Approved 1-19-84
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Marvin Littlejohn
Chairperson at

1:30 a.m./p.m. on January 12, 1984 in room 423-S of the Capitol.

All members were present except:

Rep. Bill Reinhardt, Rep. Susan Roenbaugh, Rep. Theo Cribbs, all excused.

Committee staff present:

Emalene Correll, Research
Norm Furse, Revisor
Sue Hill, Secy. to Committee

Conferees appearing before the committee:

Dr. Robert C. Harder, Secretary of Department of SRS

Visitor's register, Attachment No. 1.

Chairman Littlejohn called the meeting to order, welcoming all members of the committee back for an exciting and busy year. He further welcomed two new committee members; Representative Vernon Williams, and Representative Ed Rogers, and introduced them to all present. He then introduced staff members, Emalene Correll, Norm Furse, and Sue Hill. It was noted that Bill Wolff from Research will also help staff this committee at times, however Mr. Wolff was not present this date.

It was called to the attention of committee that last day to request bills is January 20th, and last day to introduce bills is January 22nd.

Dr. Robert Harder was introduced and gave a brief outline of the SRS Annual Report for 1983 that was given to each committee member. (This Report is on file.) Committee and Staff asked several questions during Dr. Harder's remarks on this report.

See (Attachment A.) This Attachment from Dr. Harder shows requests for bills showing 13 items. Chairman entertained a motion, and Representative Branson made such motion to introduce these bills and ask they be returned to Public Health and Welfare committee for hearings. Motion seconded by Rep. Blumenthal. No Discussion, Motion carried.

See (Attachment B.) This Attachment from Dr. Harder shows requests for 4 bills. Chairman entertained a motion, and Rep. Wagnon made such a motion that the items 1, 2, 3, on this attachment be recommended they be introduced, but leave to Leadership where they will be referred. Rep. Green seconded this motion, no discussion, and motion carried.

Rep. Hassler moved we introduce item 4 on this attachment and ask that the bill be returned to this committee for hearings. Rep. Harder seconded the motion. Motion carried. Rep. Jerry Friedeman recorded as voting no on this motion.

Chairman noted to committee (Attachment No. C.), the Health Planning Review Commission Report given to each member.

Meeting adjourned at 3:00 p.m.

Date: Jan 12

PLEASE PRINT

GUEST REGISTER

HOUSE

PUBLIC HEALTH AND WELFARE

NAME	ORGANIZATION	ADDRESS
Jack Snowbarger	Alliance of Ch. Childrens Homes	RI Perry KS.
John Kelly	DHR	Topeka
Ed Rogers	INS	Wichita
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PROCEDURE FOR KANSAS	TOPEKA
Richard Koerth	Budget Division	Topeka
Bob Woodson	Gov Office	Topeka
Gary Petz	KDoA	Topeka
Rebecca Kregpper	Ks. Hospital Assoc.	"
Dick Hummel	Ks. Healthcare Coalition	Topeka
Ken Schafermeyer	Ks Pharmacists Assn	Topeka
Denise Taylor	Office of Jud. Admin.	Topeka
Jerry SLAUGHTER	KS MEDICAL SOCIETY	TOPEKA
Arlen Whitfield	SRS	Topeka
Robert C Harder	SRS	Topeka
Gary Robbins	Ks Optometric Assn	Topeka
Barb Reinert	KWPC	"
Diane Bottorff	KSNA	"
Sherm Parks, Jr	Ks Chiropractic Assn.	"

Attm #1
1-12-1984

1-12-84 Att a

STATE OF KANSAS

JOHN CARLIN, Governor

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

ROBERT C. HARDER, Secretary

STATE OFFICE BUILDING
TOPEKA, KANSAS 66612

House Public Health and Welfare Committee
(possible assignment to PH&W)
January 12, 1984

1. Debt Collection at State Hospitals.
2. Adult Abuse Reporting - Adult Care Homes and Medical Facilities.
3. General Assistance Fraud Convictions.
4. Generic Brand Exchange of Prescriptions.
5. Cost of Prescription Drugs.
6. Health insurance paid to group homes. Prohibiting exclusionary clauses related to health insurance.
7. Child Abuse as it Relates to Boarding Homes or Family Day Care Licensure.
8. Sexual Abuse as Defined Regardless of a Child's Age.
9. Alcohol Commitment Act Amendments.
10. State Institutions for the Mentally Retarded.
11. Appointment of Interpreters for Deaf and Hearing and Speech Impaired Persons.
12. Kansas Department of Social and Rehabilitation Services Placement Agreement with Kansas Department of Corrections.
13. Child Support Enforcement Bills.

2360E

Attm. # a.
1-12-1984

1. Debt Collection at State Hospitals

This bill amends K.S.A. 59-2006 in the following three areas: (1) A technical change that changes reference to patients from "his or her" to "such patient". (2) The requirement for an annual demand is changed to periodic demands that will be made not less than once per fiscal year. (3) Authorization is provided to permit contracting with a debt collection agency.

Present statutory language about an annual demand is a holdover from a time when patients and relatives were not provided with monthly or quarterly statements billing them for amounts due. The annual demand was to inform responsible parties about charges that had accured during the year. Now that monthly or quarterly statements are provided for responsible parties the former requirement is not necessary to keep persons informed. State hospitals encounter a number of patient accounts that they are unable to collect and do not qualify for legal pursuit. A private collection agency that is tied to national collection networks is better equipped to collect these problem accounts. The amendment would authorize the Secretary of S.R.S. to contract with a collection agency on a commission basis.

2. Adult Abuse Reporting- Adult Care Homes and Medical Facilities

This bill amends the current statute requiring only certain professional staff in medical facilities to report incidents of abuse and neglect of adults to include a certified psychologist, an employee of the adult care home or medical facility in which the resident resides and law enforcement officials.

The proposed legislation also penalizes those who knowingly and willfully fail to report incidents of abuse and neglect of adults (Class B Misdemeanor).

3. General Assistance Fraud Convictions

K.S.A. 39-709 currently provides that any person who has been convicted of welfare fraud in this or any other state is forever ineligible for General Assistance in Kansas. This is an extremely harsh penalty for first time offenders.

This bill provides for lessening the existing penalty to a one year period of ineligibility for first time offenders. Second time offenders would forever be ineligible for General Assistance.

4. Generic Brand Exchange of Prescriptions

This bill would amend the existing K.S.A. 65-1637 of the Kansas Pharmacy Practice Act which addresses requirements for dispensing of prescriptions. The present statute permits pharmacists to exercise brand exchange to achieve a lesser cost to the purchaser unless the prescriber prohibits such exchange by indicating the prescription is to be dispensed as written.

The proposed amendment to this legislation would eliminate the prerogative of a prescriber override for prescriptions dispensed in programs developed by the Secretary of SRS. The purpose of this change is to provide less restriction to the potential utilization of lesser cost bioequivalent generic drug products.

5. Cost of Prescription Drugs

This bill would provide new legislation requiring that the price of prescription drug products sold to Kansas pharmacies be at a price which is not greater than the lowest price for that product anywhere in the continental United States. The purpose of this proposal is to assure that purchasers of prescribed drugs in the state of Kansas receive benefit of the lowest product cost available for each product.

6. Health Insurance Paid to Group Homes Prohibiting Exclusionary Claims Related to Health Insurance

This proposed legislation prohibits individual, group health, accident and sickness insurance policies in Kansas from excluding or limiting coverage because an insured is eligible for Medical care under a plan developed by SRS.

Any group health or accident and sickness insurance policy in this state, on or after the effective date of this act, shall provide coverage for the treatment of emotionally handicapped children in a boarding home for children licensed by the Secretary of Health and Environment if the policy provides coverage for inpatient hospital medical coverage. Coverage shall be on the same basis as inpatient hospital medical coverage provided under the policy.

7. Child Abuse as it Relates to Boarding Homes or Family Day Care Licensure

This proposed legislation amends K.S.A. 1983 Supp. 65-516, K.S.A. 1983 Supp. 65-519. The first amendment in K.S.A. 1983 Supp. 65-516 prohibits a person from maintaining a boarding home for children or a family care home if in such facility there resides a person who "(i) has committed an act of child abuse as confirmed by the State Department of Social and Rehabilitation Services." Section 2 amends K.S.A. 1983 Supp. 65-519 in a like manner in regard to registration of family day care homes and authorizes the Secretary of Health and Environment to have access to any report of confirmed child abuse if such request is in conjunction with the Secretary's licensing or registering responsibilities.

8. Sexual Abuse as Defined Regardless of the Child's Age

This proposed legislation amends K.S.A. 1983 Supp. 38-1502 in section (c) defining "sexual abuse" to broaden the ages covered by the criminal those acts described in K.S.A. 21-3602 or 21-3603 and amendment thereto to

include all children under the age of 18 years by adding the phrase "regardless of the child's age." This amendment is needed to bring us statues in article 35, chapter 21 of the Kansas Statutes Annotated and into compliance with federal regulations regarding "sexual exploitation" of children. This correction must be made this legislative session in order for Kansas to be eligible for the federal child abuse formula grant money distributed next September.

It should be noted that we have asked for an Attorney General's opinion regarding the need for this change, but a formal opinion has not been received.

Section 2 of this bill deletes sub-section (f) from K.S.A. 1983 Supp. 38-1508 in order to eliminate the problem with eligibility for the federal child abuse formula grant money that we had last summer regarding confidentiality of law enforcement records. Sub-section (f) was the section deemed too broad and too loose to conform to the federal regulations by the federal people. There should be no repercussions from deleting this section, as all valid interested parties continue to have access to the records they need.

9. Alcohol Commitment Act Amendments

This bill amends the existing Alcohol commitment statutes. The changes are proposed so that the alcohol procedures follow the same criteria as the Mental Illness commitment statutes. In addition, this bill will allow a psychologist or a physician to determine if a person is incapacitated by alcohol. This bill lowers the maximum time for short term care or treatment or an order for referral not to exceed 60 days, in order to comply with existing treatment program length. This bill allows the Secretary of SRS to determine the county of residence of a patient or the county that has the closest nexus to the patient in order to determine source of payment for cost of treatment to the patient.

10. State Institutions for the Mentally Retarded

This bill establishes the process for the admission of a mentally retarded person to a state institution and establishes the rights of persons admitted to the institutions.

11. Appointment of Interpreters for Deaf and Hearing and Speech Impaired Persons

This bill amends K.S.A. 75-4351 and 75-4353 and repeals the existing sections regarding the appointment of qualified interpreters for persons who are deaf, hearing impaired or speech impaired and whose primary communication is non-verbal or through the use of sign language. The appointing authority, who is the presiding officer of the governmental entity where the interpreter is required, shall appoint interpreters from a list of qualified interpreters maintained by the Kansas Commission for

the Deaf and Hearing Impaired. In addition, the governmental entity conducting the proceedings shall pay for the services of the interpreter at the rate established by the Kansas Commission for the Deaf and Hearing Impaired and may provide for the payment of such services out of funds appropriated for its operation.

12. Kansas Department of Social and Rehabilitation Services Placement Agreement with Kansas Department of Corrections

This bill authorizes the Secretary of Social and Rehabilitation Services to enter into an agreement with the Secretary of Corrections concerning the management and utilization of vacant buildings and land at the state institutions.

13. Child Support Enforcement Bills

I Income Assignment - amend K.S.A. 60-1613. This proposal is considered by CSE to be the most important support enforcement remedy proposed by SRS, in that it would provide an expedient and inexpensive collection device which could be used by any person to whom a support obligation is owed (including, but not limited to the Secretary of SRS). This proposal would expand and strengthen the current wage assignment law found at K.S.A. 60-1613 in the following ways:

1) makes all income (not just wages and trust income) subject to the assignment;
2) mandates that a wage assignment order be issued by the court if support is 30 days past due;
3) allows the court to require the posting of a bond if the obligor is self-employed or has income from some source not subject to the court's jurisdiction
4) provides specific penalties for an employer's non-compliance with the court's assignment order and protections for the employee/obligor;
5) provides for due process and a speedy hearing if requested by the obligor.

II Administrative Process - This proposal closely parallels legislation recommended by the National Conference of State Legislatures and is similar to existing laws in 17 states including Missouri. As a method of relieving the courts from the time consuming burden of domestic enforcement of support cases, the establishment of administrative procedures to both establish and enforce child support orders concerning children who are receiving ADC assistance is proposed. The administrative authority to establish and enforce support obligations is conferred upon the director of the state Title IV-D agency. Due process is afforded the responsible parent by providing notice of the accrued and accruing support debt (which is based on the child's share of the ADC grant). An opportunity for an administrative hearing is provided as well as appeal rights into the court system.

Once an administrative support order is established, an administrative enforcement of the order may occur by establishing a lien on real estate, garnishment, and other remedies - all without involving the courts. Such an administrative process is much more cost and time efficient than traditional court methods. In Kansas, precedent for use of similar administrative processes has already been established in tax offset, workers compensation, Social Security and civil rights cases.

III Blood Tests to determine paternity - amend K.S.A. 23-131 This proposal is intended to bring the Kansas Statutes into compliance with recent case law developments concerning the admissibility of HLA and extended factor blood tests in paternity proceedings. In addition, SRS would be given standing to request an order for blood tests in cases where support rights have been assigned to the agency. The proposed amendment also includes a provision that any male witness who will testify that he had sexual relations with the mother during the time of conception be required to submit to blood tests.

To assist in introducing blood test results into evidence, the proposed amendment provides that a verified written expert's report will be admitted into evidence unless a challenge to the test is made at least 20 days before trial.

IV Reciprocal Enforcement of Support Act (URESA) - Amend K.S.A. 23-452

This amendment is proposed to bring the State of Kansas into uniformity with most other states which allow for the enforcement of arrearages based on another state's order for support. Currently, Kansas law only allows for the enforcement of arrearages accruing on the basis of a Kansas URESA order. Most other states are enforcing Kansas arrearages pursuant to the URESA. As the law exists, we cannot reciprocate as we should.

V Paternity Proceedings by the County and District Attorneys - Amend K.S.A. 38-1104.

The intention of this amendment is to bring the law in Kansas in line with two recent U.S. Supreme Court decisions which have determined that one and two year statutes of limitation concerning the establishment of paternity are unconstitutional.

VI Assignment by Operation of Law in Caretaker Relative Cases - Amend K.S.A. 39-709

To establish an assignment of support rights to SRS by operation of law in cases where parents, who possess support rights, relinquish physical custody of a child to a relative who then receives ADC for the child. This amendment would avoid the injustice of a parent who no longer has physical custody of a child continuing to receive child support while the child is being supported by the state and federal governments.

VII Amend K.S.A. 39-718a to clear up ambiguities which have caused interpretation problems. The amendment makes it clear that if a parent is absent from the home where the child resides, that parent will be responsible for reimbursing SRS for the child's share of ADC unless a court has considered the issue of support and the absent parent has fully complied with the terms of the court's order.

VIII Amend K.S.A. 39-754 in Three Ways:

1) Although current law only requires that notice of the SRS assignment be given to the Clerk of the Court, this amendment would make it clear that a copy of the notice need not be sent to the obligee or the obligor. The obligee is informed of the assignment on application for ADC and the assignment in no way affects the obligor's rights or duties. He or she must still pay the same amount of support to the Clerk of the Court in most cases.

2) To prevent huge sums of assigned support arrearages from being misdirected by the Clerks of the Court after ADC cases close, this amendment would require the Clerks to send the entire support payment to SRS if an SRS assignment is on file and if the payment exceeds the amount of the current support order. SRS would then forward the amount of current support to the obligee and retain the excess as assigned arrearages.

3) Currently, most Clerks of Court are refusing to record, on the obligor's payment ledger, collections of support mdae directly by SRS pursuant to state and federal debt setoff procedures and collections from unemployment compensation. In order to maintain the integrity of the court's payment ledger - which serves as a public record of existing judgment liens - this amendment is necessary.

IX Amend K.S.A. 39-755 to make it clear that SRS does have the right to enforce assigned arrearages which are based on any support order (not just orders established by SRS) and the right to modify such orders as the assignee of support rights. By policy, we only modify orders to benefit the child.

X Amend K.S.A. 39-758 to require private employers to disclose information to the state IV-D unit for use in the establishment and enforcement of support orders. Information possessed by employers is essential if the state is to be reimbursed for welfare costs.

XI Amend K.S.A. 44-514 to make workers compensation payments subject to collection for the purpose of support enforcement. Such an amendment would remedy the injustice of obligors with large support arrearages receiving workers compensation awards which cannot be attached.

XII Amend 44-718 to allow for the collection of spousal support as well as child support from unemployment compensation by the state IV-D agency. This amendment is required by federal mandate.

In addition, the proposal would specifically provide that collection of unemployment compensation for child support could be accomplished by state setoff procedures.

XIII New section to be placed in the domestic code regarding settlements or agreements when support rights are assigned to SRS

Because private attorneys will often settle away support which has been assigned to SRS in behalf of the state, this new section provides that no settlement, satisfaction, release or other agreement concerning assigned support may be achieved without the written consent of the Secretary of SRS. The intention of this proposal is to prserve the state's claim to assigned support.

XIV Default judgments in paternity cases - Amend K.S.A. 60-255 to specifically provide that statutory default judgment provisions apply to paternity suits. Although most judges grant such default judgments, some judges are reluctant to do so. The result is that a putative father can defeat a judicial proceeding by merely ignoring the service of process.

IV Temporary Support - Amend K.S.A. 60-1607 to require that assigned temporary support be journalized as a final judgment in favor of SRS at the time a divorce is finalized or dismissed. Once again this proposal is intended to preserve the state's claim to assigned support.

XVI Amend K.S.A. 60-1610 - to establish the receipt of ADC as a material change in circumstances which would allow reconsideration of the support order. In addition, the receipt of ADC is added as a relevant factor for the court to consider in determining the amount of support to be paid.

XVII Amend K.S.A. 60-2310 to provide that arrearages based on a Kansas order which are assigned to any other state's title IV-D program may be enforced by garnishment. This amendment is suggested so that Kansas may properly reciprocate with other states in a national support enforcement effort.

XVIII Amend K.S.A. 60-2403 (Dormancy of Judgments) - Since child support has been determined by the courts to be a right that belongs to the child, dormancy provision should not begin to run until after the child is able to enforce those rights in his or her own name as an adult.

This amendment would provide a child support exception to existing statutory law which causes judgments to lapse into dormancy after five years and become void after seven years. Dormancy would not begin to occur until five years after the child becomes an adult. If enacted, this amendment would benefit children and the general public, as well as SRS. In many cases, deserted children and mothers are unable to locate the obligor to attempt some legal action to keep judgments for support alive until after they have become dormant or void.

XIX Another held over bill concerns an amendment to K.S.A. 65-2422b which would require the parties to a divorce to give their social security numbers as part of a divorce worksheet already required by this statute.

Social security numbers are vital in location efforts if support enforcement becomes necessary or in cases of parental kidnapping.

1-12-84 #B

STATE OF KANSAS

JOHN CARLIN, *Governor*

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

ROBERT C. HARDER, *Secretary*

STATE OFFICE BUILDING
TOPEKA, KANSAS 66612

House Public Health and Welfare Committee
(possible referral to other committees)
January 12, 1984

1. Continuation of the Advisory Commission on Juvenile Offender Programs

2. Continuation of the Commission for the Hearing Impaired and Expanding the Commission's Authority

3. Interference with Parental Custody

4. Establishment of a Commissioner of Special Services, SRS

2392E

Attm. # B
1-12-1984

1. Advisory Commission on Juvenile Offender Programs

The Advisory Commission on Juvenile Offender Programs was established by statute (K.S.A. 75-5390) during the 1982 Legislative session. The Commission is subject to the provisions of the Sunset Law. The Commission will be abolished on July 1, 1984.

2. Continuation of the Commission on Hearing Impaired and Expanding the Commission's Authority

The Kansas Commission for the Hearing Impaired was established by statute (K.S.A. 1982 Supp. 75-5391 et. seq.) which became effective on July 1, 1982. The purpose of the Commission is to provide a centralized source for information collection and dissemination and to facilitate coordination and communication between public and private organizations which serve deaf or hearing impaired persons. The Commission is subject to the provisions of the Sunset Law. The Commission is to be abolished July 1, 1984.

This bill amends the current statute to extend the Kansas Commission for the Hearing Impaired for eight years beyond its current abolition date of July 1, 1984, and expands the Commission's authority in the following ways.

1. Provide authority for the Commission to offer interpreter services, funded from fees charged users.

2. Provide authority for the Commission to expand its message relay services by implementing a statewide toll free line.

3. Provide authority for the Commission to conduct sign language classes in various communities across the state, supported by fees charged persons who enroll.

3 Interference with Parental Custody

This bill amends K.S.A. 21-3422 by increasing the penalty in Kansas for interfering with parental custody. The penalty will increase from a Class A misdemeanor to a Class E felony. It is hoped that a more severe penalty will deter non-custodial parents and others from absconding or kidnapping children not in their legal custody

4. Establishment of a Commissioner of Special Services, SRS

This bill establishes within the Department of Social and Rehabilitation Services, Special Services, the head of which shall be the Commissioner of Special Services.

The creation of Special Services under the umbrella agency of SRS would provide for the establishment of a special school district under the supervision of the Commissioner of Special Services. The creation of a special school district to administer SRS' educational program provides an administrative mechanism to centrally control the schools located at SRS' Youth Centers and provides the structure for reimbursement of tuition expenses for Kansas residents placed in out-of-state placements. The Youth Center educational programs are currently administered under contracts developed with local school districts. While these arrangements provide for an adequate staff, they do not mesh well with the budget process. Another area of concern with the individual contracting system revolves around who is ultimately responsible for program managements, staff recruitment, planning, fiscal management, etc.

2391E

1-12-84 "A"

REPORT OF THE HEALTH PLANNING REVIEW COMMISSION

The 1983 Legislature, in enacting Chapter 248, 1983 Laws of Kansas, provided for the naming of an eleven-member commission composed of legislative and public members, to study the future of health planning in Kansas and to report to the Governor and the 1984 Legislature.

Under the provisions of Chapter 248, the eleven members of the Health Planning Review Commission were selected as follows: two members of the Senate were appointed by the President of the Senate; two members of the House of Representatives were appointed by the Speaker of the House; one member of the Senate and one member of the House were appointed by the Senate and House Minority Leaders; and five members were appointed by the Governor. The membership of the Commission represented legislators, health-sector providers, and consumers.

As directed by the legislation which created the Commission, the members of the Health Planning Review Commission elected a chairman and vice-chairman from among the members of the Commission.

Charge

Chapter 248 charged the Commission created thereunder to:

Study and evaluate the role of health planning in Kansas including, but not limited to, the effectiveness of health planning, the current structure of health planning, and the level and quality of health planning programs.

Examine ways of coordinating health planning with other governmental functions.

Examine the role and structure of local input in the state health planning process.

Attm. #C
1-12-1984

Examine the role and structure of local input in the state health planning process.

Examine the funding needs and financial support available for health planning.

Develop goals and priorities for state health planning.

Commission Activity

In order to carry out the responsibility assigned to the Commission, the members met a total of seven days; heard 42 conferees, reviewed the existing Kansas planning laws, reviewed and monitored proposed federal legislation, and reviewed various data prepared for the Commission.

The Commission met with a professor of regional and community planning from Kansas State University; heard or received written communications from the present and all former chairmen of the Statewide Health Coordinating Council (SHCC); and the present and the former director of Health Planning in the Department of Health and Environment; reviewed the funding and activities of both the State Health Planning and Development Agency — the Secretary of Health and Environment — and the functioning health systems agencies; reviewed the minutes of the Statewide Health Coordinating Council and the health systems agencies; and met with the Secretaries of Health and Environment, Aging, and Social and Rehabilitation Services and with the Director of the Division of the Budget.

During the course of the Commission study, the members met with representatives of: the Health Systems Agency of Northeast Kansas, the Kansas State Nurses Association, the Kansas Hospital Association, the Kansas Employers Coalition on Health, the Kansas Association of Osteopathic Medicine, the Kansas Health Care Association, the American Association of Retired Persons, the National Retired Teachers Association, the Kansas Medical Society, the Kansas Pharmacists Association, the Kansas Dental Association, the Kansas Health Care Association, Presbyterian Manor, Kansas Methodist Homes, the Health Systems Agency of Southeast Kansas, the Central Kansas Medical Park in Great Bend, ADAPT, the Hutchinson Hospital

Corporation, Shawnee Mission Medical Center, Day Surgery, Inc., Blue Cross-Blue Shield of Kansas, Great Plains Health Alliance, the Kansas Coalition of Independent Health Professions, the Ad Hoc Committee on Certificate of Need, the Kansas Conference of Catholic Health Affairs, and the Mid-America Coalition on Health. In addition, the Commission met with a former member of the Statewide Health Coordinating Council who now serves on the Health Systems Agency of Southeast Kansas, a former local health planning agency director now engaged in hospital planning, and a physician associated with a hospital-based ambulatory surgical unit.

Background

Although the current structure through which formal health planning is carried out is relatively recent, resulting as it does from federal legislation enacted at the very end of 1974 and Kansas legislation enacted early in 1976, the concept of planning for health services and the allocation of health resources is one that has evolved over the last 50 years.

Community planning for health and welfare services developed in urban areas in the period immediately following World War I and was characterized by the creation of voluntary community councils or federations composed largely of health and welfare professionals and charitable donors. These councils or federations were primarily concerned with the identification of community needs, the coordinated delivery of services and the allocation of private charitable funds rather than governmental resources. Health facility planning at the community level developed in the 1940s when it was recognized that massive expenditures for hospitals and other health facilities were necessary to replace the capital expenditures that were foregone during the Depression years and the war years of the 1930s and early 1940s.

States became formally involved in planning for health facilities with the enactment of the Hospital Survey and Construction (Hill-Burton) Act in 1946. Under

the federal legislation, each state was required to survey its hospital system and to develop a plan for remedying deficiencies in the system as a condition of participation in the federal grants available for health facility construction.

The infusion of federal funds for health facility construction also stimulated the development of community level voluntary hospital review councils, which usually were not a part of a coordinated community health planning effort. Federal legislation enacted in 1961 provided for federal financial support for nonprofit community hospital review and planning councils, but provided no enforcement authority to such groups.

Federal support for segments of health planning expanded during the 1960s with enactment of the Community Mental Health Center Act, the Community Mental Retardation Center Act, and the Comprehensive Rehabilitation Act. Each of these acts delegated planning and administrative responsibilities to the states, each required a coordinated system of services for the populations served and each required statewide comprehensive program planning, as distinguished from solely facilities planning. These federal acts also fragmented health planning efforts by breaking out programs for specific populations from overall planning functions.

In 1966, Congress enacted the Comprehensive Health Planning and Public Health Services Amendment, P.L. 89-749, which authorized federal funding for comprehensive health planning at both the state and local level. The local or areawide agencies that were created pursuant to P.L. 89-749 reflected a further evolution in health planning; however, they lacked any formal method of forcing compliance with area plans, depending instead on developing a consensus on the direction health services should take. In Kansas, the Department of Health and Environment was designated by the Governor as the single state agency to receive federal health planning grant funds. The agency was assisted by a state health planning advisory council. One significant change in the evolving health planning structure resulting from enactment of P.L. 89-749 was the addition of consumers to the health planning process.

Health planning took a new direction in 1974 with the passage of the National Health Planning and Resource Development Act, P.L. 93-641, which led to the creation of a nationwide system of local and state agencies charged with planning for

all components of the health system. In Kansas, the formal structure of planning for health is reflected in the Kansas Health Planning and Development Act, K.S.A. 65-4701 et seq., enacted in 1976. In 1976, the then existing Kansas certificate-of-need statutes were repealed and the current health facility development regulatory structure was enacted as K.S.A. 65-4801 et seq.

P.L. 93-641 and the corresponding Kansas statutes led to the development of new institutional structures to provide for areawide decision making about the health system, i.e., health systems agencies. Four of these agencies were named in Kansas, although one of the four represented a bi-state agency functioning in the metropolitan Kansas City area.

At the state level, Kansas statutes designated the Secretary of Health and Environment as the State Health Planning and Development Agency (State Agency) and provided for the creation of a thirty-one member Statewide Health Coordinating Council which is attached to Health and Environment for the purposes of budgeting and staffing.

P.L. 93-641, although enacted at a time when the health care system was entering into a period of intense public scrutiny and change in priorities, reflects in the planning goals set out in the act, the philosophies of the 1960s, i.e., that health care is a right and that quality health care should be available to all persons. The four basic goals set out in the federal act are: to improve the health status of the population; to increase the accessibility, acceptability, and the quality of health services, manpower, and facilities; to restrain increases in the cost of providing health services; and to prevent unnecessary duplication of health resources. In 1979, P.L. 93-641 was amended to revise the description of national health priorities to emphasize cost containment and competition through: (1) identification and discontinuance of unneeded, duplicative facilities and services, (2) elimination of inappropriate institutionalization, (3) promotion of outpatient care, when appropriate, and (4) other policies which would foster appropriate and efficient use of the health care system.

In 1981, Congress began to consider the merits of the health planning program created pursuant to P.L. 93-641 in preparation for action in 1982 on the federal legislation which was due to expire in September of 1982. In 1982, the Administration took the position that all federal funds for health planning should be eliminated and, for a while, it appeared that the federal grant program would be terminated. The uncertainty of continued funding led to the termination of the Health Planning Association of Western Kansas, the health systems agency representing the entire western part of Kansas. Later the bi-state health systems agency involving the greater Kansas City area was also terminated.

Although Congress did not enact health planning legislation in 1982, it did continue federal grants for the health planning system through enactment of a continuing resolution. In 1983, three bills were introduced in the Congress which would have changed the federal role in health planning, generally by giving more flexibility to the states in both planning and certificate-of-need programs. No new legislation was enacted in 1983, but federal grant funding was continued through fiscal year 1984.

At the time of the Commission's study it appears that some form of federal support for health planning carried out at the state and local level will continue in the foreseeable future. The Administration has now expressed support for health planning with some changes in the federal role, and the Congress appears to support continued funding for the health planning function. Late in 1983, several of the national organizations that are most involved in the health planning debate reached agreement on some of the issues that are involved in the Congressional debate on health planning legislation. Thus, it appears that the new Congress may enact health planning legislation that grants more flexibility to the states in how they operate health planning and certificate-of-need programs.

Evaluation of Health Planning

The conferees who met with the Health Planning Review Commission were nearly unanimous in their support of the planning functions which are carried out by the Statewide Health Coordinating Council and of the organization and functioning of the

Council. In general, the Council is seen as a broad-based structure representing a mix of consumers and providers of health services and a geographic representation of Kansas health services and needs. Conferees expressed support for the continuation of the Statewide Health Coordinating Council as a forum for debating and developing consensus on health-related issues and a mechanism for identifying health policy issues and developing alternative actions on such issues for consideration by state and local policy makers. The State Health Plan, prepared annually by the Statewide Health Coordinating Council, was cited by a number of conferees as an important resource document. Concerns were expressed about the lack of visibility of the Council. Conferees were agreed that the work product of the Council is of high quality, but noted that the Council's studies and recommendations are not well known by the public.

In terms of the testimony presented to the Commission in regard to the State Health Planning and Development Agency, two specific strengths were identified. One related to the generally high quality of the health planning staff in the agency, and the second concerned the quality and depth of data which has been developed by the State Agency as a part of the health planning process. Concern was expressed by a number of conferees about reductions in the planning staff that have occurred over the past two years and about the placement of the health planning function within the agency in the reorganization of the Department of Health and Environment.

Support for the role in health planning played by the health systems agencies was mixed in the testimony presented to the Commission. While there was generally support expressed for a continued local input into the total health planning process, there was not unanimous support for continuing the role of the existing health systems agencies in the present form. Concerns were expressed by some conferees about the continued role of health systems agencies in the certificate-of-need process. Many conferees noted that local planning efforts should be continued in some form and stated that staffing and consumer, as well as provider representation, should be components of health planning. Several conferees noted that local health planning under the old Comprehensive Health Planning Agencies had been ineffective and recommended that such agencies not be a model for local planning structures in the future.

In general, conferees evaluated the current health planning structure as being highly successful in terms of the development of data on which rational decisions can be based, in educating consumer members of the planning structure about the health delivery system and health issues, and in developing a cadre of volunteers who are knowledgable about health issues. Most conferees also credited the health planning structure with bringing consumers into full partnership with providers in the development of health policy. Criticism of the current structure generally related to issues of visibility at both the local and state level of the health planning structure. Several specific special-interest issues relating to the certificate-of-need program were presented to the Commission. Conferees, in general, supported continuation of the current state health planning structure and continuation of some form of local input into the state health planning process.

Coordination

While there was testimony presented to the Health Planning Review Commission regarding informal coordination between the Statewide Health Coordinating Council and the State Health Planning and Development Agency with several other state agencies, it appears that any such coordination is sporadic and not the result of a structured effort to coordinate data and policy development in the health field.

No formal linkages between local health planning and local governmental decisions relating to health were identified, although health systems agencies have, in the past, identified both gaps in health services and unserved populations.

Local Role

Presently, the state has two functioning health systems agencies carrying out health planning functions as mandated by P.L. 93-641 and state law. These agencies

include northeast Kansas and southeast and southcentral Kansas within their planning regions. The remainder of the state, including the Kansas counties included in the Kansas City metropolitan area and all of western Kansas, no longer has a formal structure through which local health planning is conducted although these areas are represented on the Statewide Health Coordinating Council.

Testimony presented to the Health Planning Review Commission suggested that the perception of the role of health systems agencies may have been influenced by their role in the certificate-of-need process, leading some observers to perceive the local planning agencies in an adversarial role. Other conferees evaluated the health systems agencies as having an important role to play in the development of a consensus on health policy issues. Several conferees suggested that the current role of the health systems agencies should be modified if federal mandates are changed. An example would be elimination of the appropriateness review function.

The majority of conferees expressed the belief that health planning should be continued at the subregional or regional level should health systems agencies cease to be funded. Those who spoke to this issue suggested that some form of staffing is necessary for effective health planning, whether such staffing is provided by state or local personnel. It was suggested that some funding is necessary to reimburse the travel expenses of volunteers who participate in health planning at the local or regional level.

Funding

According to testimony presented to the Commission, federal grant awards for the state component of the health planning structure, i.e., State Agency and Statewide Health Coordinating Council, reached a peak of $402,551 in fiscal year 1982 and have declined to $246,815 in fiscal year 1984. The Legislature reduced the percentage of state matching funds from 35 to 29 percent and allocated only $243,382 of the federal grant to health planning in fiscal year 1984. Thus, the state match of $101,685 added to the allocated federal funds totals $345,067 available for the current fiscal year.

Federal grant funds for the operation of the four health systems agencies then operating peaked in federal fiscal year 1980 at $991,993.* In federal fiscal year 1983, the federal grants to the two operating health systems agencies total $332,240.

Several conferees who met with the Commission recommended that the certificate-of-need fees authorized by the 1983 Legislature be allocated to the health planning budget, rather than be deposited to the State General Fund. Others suggested that foundation grants and other sources of funding be sought for the support of area and subarea planning.

Goals

Conferees who met with the Commission suggested various goals which should be met by health planners in the near future and long-term.

In terms of short-range goals and priorities, a number of conferees spoke to the need to monitor and evaluate the effect of new reimbursement policies on access to health care, the quality of health care, and the cost of health care.

Other conferees stressed the need to consider cost containment as a long-range goal of health planning, with continuing attention to alternative ways of delivering health care and to public education relating to cost-effective health care choices. Encouraging competition in the delivery of health services and developing a range of services for the elderly and disabled were also long-term goals noted by conferees. Continuing to maintain a forum for the development of consensus on health issues and ensuring local input into this process were cited as desirable short-range and long-term goals for the health planning process.

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* The Mid-America Health Systems Agency served eight counties, three of which were in Kansas. The federal grant was not made in a manner which allows isolation of the Kansas total. It should be noted that this amount does not include a pro-rata share of the total grant to the HSA for the three Kansas counties.

Certificate-of-Need

Conferees who met with the Commission generally agreed that the certificate-of-need program should be continued at least until the changes in the reimbursement system arising from Medicare and private third-party payors are fully phased in and there is some data on the effect of such changes in reimbursement policies. Some conferees suggested that changes in the reimbursement system may have a dramatic effect on all aspects of the health care delivery system.

A number of persons who spoke to the certificate-of-need system recommended that the procedure be "streamlined." Setting specific times for reviewing all applications for a specific health facility service or "batching" was suggested by a majority of those conferees who spoke to the certificate-of-need procedure. It was also suggested that the thresholds that trigger certificate-of-need reviews be flexible, i.e., be set by rule and regulation rather than by statute, in order that the thresholds may be raised as permitted by federal law. Several conferees suggested that "batching" might slow the certificate-of-need process.

Two other recommendations relating to certificate-of-need programs were suggested for Commission consideration by more than one conferee. The first, proposed by a majority of the conferees, was a recommendation that has been before the Kansas Legislature on several occasions; i.e., to expand certificate-of-need reviews to include the purchase or acquisition of major medical equipment by all providers. Currently, the certificate-of-need review is limited to the acquisition of major medical equipment by health facilities or by other providers if such equipment is to be used for health facility services. A second suggestion was that an annual cap be set on all health expenditures for construction, renovation, or modification. Certificate-of-need decisions would then be made within the framework of the annual expenditure limitation.

Conclusions

Evaluation

The Health Planning Review Commission has concluded, through the Commission's evaluation of health planning, that there is a continued need for both a strong health planning function to be carried out at the state level and a level of local planning. The Commission sees many positive results arising from the health planning structure that has been in place since the 1970s, including the development of a data base that did not exist prior to the creation of the current planning structure, the development of resources that allow increased citizen participation in decisions about the health care delivery system, improved decision making based on developed criteria, and the positive implementation of some of the recommendations arising from the health planning process. Indeed, the Commission believes that the retention of the health planning structure generally in its current format is most important in a time when rapid and dramatic changes are being imposed on the system through which health care is delivered. It is of particular importance that new policies relating to reimbursement and alternate forms of health care delivery be monitored and assessed through a system that provides for public participation in the process.

Structure

The Commission has concluded that the Statewide Health Coordinating Council is an effective mechanism for identifying health issues and developing health policies and a State Health Plan. The Commission also believes that the Council has an important role to play in developing a statewide consensus on the direction the state should take on health issues.

The members of the Commission believe that the Statewide Health Coordinating Council should be a more visible part of the planning and consensus building process and that Council studies and recommendations should be more widely circulated and debated. The Commission notes that the ability of the Council to hold hearings around the state and to meet as frequently as previously has been curtailed through funding cutbacks.

The Health Planning Review Commission is concerned about the location of the health planning function within the newly-reorganized Department of Health and Environment. The Commission questions whether the current location of health planning gives this function the stature and visibility the Commission believes it should have within the state agency. Health planning is now a part of an Office of Health and Environmental Planning within a division which has, as its other functional responsibilities, information systems and management analysis and evaluation, as opposed to being a separate office directly under the Secretary of Health and Environment.

The Commission has concluded that the health planning function should be coordinated both with other agencies of the state and with other functions within the Department of Health and Environment. Having reached this conclusion, the Commission believes that such coordination should be given a high priority by the Secretary of Health and Environment and that the recommendations arising from planning should be a part of the regular policy review and analysis of agency responsibility.

Coordination

The Commission has concluded that health planning is not being as effectively coordinated with other governmental functions as is desirable. While informal coordination may exist at both the state agency and health system agency level, such coordination is not sufficiently structured, mandated, nor implemented as a part of the planning process. The Commission finds that health planning should be coordinated with other governmental functions and agencies at the state level of government and has developed several recommendations to implement improved coordination and data sharing.

Local Input

The Health Planning Review Commission has concluded that local input is an important part of the health planning process if consensus on the directions health initiatives should take is to be developed, policies are to be identified, and

recommendations are to be implemented. Because of the uncertainty of funding, the Commission finds the future role of health systems agencies in the health planning structure to be unpredictable. The Commission has concluded there appears to be little possibility of total state funding of health systems agencies should federal grants be discontinued. The realities of funding dictate that local health planning will have to continue to depend heavily on voluntary efforts.

The Health Planning Review Commission has concluded that the viability of local participation in the health planning system would be improved if local planning efforts were not frequently seen as an adversary role and has developed a recommendation in regard to the role of local planning in the certificate-of-need process.

Funding

The members of the Commission also have concluded that, if the health systems agencies are terminated and subarea councils or other mechanisms become the source of local input into the health planning system, state support will have to be increased. The Commission believes that local planning efforts serve an important role in educating local citizens about issues that affect health and health care and should be supported by state personnel and state funding of travel expense should federal grants no longer be available for the support of local planning efforts.

The Commission members believe that state planning functions carried out by the Statewide Health Coordinating Council and the State Agency should be supported by adequate staff and notes with concern the reduction in staff that has taken place over the last several years. The strong support of the Governor, the Legislature, and the Secretary of Health and Environment and adequate staff and resources are critical if planning is to make the impact on health policy the members believe it should have.

Priorities and Goals for Health Planning

The Commission determined that health planning priorities should include the development of an adequate data base, cost containment efforts, the development

of standards for review of certain health resources, and health promotion and disease prevention functions.

Recommendations

The Health Planning Review Commission recommends that the health planning and certificate-of-need programs currently in existence be continued through the existing statutorily prescribed structure through July 1, 1987. In making the recommendation, the Commission notes that the changes now taking place in the health care delivery system may bring about dramatic changes in the structure of the system and believes it is imperative that a planning system be in place to monitor changes and the effects of changes as well as to develop alternative courses to be followed in health care during such a period of dramatic change.

The Commission has drafted H.B. 2649 and H.B. 2648 to implement its recommendation to extend both the health planning and certificate-of-need statutes through fiscal year 1987 and recommends that the bills be enacted by the 1984 Legislature.

The Commission has two recommendations relating to the coordination of health planning with other state governmental functions and improved visibility of the results of health planning. The first recommendation is that the Governor appoint the Secretary of Social and Rehabilitation Services and the Secretary of Aging or the designees of the secretaries to the Statewide Health Coordinating Council. The second recommendation relating to coordination and visibility is a strong recommendation to the Governor to convene cabinet level meetings to discuss health planning, health policy, and the recommendations of the Statewide Health Coordinating Council as set out in the State Health Plan. Further, the Commission recommends that the Governor give such health policy discussions a high priority.

The Commission recommends that the Legislature delete the role of the health systems agencies in the certificate-of-need process and place the responsibility for certificate-of-need administration solely within the Department of Health and Environment. Local input into the certificate-of-need process should come about through the health planning structure and State Health Plan development. The

Secretary of Health and Environment should then consider the State Health Plan in making decisions relating to the granting of certificates-of-need.

The Health Planning Review Commission supports "streamlining" the certificate-of-need process. The Commission recommends that the Statewide Health Coordinating Council give further study to "batching" reviews and other procedural changes and make recommendations to the Secretary of Health and Environment in regard to certificate-of-need procedures.

The Commission was divided on the issue of including all acquisitions of major medical equipment under the certificate-of-need program and thus makes no recommendation to the Legislature in regard to this issue. The Commission notes, however, that this issue may be resolved by the implemention of new systems of reimbursement for health care.

The Commission recommends that the Legislature appropriate all federal grant funds available for state health planning to the Department of Health and Environment.

The Commission recognizes that the recommendations contained in this report require adequate staffing and recommends that the Secretary of Health and Environment amend the Department's C level budget to request ten full-time equivalent positions for health planning.

The Commission urges increased coordination and cooperation on the part of all health care providers for the benefit of all Kansans.

John Holmgren, Chairman
Sen. Roy Ehrlich, Vice-Chairman
Sen. Bert Chaney
Sen. Frank Gaines
Rep. Marvin Littlejohn
Rep. Juith Runnels
Rep. Joan Wagnon
Mr. Norman Durmaskin
Dr. Douglas M. Elder
Ms. Nadine Griffin
Dr. Allene Vaden

83-342/EC