless proliferation and

1 duplication of health services across the Commonwealth.  
2 while we understand recent efforts toward CON  
3 modernization, we believe it is critical that ambulance  
4 service be maintained within the Plan under Formal Review.

5 we believe removing ambulance service  
6 from the State Health Plan will detrimentally impact our  
7 service as well as ambulance services across the  
8 Commonwealth, many of which are dependent upon their  
9 county government and tax-paying constituents for  
10 financial means to even maintain a quality ambulance  
11 service. We believe comments by the Kentucky Ambulance  
12 Providers Association are evidence of this conclusion,  
13 among other comments that will be submitted.

14 The Medical Center is a not-for-profit  
15 hospital serving as a regional referral center to close to  
16 300,000 people in Southcentral Kentucky. We have owned  
17 and operated the ambulance service in Warren County for  
18 the past 41 years. We respond to more than 21,000 calls  
19 per year. And we are one of two ambulance services in the  
20 Commonwealth of Kentucky accredited by the Commission on  
21 Accreditation of Ambulance Services or CAAS.

22 Our service stretches well beyond  
23 traditional ambulance runs. We provide community outreach  
24 and education services, health education for local  
25 schools, and play an instrumental role in local, regional,

1 and even statewide disaster preparedness planning.

2 Our ambulance service is also  
3 instrumental in helping our hospital to achieve an  
4 accredited Chest Pain Center status as well as Primary  
5 Stroke Center status in addition to the accolades that the  
6 EMS service brings upon itself.

7 We take great pride in the Medics,  
8 EMTs and support staff who run Medical Center EMS and care  
9 for patients each and every day. We believe we run an  
10 exceptional service to focus on providing the best in  
11 patient care.

12 Medical Center EMS does not receive,  
13 nor have we requested, a tax subsidy from our local  
14 government. During our most recent fiscal year, The  
15 Medical Center subsidized our EMS operations to the tune  
16 of 1.5 million dollars. That annual subsidy usually  
17 ranges between 1.2 and 1.5 million dollars per year.

18 We choose to relieve our city, county  
19 and taxpayers of this burden. It has been our honor and  
20 privilege to do so for the past 41 years because we  
21 believe a high-quality ambulance service is vital to  
22 maintaining an effective healthcare delivery system in  
23 Warren County.

24 Stripping ambulance service from the  
25 State Health Plan will jeopardize our ability to continue

1 subsidizing EMS operations in Warren County. Moving  
2 ambulance service to Non-sub Review will enable for-profit  
3 services to set up shop in counties throughout the  
4 Commonwealth and to effectively pick off the more  
5 lucrative, non-emergent runs, leaving county-run services  
6 and services such as ours to provide the more  
7 cost-intensive, emergent runs, thereby placing added  
8 financial strain on services already struggling to  
9 survive.

10 At the end of the day, counties will  
11 be faced with raising additional tax dollars to further  
12 subsidize their operations; or, as in our case, The  
13 Medical Center will seriously consider turning to local  
14 government for support. It should be noted that our local  
15 government is very happy and content with the service that  
16 Medical Center EMS provides. Judge-Executive Mike  
17 Buchanan has already made clear his strong opposition to  
18 this proposal, as have other Judge-Executives throughout  
19 the Commonwealth.

20 Again, The Medical Center opposes the  
21 removal of ambulance service from the State Health Plan.  
22 And we appreciate the opportunity to offer some comments  
23 here this morning. Thank you.

24 MS. WOLSING: Thank you, sir. Our  
25 next person is Charles Papp. I should say Charles Papp

1 and friends, ---

2 DR. PAPP: Good friends, yes.

3 MS. WOLSING: --- as a couple of  
4 people have come up with Mr. Papp. I believe that their  
5 plan is that if they have any comments after Mr. Papp,  
6 they will state their names and, then, make their  
7 comments. Mr. Papp, please continue.

8 DR. PAPP: Thank you for this  
9 opportunity. My name is Charles Papp, and I represent  
10 CSG, or our long-winded name Colorectal Surgical and  
11 Gastroenterology Associates of Lexington, Kentucky. And  
12 these are two of my associates with me today. So, again,  
13 thank you for this opportunity.

14 As a private physician, I would like  
15 to commend the Cabinet for Health and Family Services for  
16 developing the proposed changes to the State Health Plan;  
17 specifically, Article 6, that concerns a physician or a  
18 physician group. Our group, as well as several other  
19 groups in the state, provides cost-effective, high-quality  
20 ambulatory surgical services in our offices.

21 The current CON process makes it  
22 nearly impossible for these practices to obtain a CON. In  
23 2013, the Cabinet commissioned Deloitte Consulting to  
24 conduct a healthcare facility capacity study to evaluate  
25 the Commonwealth's facility capacity through 2017 in light

1 of the many changes that have occurred in healthcare.

2 The study found that the national use  
3 rate for outpatient surgery is 56% higher than it is in  
4 Kentucky, and ambulatory surgical facilities in Kentucky  
5 are already seeing high utilization. There is not enough  
6 ambulatory surgical capacity in Kentucky.

7 Currently, there are a small number of  
8 physician practices that have high-quality, Joint-  
9 Commission-accredited outpatient surgery centers that are  
10 built to state standards. Because they cannot obtain a  
11 CON, they cannot assist in providing surgical services to  
12 Medicaid, Medicare and the current programs available  
13 through the Affordable Care Act.

14 As time goes by, it is very likely  
15 many more Kentuckians will join these or other  
16 state-sponsored programs. This will severely limit the  
17 number of patients these centers will be able to care for  
18 in the future and cause these physician-owned surgery  
19 centers to close their doors and lay off the nurses and  
20 skilled technicians that they employ. This will only  
21 exacerbate the shortage in outpatient services predicted  
22 by the Deloitte study.

23 Article 6 in the proposed changes  
24 wisely addresses this problem. It would allow the few  
25 practices that meet the proposed standards access to a

1 CON. These facilities are already functional and would  
2 immediately have the ability to assist in tackling the  
3 significant need for outpatient surgical services in the  
4 Commonwealth. Utilizing these centers would significantly  
5 decrease costs, save the state money and improve  
6 healthcare access to its citizens.

7 My associates, our 73 employees and I  
8 strongly urge the Cabinet to approve Article 6 of the  
9 proposed revisions in the State Health Plan. And I don't  
10 know if anybody has anything to add to that.

11 DR. RAE: I'm Jennifer Rae, as well  
12 from CSGA, here this morning. And I just wanted to add a  
13 prospective from a new physician that has just begun  
14 working in Kentucky. And I'm not only just a new  
15 physician here, but my general surgery residency and  
16 colorectal surgery fellowships were among the top in the  
17 country. I scored in the top ten on my American Board of  
18 Colorectal Surgery exam.

19 And I feel like this legislation in  
20 favor of Article 6 of the amendment here would really  
21 provide much-needed resources to groups like ours to  
22 recruit and keep the top-notch physicians that we need to  
23 take care of the citizens of the state. Thank you for  
24 your time.

25 DR. PAPP: I think we're done. Thank

1       you.

2                               MS. WOLSING: All right, thank you,  
3       Mr. Papp and friends. I believe our next person is Tim  
4       Herber.

5                               MR. HERBER: My name is Timothy  
6       Herber. I am the Administrator at Taylor Regional  
7       Radiation Oncology in Campbellsville, Kentucky. This is a  
8       physician-owned radiation therapy service. We have filed  
9       for a Certificate of Need application to establish a  
10      megavoltage radiation therapy service in Campbellsville.

11                              I'm speaking in favor of the proposed  
12      changes to the State Health Plan Review Criteria of  
13      megavoltage radiation equipment. The changes will  
14      increase access to this important and life-saving service.  
15      Specifically, we support the revision defined of  
16      megavoltage therapy -- radiation therapy program to  
17      include the current licensure service and the service that  
18      is not licensed and has an outstanding or unimplemented  
19      Certificate of Need which has no longer than three years  
20      prior been filed.

21                              It is necessary due to changes in  
22      Taylor County, we believe, and other counties that the  
23      entities receiving a CON approval prior to 2006, which is  
24      nearly ten years ago, -- the entity has done nothing to  
25      implement the change or the CON.

1                   There are a number of items that have  
2 come up; one of them being they have purchased no land or  
3 building or equipment. Their application is the address  
4 -- the application address is the building that we now  
5 occupy and have occupied since prior to their Certificate  
6 of Need. Because it cannot occupy that site, this  
7 application address has to be changed. And that would  
8 also require a new Certificate of Need application which  
9 has not been filed.

10                   The above remains true even in the  
11 most progressive Progress Reports and nothing has changed  
12 even though they have had this project on the board for  
13 ten years. They have filed numerous Progress Reports that  
14 are just one copy after another. No change has been made  
15 to their Progress Reports in the last ten years.

16                   The passage of nearly ten years, no  
17 progress has been made in the implementation of this  
18 project despite being granted over a dozen extensions. It  
19 is time to revoke this CON or at least make it irrelevant  
20 to any attempt by another provider in this service area.  
21 This proposed change would do that, and we urge the  
22 Cabinet to adopt the change. Thank you.

23                   MS. WOLSING: Thank you, Mr. Herber.  
24 Our next speaker is -- and I'm not positive I can read  
25 this person's handwriting -- but I believe it's Rob

1       Rothenburg.

2                               MR. ROTHENBURGER: Yes, that's  
3       correct.

4                               MS. WOLSING: Excellent.

5                               MR. ROTHENBURGER: Yeah.

6                               MS. WOLSING: Thank you, sir.

7                               MR. ROTHENBERG: Thank you. Ladies  
8       and gentlemen, my name is Rob Rothenburger. I'm the  
9       Judge-Executive for Shelby County, Kentucky. I'm going on  
10      record to oppose any revocation or diminishment of CON for  
11      Emergency Medical Services in Kentucky.

12                              As previously stated, in Kentucky, we  
13      have ambulance services that their primary revenue comes  
14      from Medicaid or Medicare. About 80% of their budgets are  
15      from that. Any attempt to reduce a CON, which basically  
16      brings in more people to apply for CONs and come into your  
17      county, could be detrimental to EMS-based services in  
18      Kentucky.

19                              It could actually cause them to go out  
20      of business. Because we know if private services come in  
21      -- and I'm not opposed to any private service because we  
22      have a great working relationship in my county with  
23      private services. But should they come in, they can come  
24      in and essentially cherry-pick any runs that are paying  
25      runs in your community, which, thus, leaving you with the

1 indigent care and possibly could run your EMS services out  
2 of business. It could be extremely detrimental.

3 The other point that I want to bring  
4 out is that we have a mutual aid agreement in place with  
5 private services and other public agencies in Kentucky to  
6 provide emergency medical care in our community. Should a  
7 disaster occur or should we just have all our trucks in  
8 the field, we develop those relationships so that we can  
9 call upon another service to come in and provide quality  
10 care in our community.

11 With that mutual care, we have  
12 developed training relationships with these communities.  
13 We actually come in. We work with our private services  
14 outside of our county and other public agencies so that  
15 our First Responders and our Fire Service learn to work  
16 with these other services as they come in. So that if we  
17 have a vehicle extrication, they know the people they're  
18 working with, as well as the people in our own community.

19 If we open up the CON or we revoke it  
20 or we lessen it for private services, we don't know who  
21 we're going to be working with from day-to-day. And that  
22 can be very detrimental to the patient care in Kentucky.

23 I've already mentioned that it's very  
24 possible layoffs or closures of EMS services in Kentucky  
25 could be possible, which could be extremely detrimental.

1 As previously stated down in Bowling Green, we have to  
2 supplement our EMS service with about \$1.2 million. It's  
3 not a money-maker for us; but if you allow the competition  
4 to come in and just, as I said before, cherry-pick runs,  
5 then, we're looking that we may have to lay off crews,  
6 which could be very detrimental to our patients.

7 So, I just want to, in closing, say  
8 that I oppose any revocation or diminishment of CON as it  
9 relates to Emergency Medical Services in Kentucky. Thank  
10 you very much.

11 MS. WOLSING: Thank you, sir. For  
12 those who have come in a little bit late, please note that  
13 there is a sign-in sheet right up here at the front table.  
14 So, if you wish to speak or if you wish to have a copy of  
15 the responses to the comments here today, please go ahead  
16 and sign up. Our next speaker is Brian Lebarian (sic).

17 MR. LEBANION: Lebanion.

18 MS. WOLSING: Lebanion.

19 MR. LEBANION: Good morning. Thank  
20 you for this opportunity to speak here today. My name is  
21 Brian Lebanion; and I am speaking on behalf of  
22 Professional Home Health Care Agency, Incorporated, as  
23 well as Friends and Companions Adult Day Health Care.

24 Professional Home Health is a  
25 non-profit home health agency that's been serving patients

1 since 1977. We provide services in Knox, Laurel, Whitley  
2 and Fayette Counties in Kentucky, as well as seven  
3 counties in Tennessee. Friends and Companions is a  
4 pioneer of adult day health care. It started in 1997, one  
5 of the first ones in Kentucky. And it currently has  
6 centers in Knox, Laurel and Whitley County as well.

7 We oppose five proposed changes to the  
8 2015-2017 State Health Plan. Those are, number one,  
9 removal of the added Criteria #4 for home health services  
10 in its entirety that would allow a licensed Kentucky  
11 acute-care hospital proposing to establish a home health  
12 service in the county in which the hospital is located or  
13 in a contiguous county if they document their outcome  
14 performance is better or equal to select criteria.

15 Number two, we oppose removal of the  
16 added Criteria #5 to home health services in its entirety  
17 that would allow an existing, licensed Kentucky home  
18 health agency to expand a home health service if select  
19 outcome criteria are met.

20 Number three, we oppose the removal --  
21 or we support the removal of the added Criteria #6 for  
22 home health services in its entirety that would allow  
23 Kentucky-based, federally-qualified Accountable Care  
24 Organization, or ACO, or the Next General ACO Model or by  
25 a Kentucky-affiliated home health agency if they're

1 associated with the ACO to establish a home health service  
2 in a county in which it is not currently authorized to  
3 operate but in which the ACO does.

4 We also oppose Criteria #7 of home  
5 health services in its entirety that would require  
6 participation of a home health agency in the Cabinet's  
7 National Background Check Program.

8 And, finally, we advocate for the  
9 restoration of the adult day health care criteria back  
10 into the State Health Plan.

11 We resolutely oppose these changes for  
12 the following reasons: Number one, there simply is no  
13 need for additional home health agencies in Kentucky. We  
14 have 120 counties. And of those 120 counties, 116 are  
15 served by at least one home health agency. There are  
16 several counties or a majority of counties that are served  
17 by two or more home health agencies.

18 There is no documentation that  
19 supports the need to include language for a licensed  
20 Kentucky acute-care hospital to be allowed to establish a  
21 home health service based on Hospital Compare criteria.  
22 Hospital Compare criteria has absolutely nothing to do  
23 with home health services. There is no correlation  
24 between improved outcomes for a hospital-based home health  
25 agency versus a non-hospital-based home health agency.

1                   There is also no documentation that  
2 supports the need for existing, licensed Kentucky home  
3 health agencies to expand based on criteria. There is no  
4 foundation for allowing expansion of home health services  
5 by an existing agency based on outcomes. There's already  
6 enough home health agencies that are providing quality  
7 services. If you compare Kentucky's averages to the  
8 national averages for outcomes, you'll see that the  
9 majority of those are being met by the existing home  
10 health providers.

11                   There is no documentation that  
12 supports the need for an ACO or an Accountable Care  
13 Organization to be able to establish a home health service  
14 based solely on the type of entity that they are.  
15 Existing home health agencies are already providing  
16 quality care, as I've said; and patients are already  
17 receiving home health services and regularly participate  
18 in coalitions. They make agreements with other entities.  
19 They provide care coordination between hospitals and other  
20 long-term facilities, and they improve access to care.  
21 And their outcomes are also good.

22                   There is no rationale to require home  
23 health agencies to utilize the National Background Check  
24 Program. The program is cost-prohibitive. Right now, it  
25 has a grant that is allowing reduced costs to those who

1 choose to participate in it; but, eventually, that grant  
2 -- funds are going to run out and that cost is going to  
3 increase to home health agencies. Also, it has overly-  
4 burdensome requirements within that regulation. And I'll  
5 talk more about that in just a moment.

6 Removal of the adult day health care  
7 provision from the State Health Plan will be  
8 counterintuitive, and the intent of the State Health Plan  
9 will be questionable because of its removal. It will  
10 allow unnecessary proliferation of adult day health  
11 providers under the Non-substantive Review Criteria. This  
12 is going to increase costs to the Commonwealth and weaken  
13 resources for existing providers.

14 And, finally, if these changes are  
15 approved, it will dilute the importance and the efficacy  
16 of the CON process for home health agencies and adult day  
17 health care providers. If you look at the State Health  
18 Needs -- the latest projections of September 2014 --  
19 you'll see that there is less than 6% of counties in  
20 Kentucky that currently show a need for a home health  
21 agency to be established. Therefore, that shows you that  
22 the State of Kentucky is very well-served by existing  
23 providers.

24 If we look at our neighboring states,  
25 such as Tennessee, they removed their CON requirement from

1 home health agencies; and, subsequently, they reinstated  
2 that. Because when they removed it, they did not have  
3 control of home health agencies, nor did they have control  
4 of the processes. Therefore, they re-implemented that in  
5 order to gain that. The Commonwealth currently has that  
6 for home health agencies. And if we allow these changes  
7 to go in, then, that's going to weaken the quality of home  
8 health agencies.

9 Also, we can look at the State of  
10 Florida. Florida has no CON process, and they're  
11 constantly in the news. There are recoupments of over  
12 \$50,000,000 by the Federal Government in fraudulent claims  
13 on a yearly basis in Florida alone. They have no CON  
14 process. And the Federal Government has actually  
15 implemented a mandate to have those certain counties in  
16 Florida to not be able to open anymore home health  
17 agencies. They're trying to do that in order to gain  
18 control.

19 If we look at the Kentucky Hospital  
20 Association's comments, their expert, Dan Sullivan, stated  
21 -- and I'm going to read this -- An analysis of historical  
22 home health utilization data indicates that there is  
23 little correlation between the number of agencies serving  
24 in a county and the rate of home health utilization in  
25 that county. Therefore, approving more agencies, whether

1 hospital-based or freestanding, for counties with numerous  
2 existing providers will do little to change historical  
3 utilization patterns. Therefore, he agrees that simply  
4 having more home health agencies approved is not going to  
5 mean more patients served. Also, it's going to do nothing  
6 for quality. There's already existing quality within the  
7 state and with the existing providers.

8 After personal study of the state  
9 demographics and statistics, the need calculations  
10 utilized by the Commonwealth have proven to be an accurate  
11 indicator of need. In my experience, in Whitley County,  
12 Kentucky, we had another provider that was approved for  
13 services; and there was no increase in utilization. There  
14 was no change in quality of care. That provider simply  
15 took resources that the existing providers would have  
16 received by taking care of those same patients and they  
17 used them. Therefore, you have a dilution of resources in  
18 that county.

19 Furthermore, my experience in Fayette  
20 County has been just as informative. We obtained a  
21 Certificate of Need for Fayette County, and we were able  
22 to identify a specific need for a given population. Those  
23 were the people that were under 65. And our proposal has  
24 been fruitful, and it's actually held true. Those are the  
25 patients that we're serving in Fayette County. Therefore,

1 the need calculations are a valid indicator of the need  
2 for home health agencies.

3 The Deloitte Study of Kentucky  
4 healthcare facility capacity, they acknowledged that  
5 despite the fact that few new home health agencies have  
6 received CON approval in Kentucky in recent years, the  
7 rate of home health utilization has actually increased by  
8 15% between 2006 and 2012. So, there is no problem with  
9 capacity. The existing providers have been serving more  
10 patients over the past ten years. The limited number of  
11 CON approvals is a reflection of the fact that there is an  
12 abundance of existing providers with the ability to expand  
13 to meet patient population needs.

14 Let's talk about quality. Quality of  
15 care will be a function of the case management systems  
16 implemented by organizations as defined by their business  
17 model. The proposal to change the home health portion of  
18 the State Health Plan will have a severe impact on this  
19 because you're going to diminish the quality of care by  
20 reducing volumes across all providers. You're going to  
21 have more providers that are going to stretch the  
22 resources available.

23 The current CON standards support  
24 quality as a CON criteria. So, it's already there. And  
25 seek to ensure that new facilities operate at volumes that

1 are sufficient to provide quality care services, as well  
2 as assuring that the volume does not come at the expense  
3 of existing providers where the lowering of their volumes  
4 would reduce quality in the existing programs.

5 Furthermore, as I said earlier, there  
6 is not correlation between hospital performance on  
7 Hospital Compare and whether or not there is a need for  
8 another home health agency. In fact, it would seem that  
9 if the hospitals already exceed the national averages,  
10 then, they already have a process in place. They already  
11 have existing relationships with home health agencies that  
12 is supporting the hospital and able to meet those  
13 criteria. So, if you're already meeting and you're  
14 exceeding the quality indicators, then, you have that  
15 infrastructure in place that Accountable Care  
16 Organizations want to achieve.

17 Professional Home Health works  
18 regularly with acute-care facilities and other healthcare  
19 providers to transition patients and assure that the level  
20 of care is met. In fact, we just responded Kentucky  
21 HealthOne's request for information. So, we've been  
22 working with that Accountable Care Organization as well.

23 Programs that incorporate  
24 state-of-the-art telemonitors in congestive heart failure  
25 standing orders are just a few that Professional Home

1 Health has developed to improve patient outcomes. These  
2 programs, in particular, assist patients discharged from  
3 acute-care facilities to be monitored on a daily basis and  
4 implement interventions that prevent unnecessary  
5 rehospitalizations and Emergency Room visits.

6 We also regularly participate in the  
7 healthcare coalitions in Southeastern Kentucky and Central  
8 Kentucky to work and facilitate coordination of care and  
9 achieve these common goals. In fact, we've participated  
10 with a local coalition for over two years. This coalition  
11 worked with providers across the spectrum. So, we had  
12 every type of provider there represented -- the acute-care  
13 facility. However, the coalition abruptly stopped when  
14 grant funds were not obtained. Therefore, the coalition  
15 was not truly patient-driven. There was evidence that  
16 historically hospitals have not been interested in home  
17 health care.

18 The intent of Accountable Care  
19 Organizations when those laws were passed were to improve  
20 the safety and quality of care and reduce healthcare costs  
21 in Medicare. It is still a voluntary program, and it's  
22 not required. The ACO was never intended to create a  
23 situation where hospitals monopolize the healthcare  
24 market. So, allowing them to establish a home health  
25 agency just simply because they are an Accountable Care

1 organization would do just that.

2 The provision to allow an ACO or other  
3 listed entity to establish a home health service in a  
4 county in which it's not currently authorized to operate  
5 would create a situation where they could select their  
6 patients that they send to their own home health agency  
7 versus what they're going to send to other providers,  
8 similar to what someone else was saying here this morning.

9 And that is going to impact  
10 everybody's outcomes. One home health agency that does  
11 not receive the type of patients that an ACO might be  
12 looking for will have a harder time showing improved  
13 outcomes because their patients are going to be sicker and  
14 their case mix is going to be higher.

15 Finally, in regards to the removal of  
16 adult day health care from the State Health Plan, this  
17 action will reduce access to care by destabilizing local  
18 healthcare systems. Again, you're going to create a  
19 situation where more providers are going to be able to  
20 enter the market, and that's going to dilute the funds  
21 that are already available to existing providers.

22 Also, adult day health cares serve the  
23 fragilest (sic) of our population; and they serve patients  
24 that cannot get care elsewhere. Taking out adult day  
25 health care from the CON process and to put them in

1 non-sub review is going to make it easier for those CONS  
2 to be approved. In reality, we should be making it harder  
3 for adult day health cares to be approved simply because  
4 you want quality care for those individuals. You want to  
5 make sure that when someone enters the market, that they  
6 are able to take care of that patient and they meet  
7 stricter criteria, not lesser criteria.

8 Finally, the background checks.  
9 Background checks in 906 KAR 1:190 is unnecessarily  
10 burdensome for home health agencies. For one, the program  
11 is funded by the grant, which I've already spoke about.  
12 When those funds run out, the cost is going to be three  
13 times what it would be to run a background check.

14 Additionally, they require what's  
15 called provisional employment. That can last up to 60  
16 days. Home health can't do that. We can't supervise a  
17 home health aide for 60 days and not have them out  
18 working. It requires them to have one-on-one supervision,  
19 and we simply can't do that. It's going to create a  
20 situation where you're unable to hire staff. They're not  
21 going to be able to wait 60 days. They're going to go and  
22 get other employment during that 60-day period. Also, the  
23 healthcare market is already a hard place to find  
24 qualified staff. And it's going to make it even more  
25 harder if we have to wait for the 60-day period.

1                   Finally, access to home health and  
2                   adult day health care is being attacked already.  What  
3                   you're going to create if these provisions are passed that  
4                   I've talked about is a situation where patients are going  
5                   to be locked out of the system.  We've seen this in other  
6                   changes, such as the MWMA system that was recently  
7                   implemented.  And it was supposed to be a fix to a lot of  
8                   situations.  It was going to be a one-stop shop, much like  
9                   the ACOs, much like the acute-care facilities that want to  
10                  have other types of providers.  And, basically, the MWMA  
11                  system is going to foreshadow what these changes are going  
12                  to create.

13                         We had a patient that was a 47-year-  
14                         old man who was dying of cancer, and he tried to access  
15                         the MWMA system.  He couldn't get access.  All his wife  
16                         wanted was the care that he needed.  We contacted the  
17                         Cabinet.  We contacted multiple individuals to try to get  
18                         this patient care.  But in a new system like this, it  
19                         became impossible to get him the care that he needed.  So,  
20                         basically, we as the home health agency called the  
21                         physician.  And the physician saw the need for home health  
22                         services as well.  We got that referral, and we were able  
23                         to take care of patient because that's simply what we do.

24                                 In closing, it's premature to make the  
25                                 changes to the State Health Plan that will result in

1 greater fragmentation rather than integration of  
2 providers. Changes should only be made in accordance with  
3 valid home health planning principles which consider  
4 actual changes in the delivery system and data documenting  
5 needs and gaps in services. Thank you.

6 MS. WOLSING: Thank you, sir. Our  
7 next speaker is Ron Jackson.

8 MR. JACKSON: I'll submit one.

9 MS. WOLSING: All right, thank you,  
10 sir. Our next speaker is Kip McNally.

11 MR. McNALLY: Thank you. I'm Kip  
12 McNally. I'm an attorney. And I'm here representing  
13 Commonwealth Eye Clinic that has an ambulatory surgery  
14 center in Lexington, Kentucky. I'm addressing the  
15 criteria for the granting of -- or relaxing the standards  
16 or criteria for a physician office exemption in Criteria  
17 6. We are opposed to the lessening of the criteria for a  
18 physician office exemption. That criteria creates a  
19 pathway to receive CON by a physician office.

20 For example, if a private office  
21 exemption is requested, then, a physician must demonstrate  
22 that he or she is performing an adequate volume of  
23 procedures to ensure the financial viability of the ASC  
24 and justify the issuance of a CON. Doing several hundred  
25 procedures yearly would most likely not cover the

1 regulatory and administrative costs of an accredited  
2 facility, not to mention regular overhead and fixed  
3 variables.

4           It appears that the regulation relies  
5 on accreditation by four accrediting agencies or groups.  
6 A couple of problems with that. Each agency has its own  
7 criteria. It sets its own criteria. And those criteria  
8 change from time to time for various reasons. So, how can  
9 a party like me look at the regulation and figure out what  
10 the law is? I have to go study four accrediting agencies.  
11 And, then, are they going to disclose on an application  
12 which accrediting agency is accrediting them?

13           The regulations go on to say there's  
14 no requirement of how many procedures have to be  
15 performed. So, it raises numerous problems. How many  
16 surgical procedures are supposed to be performed during  
17 the five-year period? Could it be as little as two  
18 procedures in a five-year period or one per year? The  
19 criteria doesn't state.

20           Now, those comments are inconsistent  
21 with requiring it be accredited by the accreditation  
22 groups because the accreditation groups would require you  
23 to be -- have all these facilities and perform services on  
24 a regular and continuous basis; but the regs don't say  
25 that.

1                   And, then, the problem with that is I  
2 could foresee that relying on an outside agency to provide  
3 regulatory review by a state agency could violate due  
4 process requirements of federal and state law, Equal  
5 Protection requirements of federal and state law. So, a  
6 Court could easily find a basis for -- also, it could be a  
7 violation of the Kentucky Administrative Procedures Act  
8 and the enabling statutes that are applicable here.

9                   So, if a Court threw out the  
10 requirement that an office be accredited by an accrediting  
11 agency, then, you're just left with the remaining  
12 criteria; and they're very loose. They appear to rely on  
13 the accreditation organizations.

14                   Criteria 6.a., for example, requires  
15 that the office be organized and in continuous operation  
16 in Kentucky for a period of ten years prior to the date  
17 the application is submitted. However, Review Criteria  
18 6.b. does not require -- have any requirements for regular  
19 and continuous performance of surgical procedures in the  
20 physician's office during the five-year period.

21                   Now, the accreditation standards may  
22 fix that; but if you operate under the assumption that the  
23 accreditation standards might be set aside by a Court,  
24 then, that becomes of great concern. For example,  
25 ignoring the accreditation part and just looking at the

1 other criteria, what's to prevent mobile units from coming  
2 in and setting up in the parking lot and saying I've --  
3 I've performed one day a year of service. And we don't  
4 know exactly what all these accrediting agencies will do.

5 Then, another issue with that, there's  
6 four listed in the proposed regs. why not more? You  
7 know, I could see other accrediting agencies may want to  
8 move into the state and start a business and claim that  
9 that's an anti-trust violation because they've been  
10 excluded by the regulation.

11 And, then, the criteria does not  
12 specify that the CON will be limited to surgical  
13 procedures performed in the private physician's office  
14 during the five years that are submitted to establish the  
15 application Review Criteria. Is it going to be a  
16 wide-open CON? Is it going to be very narrow for that  
17 specialty and the actual procedures performed?

18 I mean, at a minimum, it should be  
19 limited -- if it's going to be a physician office, it  
20 should be limited to the procedures that physician is  
21 licensed to perform. There's no mention of that in the  
22 regulation.

23 The regulation has no -- does not even  
24 mention restrictions on transferability of the facility  
25 once they're granted a CON. They could transfer it to a

1 for-profit ambulatory surgical company or to a hospital;  
2 and, then, it's no longer a physician office exemption.  
3 It was granted under it, but it no longer is. I mean, for  
4 example, the criteria could limit transfers to other  
5 similarly-duly-licensed physicians and that meet the other  
6 Review Criteria.

7 The primary problem with the Review  
8 Criteria is it does not require any demonstration of  
9 financial feasibility. An unprofitable facility is more  
10 likely to take action to minimize costs which could  
11 endanger patient safety. And we're probably going to have  
12 a proliferation of numerous facilities. And, then, as  
13 these facilities compete for patients, you're going to  
14 have more likelihood of failed facilities. I mean, in  
15 this state, we haven't had a failed healthcare facility in  
16 some time; or they get merged into other facilities.

17 The CON applications currently on file  
18 and deferred in the most recent Newsletter have project  
19 costs ranging from a low of 500,000 to a high of 9.2  
20 million with an average of 6.3 million for seven  
21 applications. Unless the applicant can demonstrate  
22 sufficient volume of cases to pay for the initial  
23 investment and ongoing operating costs, the applicant  
24 should not be granted a CON. It's a huge investment.

25 That's all I have on this today. I

1 plan to submit supplemental comments before June 30th.  
2 Thank you very much for allowing me this opportunity to  
3 speak.

4 MS. WOLSING: Thank you, sir. Our  
5 next speaker is Randall Strause.

6 MR. STRAUSE: Good morning. I'm Randy  
7 Strause. I'm an attorney representing Maxim Healthcare  
8 Services. And I will be submitting additional comments  
9 after my little talk here. I'm going to address the home  
10 health services, in particular, proposed Criterion 5, and  
11 speak to existing, licensed Kentucky home health agencies'  
12 applications to expand a home health service will be found  
13 consistent -- it is now being proposed with this Plan --  
14 if the following conditions are met.

15 a. The agency's most recently-published  
16 rate by CMS Home Health Compare for "How often home health  
17 patients had to be admitted to the hospital" is equal to  
18 or better than the national average; and, b., The agency's  
19 most recently-published rate by CMS Home Health Compare  
20 for "How often patients receiving home health care needed  
21 any urgent, unplanned care in the hospital Emergency Room  
22 without being admitted to the hospital" is equal to or  
23 better than the national average.

24 An issue that we feel as far as --  
25 Maxim agrees that this State Health Plan should include an

1 additional criteria for existing agencies to expand if  
2 they're providing quality services. But the exclusive use  
3 of CMS Home Health Compare indicators is prejudicial to an  
4 agency such as Maxim that predominantly provides  
5 Medicaid-covered services.

6 Home health agencies that accept only  
7 Medicaid, private insurance or private pay by their  
8 patients aren't required to report quality information.  
9 Also, agencies that primarily provide pediatric care  
10 aren't required to report on quality measures. Therefore,  
11 some agencies aren't include on the Home Health Compare.

12 Basically, the bottom line is quality  
13 information for agencies such as Maxim that focus in  
14 providing care to the often underserved Medicaid and  
15 pediatric populations will likely not have sufficient data  
16 for a meaningful analysis in Home Health Compare.

17 We propose the following. That an  
18 existing, licensed Kentucky home health agency's  
19 application to expand a home health service will be found  
20 consistent with this Plan if a minimum of one of the  
21 following conditions are met: a. The agency is  
22 accredited by the Accreditation Commission for Health  
23 Care, or, b., the agency is accredited by the Joint  
24 Commission.

25 The inclusion of the criterion will

1 allow agencies that do not provide services in the  
2 traditional Medicare model to expand home health services  
3 upon evidence that an independent accrediting body is  
4 holding it accountable and to a high standard in the  
5 quality care it provides.

6 And, again, we will provide by I  
7 believe the 30th additional comments. Thank you very  
8 much.

9 MS. WOLSING: Yes, sir. Thank you,  
10 Mr. Strause. And I'll second what he said. We have a  
11 deadline for June the 30th for additional comments. So,  
12 anyone hoping to submit anything in writing needs to do so  
13 by that date to Ms. Orme, who is sitting right here in the  
14 front row. Our next speaker is Mark Leach.

15 MR. LEACH: My name is Mark Leach.  
16 I'm here on behalf of Tran-Star Ambulance Service, and  
17 we're here to express our opposition to the removal of  
18 ambulance service from the State Health Plan. With me is  
19 Terry Music, a 20-plus-year member of the Emergency  
20 Services industry and a paramedic with Tran-Star and Ben  
21 Johnson, a CPA and Chief Financial Officer for Tran-Star.  
22 They're going to have their remarks; and, then, I'll have  
23 some closing remarks, if that's okay.

24 MS. WOLSING: That is just fine, sir.

25 MR. LEACH: Thank you. Mr. Music.

1 MR. MUSIC: My name is Terry Music.  
2 I'm a Paramedic and Director of Training and Safety with  
3 Tran-Star Ambulance in Prestonsburg, Kentucky. And we  
4 oppose the removal of ambulance service from the State  
5 Health Plan.

6 In the past, we had an ambulance  
7 service that got bought out. And there was no review of  
8 the CON for this new company coming in, and they had  
9 substandard equipment, substandard personnel. Some of  
10 their personnel were also released of their license and  
11 certifications due to substance abuse at work.

12 This is a checks and balances. CON is  
13 a checks and balances to make sure that there's quality  
14 care and there's quality people coming in to provide care  
15 for the citizens of an area, and we need to make sure that  
16 that stays that way. If it's broke, don't fix it. We  
17 need to move forward, not backward. And by removing  
18 ambulance services from the State Health Plan, we are  
19 definitely moving in the wrong direction.

20 I've been in EMS for 26 years. I've  
21 watched EMS in this state flourish, move forward. This  
22 would definitely be a step back. This has happened in  
23 South Carolina. Greenville, South Carolina alone has 12  
24 ambulance services. It's like a feeding frenzy. It's  
25 created such a debacle in Medicare that now in the State

1 of South Carolina, people have to be pre-authorized for  
2 transportation for non-emergency, repetitive transports.  
3 we don't need that in this state. We need the CON to  
4 protect our citizens. And that's all I have. Thank you.

5 MS. WOLSING: Thank you, Mr. Music.

6 MR. JOHNSON: Good afternoon, and  
7 thank you guys for allowing us the opportunity to come and  
8 speak. My name is Ben Johnson. I'm the CFO for Tran-Star  
9 Ambulance. I work with Terry here closely and Mark. We  
10 have operations in Eastern Kentucky; Floyd County, Pike  
11 County, Maggofin County, Knott County and Leslie County  
12 primarily.

13 And as part of the CON process, one of  
14 the big things is a cost feasibility study. In order for  
15 a new service to come into our area, they would have to  
16 provide a cost feasibility study as to basically whether  
17 or not there's enough volume there -- run volume there to  
18 substantiate that all of us can remain a going concern  
19 financially. Okay?

20 And in regards to that, our breakdown  
21 is roughly 60, 65% of our runs are non-emergency. And as  
22 the gentleman earlier spoke, should anyone be able to come  
23 into our area, they could cherry-pick a lot of those  
24 non-emergency runs and, therefore, creating financial  
25 instability for us to maintain and keep the quality up for

1 the emergency runs.

2                   Going in that direction would also  
3 jeopardize our ability to invest in new equipment. We'd  
4 have to make tough decisions in regards to possibly  
5 layoffs. Just the financial impact of anyone being able  
6 to come into our area without justifying that there's  
7 enough volume there to be financially stable could affect  
8 patient care negatively. So, that's really -- you know,  
9 for that reason, you know, that's why we oppose the  
10 removal of the ambulance services from the State Health  
11 Plan. Thank you.

12                   MS. WOLSING: Thank you, Mr. Johnson.

13                   MR. LEACH: And, again, my name is  
14 Mark Leach. So, just some further comments. Ambulance  
15 services are treated differently by Kentucky CON  
16 currently. It has its own application. There's the  
17 application for every other health service; and, then,  
18 there's the application if you're an ambulance service.  
19 It's a recognition that ambulance service is not like  
20 every other health service. It, by its nature, involves  
21 emergency response.

22                   But as you're heard from other folks  
23 that have already spoken, one of the concerns about the  
24 removal of an ambulance service so that, then, new  
25 applicants would just go through Non-sub Review is that it

1 just makes business sense to do only non-emergency runs.  
2 They require the lowest costs with the most likely  
3 reimbursement because they're scheduled runs by people  
4 that generally can pay versus emergency runs, which are  
5 generally going to be higher costs because they definitely  
6 are going to need some supplies and equipment when you  
7 report on-scene and you're reporting with a higher level  
8 of personnel. You have a paramedic and not just an EMT in  
9 the back. And, then, those are also the least likely to  
10 be reimbursed or less likely to be reimbursed because it's  
11 an emergency. People get into emergencies whether they  
12 have health insurance or not, whether they can cover it or  
13 not.

14 One of the challenges of this  
15 rule-making proposal exercise -- and maybe it's out there  
16 and I just haven't found it -- is there's not that I could  
17 see an expressed reason for why ambulance is being removed  
18 from the State Health Plan. So, we're kind of having to  
19 comment on this guessing what the reasons are for why  
20 ambulance is being removed.

21 I know the goals of CON modernization  
22 include making Kentucky align with how other CON states do  
23 it, and I know some other CON states don't regulate  
24 ambulance but some other CON states still do. And I don't  
25 see how that alone can be a justification; that simply if

1 some states that have CON don't regulate ambulance, well,  
2 then, we won't regulate ambulance. That doesn't take into  
3 account the specifics of Kentucky versus how that might  
4 work in those states.

5 Ohio is such a state that doesn't have  
6 CON review of ambulance, but it has CON review of other  
7 things. But, then, again, Ohio is far more populated with  
8 much more major cities than Kentucky and not as rural of a  
9 population as Kentucky. So, simply saying, well, some  
10 other states don't do it isn't justification enough to say  
11 we shouldn't do it here in Kentucky.

12 Because the concerns that have been  
13 addressed and the concerns from KAPA and other ambulance  
14 providers that I expect you'll hear today about this risk  
15 of cherry-picking, it's currently addressed in the State  
16 Health Plan as it's written now. First of all, if you're  
17 going to apply, you have to put on notice all governing  
18 local agencies operating an ambulance company that you  
19 plan on moving into their territory. That gives the tax-  
20 based systems a chance to determine whether they need  
21 another provider or whether that will negatively impact  
22 the level of service in their town.

23 The challenge of folks coming in --  
24 new providers coming in and providing the non-emergency  
25 runs is that, then, it tips the balance of those services

1 that are providing emergency runs that aren't going to get  
2 reimbursed for the non-emergency runs that they do. It's  
3 going to be a higher percentage of their service of just  
4 doing the lower-reimbursed or less-likely-to-be-reimbursed  
5 emergency runs.

6 And, so, to provide emergency  
7 services, as you've heard from the two others that have  
8 already testified, is they're going to have to be further  
9 subsidized. That seems entirely counter to the entire  
10 purpose of CON, which is to avoid duplication and to lower  
11 public spending or to at least hold down public spending.  
12 This is going to increase duplication by having people be  
13 able to come in and cherry-pick non-emergency runs and,  
14 therefore, increase public spending in order to subsidize  
15 these providers.

16 The second part of the State Health  
17 Plan, then, says that if you have competing applications,  
18 the provider that's offering the higher level of service  
19 should get preference. Again, that's recognition that we  
20 prefer the service that is going to be a full-service  
21 ambulance service that is going to do both emergency and  
22 non-emergency.

23 And, then, that's reflected in the  
24 third Criteria of the State Health Plan which says if the  
25 new applicant is only applying to do lower-level,

1 non-emergency runs, then, they have to meet a higher  
2 burden of showing that the existing services cannot meet  
3 the current need for those runs.

4 The State Health Plan as written  
5 addresses the exact concerns that are going to be  
6 expressed and have been expressed by ambulance providers.  
7 And, so, without knowing what the reason is for removing  
8 ambulance service, then, at least right now there is no  
9 reason to remove ambulance service. And it should not be  
10 removed because it will be detrimental to the delivery of  
11 ambulance services across the Commonwealth, resulting in  
12 higher public subsidization in order to meet what  
13 ambulance services -- everybody else thinks of when you  
14 think of ambulance services; a 911 call when you  
15 absolutely need an ambulance to respond.

16 We need to make sure that there exists  
17 the current market as the CON governs it to allow those  
18 providers that are full-service to provide full-service  
19 and then make up those losses by doing the non-emergency  
20 runs and not have those taken away by providers that are  
21 just coming in for business sense.

22 We'll also be providing written  
23 comments by June 30th. Thank you.

24 MS. WOLSING: Thank you, sir. Our  
25 next speaker is Dave Goffman.

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MR. HOFFMAN: Hoffman.

MS. WOLSING: Hoffman?

MR. HOFFMAN: Yeah.

MS. WOLSING: Okay.

MR. HOFFMAN: Good morning. Everybody awake? My name is Dave Hoffman, and I'm an Administrator for an ophthalmology practice in Paducah, Kentucky. I attended the Health and Welfare Joint Committee Meeting last week, and I heard several interesting comments as it pertains to ophthalmology and possibly seeking an ambulatory surgery center. I just want to state a few of those.

Flexibility to transition provider business models; readily adopt technology to increase high-quality health services; provide a full continuum of care, especially in outpatient care; a discrete exemption for ASCs. These comments were made by the Cabinet's Secretary last week. And, essentially, these comments are exactly in line with what ophthalmology has been saying three years ago when I started a process to try to actually seek a legislative exemption for ophthalmologists in seeking ASCs to treat their patients as a part of their facilities.

Ophthalmology is certainly -- and the group I represent and physicians that I represent from

1 around the Commonwealth are appreciative of the efforts of  
2 the Cabinet. We applaud your efforts to modernize this  
3 process. And we do that knowing that at this point,  
4 ophthalmology is 100% excluded from the office exemption.

5 Before I explain how we are excluded,  
6 I'd like to just make a couple of points as to why  
7 ophthalmology is unique. Ophthalmology is the only  
8 medical specialty that is allowed to perform a non-covered  
9 procedure at the same time they are performing a covered  
10 procedure.

11 Essentially, what does that mean? If  
12 you go in to have a knee replacement, you go in; you get  
13 diagnosed; you have your knee replaced. You don't have a  
14 conversation with the doctor that says, you know, I really  
15 like to play tennis; and I'd like that super-duper x5000  
16 model that enables me to play tennis better. You never  
17 have those conversations.

18 Well, in ophthalmology it's different.  
19 You have several pre-surgical options that you can pay for  
20 on top of your covered procedure. Medicare, Medicaid,  
21 third-party payors are going to pay for the extraction of  
22 your cataract as well as a lens implant. However, if you  
23 choose to, say, use a laser to extract that cataract, that  
24 could be an option that a patient could pay extra for. If  
25 you want to have your stigmatism corrected, you could pay

1 extra for that. If you want a specialty lens that will  
2 allow you to see both distance and near, then, that also  
3 can be paid for. And those are out-of-pocket costs borne  
4 by the patient that are done at the time of the covered  
5 procedure.

6 That point and that distinguishing  
7 point is critical when it comes to kind of distinguishing  
8 ophthalmology from other specialties and subspecialties.  
9 And we look at the Secretary's goal of readily adopting  
10 technology to increase high-quality health services.  
11 History in the Commonwealth has shown that eye technology,  
12 as any technology, is expensive.

13 But what happens is the -- by statute,  
14 by ordinance, the surgery center, either owned by a  
15 hospital, owned by a multi-specialty ASC, they're unable  
16 to recoup costs from the patient to offset the cost of the  
17 technology. So, therefore, the technology is not being  
18 purchased by the hospitals. It's not that the hospitals  
19 are bad people. It's just a business decision. So,  
20 essentially, what happens is the technology is not, then,  
21 made available to the public.

22 Throughout the Commonwealth, the best  
23 information I have is that over the last -- this  
24 technology became available about three or four years ago.  
25 There was one hospital that purchased the technology.

1 Since they were unable to seek reimbursement from the  
2 patients for use of the technology, they were then trying  
3 to seek reimbursement from the doctor to use the laser.  
4 Well, of course, it became a financial problem, then, for  
5 the surgeons because they're taking all their fees that  
6 they're thinking -- they're using it to pay for the use of  
7 the laser. And that is the only laser that was bought,  
8 and it essentially sits unused.

9 This whole entire issue of technology  
10 and not being able to have this technology I think is a  
11 really crucial point when it comes to allowing  
12 ophthalmology to participate in the opportunity to have an  
13 office-based ASC. And it kind of relates to the Secretary  
14 speaking about the flexibility to transition a provider's  
15 business model as well as a delicate balance between  
16 competition and quality.

17 would it surprise you to know that  
18 there is not one ophthalmologist employed by a hospital in  
19 the Commonwealth of Kentucky? Yet, they have tremendous  
20 power as stakeholders to determine what we do for our  
21 business models, to determine how we treat our patients,  
22 to determine what technology we're going to provide and  
23 provide to our patients. The fact is that if  
24 ophthalmologists in certain situations were allowed to own  
25 an ASC, it would never result in a patient leaving the

1 care of the hospital to seek care elsewhere.

2 So, what I'd like to do now is address  
3 the issue of the proposed modernization language and  
4 explain why, in my opinion, it excludes ophthalmology. We  
5 can all see the language about the ten-year kind of  
6 limiter; that you have to be in business for ten years;  
7 you have to be organized; that the ASC is located in the  
8 county where the private office is located; and that there  
9 can only be one ASC per provider. And we're fine with  
10 that. We are not looking to build a network of ASCs to do  
11 hips and shoulders and get all these multi-specialties.  
12 We want to single-specialty ASCs so that we can treat eyes  
13 as part of our continuum of care.

14 But if we look at #2, it says the  
15 applicant documents that the proposed outpatient surgeries  
16 have been performed in the private office for a period of  
17 five years. And when I'm talking about ophthalmology in  
18 this, I'm talking about cataract surgery. That is the  
19 bread and butter of ophthalmology.

20 And in my knowledge, there's not one  
21 cataract surgery that has been performed in an office in  
22 five years, in ten years. It's simply not the standard of  
23 care. And from a financial perspective, you certainly  
24 have costs to do that surgery. You have disposables.  
25 And, so, if you are not getting a reimbursement from a

1 facility fee to offset the cost of doing the surgery, it  
2 does not make any sense to continue to do those surgeries  
3 in your office.

4 And I, with interest, over the last  
5 three years have heard others talk about -- that have  
6 their own ASCs talk about all of the pitfalls of allowing  
7 other physicians to have an ASC. And I listened with  
8 interest today when it was said that you were going to  
9 have a proliferation of facilities, and it's just simply  
10 not true. I mean, any physician, any business person is  
11 going to look at a financial model and they're not going  
12 to pick -- well, a perfect example is our practice.

13 Sometimes after cataract surgery, you  
14 can have scar tissue. And there's a thing called a yag  
15 capsulotomy that you can do in your office. You can  
16 certainly do that procedure in a surgery center, and you  
17 could certainly get reimbursed for it. For the  
18 convenience of our patients, we don't do it. We do it in  
19 our office. We do hundreds of them a year.

20 So, the notion that we would take that  
21 procedure and go get an ASC and invest millions of dollars  
22 so that we could do that one procedure is not going to  
23 happen. It's just simply not going to happen. Every  
24 surgeon, every business person is going to look at a  
25 financial model and say, look, do I do enough surgery, do

1 I have enough volume to sustain this surgery center.

2 I think there might be room for a  
3 solution that includes ophthalmology. And my simple  
4 solution would be that -- especially when it comes to the  
5 technology -- is that we craft language and include it  
6 that creates a very discrete exemption which accomplishes  
7 the goals of the Cabinet. And you could have language  
8 that stated that if a provider in the past five years has  
9 purchased technology or is going to purchase technology  
10 that the hospital or ASC where they currently do surgeries  
11 is unwilling to purchase, then, they would receive the  
12 exemption and they would be allowed to move forward with  
13 their hospital-based ASC; meet the ten-year requirement,  
14 only one surgery center, all those limiters.

15 And, again, these are single-specialty  
16 ASCs just to do eyes and eyeballs only; not hips, not  
17 shoulders, not any of those things. And I think that  
18 would do a lot of things. It would allow for a continuum  
19 of care, which is sought after by the Cabinet; to provide  
20 better access to care. And it would certainly reduce the  
21 cost of care to the patients who are not having to pay the  
22 premium to be -- 53% premium to have surgery done in a  
23 hospital-based ASC.

24 I thank you for your time and the  
25 opportunity to talk. And if anybody has any questions

1 from the Cabinet, I would certainly make myself available  
2 at anytime. Thank you very much.

3 MS. WOLSING: Thank you, sir. At this  
4 time, I believe I've gone through the whole list of people  
5 who have signed up to testify. Is there anyone who signed  
6 up on this sign-in sheet and indicated that they wanted to  
7 testify who I have not called? Yes, sir, please come on  
8 up. What's your name, sire?

9 MR. HALE: Steve Hale.

10 MS. WOLSING: Steve Hadle.

11 MR. HALE: H-a-l-e, Hale.

12 MS. WOLSING: Hale.

13 MR. HALE: I don't have much in common  
14 with anybody in the whole room. Probably in the wrong  
15 room. But EMTs are my heros; so, anyway, I love you guys;  
16 and I donate to anything that you all do; and I believe in  
17 everything that you do. But I'm just an old country boy  
18 capitalist that didn't know what CON stood for other than  
19 getting conned before six months ago and discovered -- for  
20 32 years, I've been a volunteer at our local rest home in  
21 Springfield, Kentucky. And I have watched numerous  
22 ownerships, and I have watched numerous stages of this  
23 rest home. And if I get out of line, you tell me my time  
24 is up. But we've gone from stench so bad you can't even  
25 walk in the building to fecal matter on the floor. And

1 for 32 years, every week, I have gone there and  
2 entertained those folks. Okay?

3 why, when I discovered six months,  
4 can't we have a new rest home in Springfield, Kentucky?  
5 And everybody says it's because of CON. Your demographics  
6 are wrong. You don't have the populous. You can't make  
7 it work. So, our people are captive to this system, and  
8 they're stuck in this nasty rest -- which I shouldn't say  
9 right at the moment because the new ownership that just  
10 took over, it smells much better. But it's still an issue  
11 that we have, and I did not understand it.

12 So, I started calling developers. I  
13 said, look, I can find you some land. C'mon down; let's  
14 build us a nice, state-of-the-art rest home. I said you  
15 can put senior living up here, stuff like that. Well,  
16 then, they started coming back, well, if you build senior  
17 living and one of four of those can go into a -- you know,  
18 and you can go that route, but you can't just build a rest  
19 home in Washington County, Kentucky; and we desperately  
20 need one.

21 I have families that I have dealt with  
22 that have threatened their children if they put them in  
23 that rest home, they will haunt them till the day they  
24 die. We have people that have to go as far away as  
25 Louisville from Washington County to get the kind of care

1 that they want. So, I just wanted to go on the record as  
2 saying that I have a major problem with a C-O-N or a "con"  
3 or whatever you want to call the thing and how it applies  
4 to people in demographic areas that actually don't meet  
5 the criteria but have a tremendous need.

6 I can't go anywhere without telling a  
7 story. So, I'm going to tell one, quick story because  
8 I've been listening to the nays and the yeas of all the  
9 things that are going on in this room. There's people  
10 that like the change. There's people that don't like the  
11 change. It reminds me of Forrest Gump dying. And Forrest  
12 Gump got to heaven and here came St. Peter running down  
13 there.

14 He said, Forrest, I heard you were  
15 coming. He said, but we've changed the rules up here in  
16 heaven now. You've got to answer three questions to get  
17 in. He says, well, Momma says stupid is as stupid does.  
18 So, he said, first question, what days of the week start  
19 with the letter "T". And Forrest studied a moment. He  
20 goes today and tomorrow. St. Peter said, wait a minute;  
21 that's not the answer I was looking for but, yeah, that's  
22 right.

23 Second question, how many seconds in a  
24 year. Twelve. He goes 12? How do you get 12? He said,  
25 January 2nd, February 2nd, March 2nd. Last question,

1 Forrest. You want to go to heaven, what is God's first  
2 name? Andy. Andy? Where did you get that? He goes Andy  
3 walks with me, Andy talks with me. He opened the gate and  
4 he said run, Forrest, run.

5 we all don't look at things the same,  
6 okay? As a capitalist entrepreneur, this "con" law bugs  
7 me bad. It eliminates free enterprise. It creates a  
8 monopoly. And it creates people being entrapped in a  
9 system that they can't get out of. Steve Hale,  
10 Springfield, Kentucky. Thanks for your time.

11 MS. WOLSING: And thank you, Mr. Hale.  
12 Is there anyone else who has -- whether they have signed  
13 up on this sheet or not -- has anything that they want to  
14 add, any testimony that they would like to provide, please  
15 raise your hand now. Okay. In that case, this concludes  
16 this hearing. We are now off the record. Thank you very  
17 much for your participation.

18 (END OF MEETING)

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STATE OF KENTUCKY

COUNTY OF FRANKLIN

I, Rita Susan Moore, a notary public in and for the state and county aforesaid, do hereby certify that the foregoing fifty-six pages are a true, correct and complete transcript of the public hearing in the above-styled matter taken at the time and place as set out in the caption hereof; that said public hearing was taken down by me in shorthand and afterwards transcribed by me.

Given under my hand as notary public aforesaid, this the 1st day of July, 2015.

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Notary Public  
State of Kentucky at Large

My commission expires January 8, 2016.