Approved February 7, 1984
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Senator Jan Meyers at
Chairperson

10 a.m./p.m. on February 3, 1984 in room 526-S of the Capitol.

All members were present except:

Senator Morris, excused

Committee staff present:

Emalene Correll, Legislative Research Department
Norman Furse, Revisor of Statutes Office

Conferees appearing before the committee:

Dr. Lois Scibetta, Kansas State Board of Nursing
John Bell, Attorney, Veterans Administration, Wichita, Kansas
Sylvia Hougland, Secretary, Department on Aging
Dick Hummel, Kansas Health Care Association
Carl Schmitthenner, Kansas Dental Association
Harold Riehm, Kansas Association of Osteopathic Medicine
Marlon Dauner, Blue Cross-Blue Shield
Dr. Robert Harder, Social and Rehabilitation Services
Jim McHenry, Commissioner, Alcohol and Drug Abuse Services for SRS

Others present: see attached list

Senator Meyers introduced John Bell, Attorney with the Veterans Administration in Wichita, who complimented the Interim Committee's attempt to rectify errors in SB 488. He said the amendment they propose would be very beneficial to the state and would allow a guardian to exercise his constitutional rights. He also expressed concern about Subsection (g)(7). Senator Meyers said she would like to meet with Mr. Bell, Mr. Furse, Mrs. Correll, and the subcommittee to discuss this.

Dr. Lois Scibetta, KSBN, distributed a copy of proposed legislation to the committee, and said there are three changes in the Nurse Practice Act which they are requesting. The first relates to interstate matters; the second relates to the authority of the Board to grant a continuance of a disciplinary hearing; and the third is related to examinations. (Attachment #1).

Senator Johnston moved that this bill be introduced. Senator Vidricksen seconded the motion and it carried.

Dr. Scibetta also distributed a memorandum regarding Health Care Cost Containment, the Prospective Payment System and DRGs. (Attachment #2).

Sylvia Hougland, Secretary, Department on Aging, said she had two items she wanted to stress: Health Care Cost Containment pertaining to the elderly, and proposed changes in Medicare and how that will impact on older people. She stated that Medicare is of concern to the state because any change will impact on state coffers. Medicare is only 20 years old, and was modeled after private health insurance. Secretary Hougland said that the predictions are that between 1987 and 1989 Medicare will be depleted or completely bankrupt, and by 1995 there will be a 200-400 million dollar deficit. Changes which the federal government is going to make in Medicare are related to what has happened in health care costs in general, and without control of health care costs in general, you can't control the expenses of Medicare. She feels the changes proposed will delay bankruptcy but will not stop it, and nothing in any of the proposals will make any difference. The federal government has to be made aware

of the state's needs in designing the changes that have to be made.

Dick Hummel, KHCA, said that Medicare accounts have been less than 2% of their revenues, and 50% is from the federal Medicaid program. He feels that in Kansas, nursing home care is a bargain. He stated that of 26,000 receiving nursing home care, 11,000 are on Medicaid, and two or three times that number receive informal care from family members. The prospective pay system is a very effective program, and is effective in holding down costs and in shifting costs. Mr. Hummel said he doesn't think anyone understands the full implications of DRG.

Carl Schmitthenner, Kansas Dental Association, distributed to the committee testimony concerning the preventive aspects of dentistry and how effective they have been. He also distributed copies of an article by Daniel Greenberg concerning health care costs. (Attachment #3).

Harold Riehm, Kansas Association of Osteopathic Medicine, said he was representing 80 osteopathic physicians. He said he agreed with most of the things Jerry Slaughter had said, but had some concerns about income containment for physicians. He also questioned whether there was going to be a containment in the cost incurred by physicians. He suggested that perhaps the physician is alienated because he doesn't feel that he has been a part of the decision-making processes. He cautioned not to forget the Osteopathic Association.

Marlon Dauner, BC-BS, stated that Medicare does not recognize different levels of acuity, and the BC-BS program does. The systems are different.

Senator Meyers asked for some distinctions. Mr. Dauner said there will be patients who have different levels of medical problems, and the BC-BS system permits the opportunity to have different levels of reimbursement. The problems of the Medicare program will not be resolved by the DRG program, but in private practice it will lower costs.

There were questions from the committee, and Jerry Slaughter was asked for a summary of his remarks concerning health care containment costs.

Dr. Robert Harder, SRS, distributed to the committee a memorandum concerning Medicaid Cost Containment Efforts Involving Institutional Care, along with a chart showing Economic Effects of SRS Established Incentives for Low Cost Medical Alternatives, and a chart showing Medicaid Inpatient Hospital Savings Resulting from Various Alternatives/Controls. (Attachment #4.)

Dr. Harder said their purpose is to indicate what actual savings have been in relation to the Utilization Review Program. He stated that they do not have any Utilization Review on home health service.

Jim McHenry, Alcohol and Drug Abuse Services for SRS, distributed to the committee a memorandum showing ADSAP programs in Kansas. Currently there are 35 ADSAP programs within the state, and 33 of these programs are meeting the ADAS standards as treatment programs. If SB 539 passes, only 8 of these programs would be certified by the Administrative Judge of the District Court, and they would not be licensed by SRS/ADAS unless they added a treatment component. (Attachment #5).

The meeting was adjourned.

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-3-84

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Dick Hummel	KS Health Care Assn
Jeanette E. Livingston	SLC: AARP
Gene Johnson	KS ASAP Coord Assn
Jack Roberts	BC-BS
Marlon K. Dauner	BC-BS
Rebecca L. Kupper	KHA
Bill Overbey	KHA
Marilyn Bradt	KINH
Mary Corrigan	KDHE
Dr Lois R. Scibetta	KSBON
J. McHenry J.	SRS/ADAS
Michael A. Flyzik	SRS/ADAS
Carl Schmitthenner	Kansas Dental Assn.
Ken Schafermeyer	KS Pharmacists Assn
John Schneider	SRS
Aileen Whitfill	SRS
Paul Johnson	PACK
Lynelle King	Ks State Nurses' Assn
Marie Bolhoff	KSNA
Jerry Slaughter	KS Medical Society
Gary Robbins	Ks Optometric Assn
[illegible] Kjorm	Ks Osteopathic Assn
R. Hman	SRS

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-3-84

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Lyman Wainford	KDOA
Jack Shumway	ACCH

#1 - 2-3-84

KANSAS STATE BOARD OF NURSING

BOX 1098, 503 KANSAS AVENUE, SUITE 330
TOPEKA, KANSAS 66601

Telephone 913/296-4929

TO: The Honorable Jan Meyers, Chairperson, and Members of the Senate Public Health and Welfare Committee

FROM: Lois Rich Scibetta, Ph.D., R.N., Executive Administrator

DATE: January 25, 1984

RE: Proposed Legislation for the Board of Nursing

Madam Chairman, and members of the Committee, my name is Dr. Lois Rich Scibetta and I am the Executive Administrator of the State Board of Nursing.

There are three changes in the Nurse Practice Act which we will be requesting this session. I am here today to briefly explain the proposed changes. Mr. Furse is working on the Bill draft for us.

65-1120 - Disciplinary Matters - two changes suggested to facilitate better in-house procedures.

The first relates to interstate matters. The Board requests the statutory authority to convene a disciplinary hearing based upon the action against a Kansas Nurse's license in another state. (Many nurses are licensed in more than one state.) We are suggesting language similiar to that used in Idaho.

The second issue relates to the authority of the Board or its designated agent to grant a continuance of a disciplinary hearing for good cause. The Board has done this in the past as a courtesy, but technically the Board does not have the statutory authority to grant this type of request.

The third area is related to examinations. In October 1983, the Board approved the direct application for examination method by the candidates (professional and practical nurses). The candidate applies directly to the examination service and pays the exam fee of $18.50 to them. This is required by the National Council of State Boards of Nursing, Inc., who control the examination.

I will be happy to answer any questions which the Committee may have.

Att. 1

#2 - 2-3-84

KANSAS STATE BOARD OF NURSING

BOX 1098, 503 KANSAS AVENUE, SUITE 330
TOPEKA, KANSAS 66601

Telephone 913/296-4929

TO: The Honorable Jan Meyers, Chairperson, and Members of the Public Health and Welfare Committee

FROM: Lois Rich Scibetta, Ph.D., R.N., Executive Administrator

RE: Health Care Cost Containment and Prospective Payment System and DRG's

DATE: January 30, 1984

Last week Don Wilson talked about three factors to be considered in the health care system, assessability, quality and price. Today, with a focus on price, I would like to discuss quality. When considering the price, I hope that we do not sacrifice quality.

About price: With these new systems, we are not talking about a cost containment system with a prospective payment system and Diagnosis Related Groupings as much as we are talking about how much will be paid for what. Personally, I question the very concept of DRG's without an attending assessment of the acuity of the patient care required. A recent study indicated that patient acuity has increased 3-4% annually since 1971, increasing costs 22%. The impact of the new reimbursement system may be disastrous for the public indeed; particularly when their DRG does not meet the "averages" established. Computed averages as best are "guesstaments."

The system is upon us however and we must all recognize the need to cut the costs of health care. However I would urge that this not be done at the cost of quality.

In the last few days, I have talked with a half-dozen nursing directors in the State, both in rural and metropolitan areas. They are all very concerned.

The following points were made: Positive aspects-Nursing care being costed out - emphasis on productivity

(1) DRG's do not take into account the acuity of the patient care required.
(2) Patients are hospitalized because they require care. With increased technology, more time and expertise is required to provide this nursing care. The actual census is down, but patients require more care.
(3) Earlier discharge has placed an increased burden on discharge planning and the supporting community health agencies and the family.
(4) All directors are struggling to cost out nursing separately.

Att. 2

Nursing budgets often include housekeeping, lab, equipment, etc. Some directors are working with their own Relative Intensity Measures, and productivity measures.

(5) Nursing hours have been reduced as a cost containment measure - again, this may present problems for the public.

(6) One director stated that health care may ultimately become a privilege for those who can affort it.

Hopefully, we can strive for cost containment and quality.

The Board is in favor of reducing health care costs, but not in favor of reducing the quality of care delivered.

Dr. Lois Rich Scibetta
Executive Administrator
Kansas State Board of Nursing

#3 - 2-3-84

KDA
KANSAS DENTAL ASSOCIATION

TESTIMONY BEFORE THE KANSAS
SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

Chairmen Members of the Committee:

I am Carl Schmitthenner, Executive Director of the Kansas Dental Association.

I've asked to appear today because of the direction most of the previous testimony has taken and I believe that some other thoughts need to be considered.

Dental Care and Dentistry have been working in the direction of prevention of dental disease since the 1940's. I think one of the most obvious accomplishments would be the support of fluoridated water supplies since 1950. A recent study funded by the Robert Wood Johnson Foundation and conducted by the National Institute for Dental Research showed that through preventive methods it is possible to achieve a 65% reduction in tooth decay but the cost was about $54.00 per child per year. The study underscored the enormous importance of fluoridation of water supplies which showed a 30% reduction at a cost of $1.00 per child per year. This figure is conservative due to the mobility of the populations.

We have consistently encouraged third party programs to include a strong preventive program. A study conducted in 1974 by Blue Cross and Blue Shield in Kansas called the Pratt Project showed the more costly procedures in dentistry could be significantly reduced by proper preventive care and if included in a prepaid program could ultimately reduce the premium required.

The cost of dental care over the past 10 years has just kept pace with the rate of inflation. Dental expenditures are a reducing share of the Nation's Total Health Dollar, from 8.4% in 1955 to 6% in 1983. Preventive techniques, improved equipment and better management have helped reduce the cost of dental care.

Another aspect of Health Care that may be important, is the overall improvement in the Health of Kansans. Fewer smokers, exercise programs, wellness programs and a better attitude toward maintaining good health, could be benefits we have yet to recognize. Maybe this increased cost of health care has provided increased benefits as well. Maybe good health care is an appropriate priority and a proper place for emphasis.

I'd like to provide the committee with a copy of an article by Daniel Greenberg which gives another thought about health costs.

5200 Huntoon
Topeka, Kansas 66604
913-272-7360

Atch. 3

Health care costs too high? Not on your life!

By Daniel S. Greenberg

Washington — Medical costs are not unreasonable, considering what we're getting for the money: progress in relief from pain and disability, increased longevity, and a healthier and more productive population.

Yet the standard view of health care is that costs are soaring, fueling inflation and aiding the destruction of the American economy. There are, however, many provocative dissenters to official and popular views of medical economics, including Dr. Richard Sabransky, vice president and medical director of the 800,000-member Medical Mutual of Cleveland, the Blue Shield health insurance plan in northeastern Ohio. Dr. Sabransky's tongue-in-cheek proposal: rolling back health-care costs to 1950 levels — provided that benefits are limited to the medical techniques of 1950.

"A 'nifty 50s' health-care contract," Dr. Sabransky says, "would not pay for open-heart surgery, coronary-bypass surgery, renal transplant surgery, vascular surgery, joint replacements, (laser-based) eye-surgery advances, lens implants, renal dialysis. Medical coverage would not include coronary care, medical intensive care, tertiary intensive care.

"Radiology would not include radiotherapy such as linear acceleration, megavoltage, cobalt, radioactive isotopes and scanning. Lab benefits would exclude stress testing, invasive vascular radiology, coronary angiography, radioactive studies or scans, ultrasound, (and) CAT scans."

Doesn't the wizardry of modern medicine cost too much in terms of family income? Dr. Sabransky's calculations of Medical Mutual fees suggest not.

Twenty-five years ago, the most comprehensive family policy cost $99.60 a year, or 2 percent of the 1958 median family income of $4,971. The 1981 counterpart costs $816 a year, 3.4 percent of median family income of $24,000.

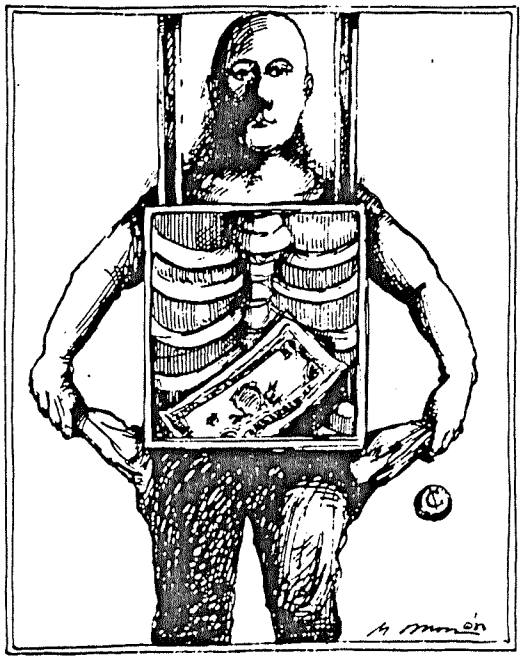
"Health care is not a pound of hamburger or a quart of milk that does not change from year to year," Dr. Sabransky notes. "Packaging alone has not been altered, rather the essence of the product has changed. This change is called medical progress."

What about health care's ever-growing claim costs, which rose from 4.4 percent of gross national product in 1950 to over 10 percent last year?

Prof. Uwe Reinhardt, an economist at Princeton University, suggests in his myth-shaking paper, "What Percentage of the GNP Should be Spent on Health?" that America can afford increasing medical fees.

Medical bills may be diverting funds that could go into building better factories, Dr. Reinhardt concedes, "but why, one may ask, should we single out health care as the sacrificial lamb? Why not cut back on automobiles, on fashion, on junk food, or on the video games now befogging our children's minds?"

As for the argument that health care is a form of consumption, Dr. Reinhardt points out that in many circumstances, such as care for children, it is clearly a form of investment.



There's no doubt that the health industry has become used to freely increasing revenues and that some costs could be cut without reducing quality. Yet illusions of vast savings have been projected when, in fact, savings have been rendered impossible by the interplay of an aging population, technological advances and public expectations.

In these circumstances, the easiest targets for reducing spending are federal health funds for the poor and elderly. Normally reductions in their health care would revolt a civilized public.

Daniel S. Greenberg is the editor and publisher of Science and Government Report, *an independent, Washington-based newsletter. He formerly was Washington correspondent of* The New England Journal of Medicine *and news editor of* Science, *the journal of the American Association for the Advancement of Science.*

H4 - 2-2-84

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

MEDICAID COST CONTAINMENT EFFORTS INVOLVING INSTITUTIONAL CARE

The two charts which follow use FY 1981 as the base year in an attempt to isolate a few of the many variables that affect institutional medical care. The first of these two charts seeks to show the beneficial cost effects of several alternatives to inpatient/institutional care. In order to see the true impact of these alternatives, it was necessary to show total costs in FY 1981 dollars. This deflation formula incorporates the general health care component of the CPI. As can be seen in these figures, the Medicaid Program cost savings strategies could not offset all of the 31% inflation which occurred between FY 82 and FY 84, however, in FY 81 real dollars our goals were achieved. It should be stated that the general health care inflation rate was used because of the variety of services involved, the inpatient hospital inflation rate was much higher as evidenced by the Medicaid Cost Per Day column of Chart #2.

The second chart zeroes in on the most volatile category of service; inpatient hospital. This chart seeks to demonstrate the combined cost savings of 1) utilization review, 2) incentives to perform 139 selected procedures in an outpatient setting, 3) prohibition of elective surgery in MediKan Program, 4) the FY 85 inpatient prospective payment system, and 5) many lesser changes. This combined effect is shown by freezing demand (days of service) at FY 1981 levels and multiplying this by the average daily cost of care for each year. The product of this computation is then compared to actual expenditures to arrive at the approximate annual savings.

Robert C. Harder, Secretary
Office of the Secretary
Social and Rehabilitation Services
296-3271
February 2, 1984

2525E/1

Atch. 4

CHART # 1

ECONOMIC EFFECTS OF SRS ESTABLISHED INCENTIVES
FOR LOW COST MEDICAL ALTERNATIVES

	Actual FY 81	Actual FY 82	Actual FY 83	Projected FY 84
HIGH COST SERVICES				
Inpatient Hospital	59,579,386	66,578,001	74,703,870	66,000,000
Skilled Nurs. Facilities	2,381,709	1,946,514	1,829,336	1,800,000
Interm. Care Facilities*	69,912,154	73,731,913	74,480,681	78,000,000
Total	$131,873,249	142,256,428	151,013,887	145,800,000
*Non MR/MH				
ALTERNATIVE SERVICES				
Outpatient Procedures	7,401,485	8,813,654	11,449,790	12,500,000
Home Health Agencies	585,906	732,349	724,719	900,000
Home/Comm. Based Services	-	-	179,120	900,000
Total	$ 7,987,391	9,546,003	12,353,629	14,300,000
Total Cost	$ 139,860,640	151,802,431	163,367,516	160,100,000
Total Cost in 1981 Health Dollars	$ 139,860,640	135,537,500	133,942,920	122,111,200

2516/1

CHART # 2

MEDICAID INPATIENT HOSPITAL SAVINGS RESULTING
FROM VARIOUS ALTERNATIVES/CONTROLS
FY 1982 THROUGH FY 1984

YEAR	STATIC DAYS OF SERVICE	ACTUAL MED. COST PER DAY	PROJ. COSTS WITHOUT COST CONTAINMENT	ACTUAL EXPENDITURES	SAVINGS
FY 81	308,116	193.37	59,579,386	59,579,386	-0-
FY 82	308,116	239.37	73,753,727	66,578,001	7,175,726
FY 83	308,116	287.90	88,706,596	74,703,870	14,002,726
FY 84	308,116	310.36/1	95,626,882	65,717,806/2	29,909,076
Total			$ 317,666,591	266,579,063	51,087,528

/1 Based on assumed inflation rate of 7.8% for hospital costs in FY 1984 (US DOL CPI Report of 9/83)

/2 Actual based on $276 per day cost used in budget appropriations

Robert C. Harder, Secretary
Office of the Secretary
Social and Rehabilitation Services
296-3271
February 2, 1984

#5 - 2-3-84

ADSAP PROGRAMS IN KANSAS
as of February 2, 1984

Currently there are 35 ADSAP programs within the State of Kansas.

** 1. Alcohol and Drug Associates, Arkansas City.
2. Northwest Kansas Council on Substance Abuse, Colby.
3. New Chance, Inc., Dodge City.
4. Butler County Foundation for Chemical Dependency, El Dorado.
5. East Central Kansas Mental Health Center, Emporia.
6. Western Kansas Foundation for Alcohol and Chemical Dependency, Garden City.
7. Northwest Kansas Medical Center, Goodland.
8. Center for Counseling and Consultation, Great Bend.
9. Mid-America Foundation for the Prevention and Treatment of Chemical Dependency, Hays.
10. Smoky Hill Foundation for Chemical Dependency, Hays.
11. Northeast Kansas Community Action Program, Horton.
12. Southeast Kansas Mental Health Center, Humboldt.
13. Wheatlands/Hutchinson Hospital Corp., Hutchinson.
** 14. Kansas City Kansas Drug and Alcohol Information School-ADSAP, Kansas City.
15. Sunrise Inc., Larned.
16. Counseling and Resource Center/Douglas County Citizens Committee on Alcoholism, Lawrence.
17. Northeast Kansas Guidence Center, Leavenworth.
18. Southwest Kansas Alcohol and Drug Addiction Foundation, Liberal.
19. Pawnee Mental Health Center, Manhattan.
20. Alcohol and Drug Services Inc., Mission.
21. FARM, Newton.
22. Prairie View Mental Health Center, Newton.
23. Drug Abuse Education Center, Olathe.
** 24. Overland Park Diversion Program, Overland Park.
25. Eleventh Judicial District ASAP, Pittsburg.
26. South Central Kansas Foundation for Alcohol and Chemical Dependency, Pratt.
27. Central Kansas Foundation for Alcohol and Chemical Dependency, Salina.
28. Johnson County Substance Abuse Services, Inc., Shawnee.
29. Syracuse Chemical Addiction Treatment of Kansas, Syracuse.
** 30. National Council on Alcoholism, Topeka.
** 31. Sunflower Alcohol Safety Action Project, Inc., Topeka.
32. Area Mental Health Center, Ulysses
** 33. Sumner County District Court, Wellington.
** 34. Municipal Court Probation Department, Wichita.
** 35. Eighteenth Judicial District, Wichita.

Currently 33 of these programs are meeting the ADAS Standards as Treatment Programs. Only the last two programs on the list are not.

** = If SB 539 passes, these programs would only be certified by the Administrative Judge of the District Court and would not be licensed by SRS/ADAS unless they added a treatment component.

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Atch. 5

SRS/ADAS CERTIFIED ADSAP PROGRAMS

Certified by request of the Administrative Judge

Currently SRS/ADAS certifies seven (7) ADSAP programs under the provisions of K.S.A. Supp. 1983 8-1008. The Administrative Judges in two (2) Judicial Districts chose SRS/ADAS to perform the ADSAP certification process.

1. East Central Kansas Mental Health Center, Emporia.
2. Center for Counseling and Consultation, Great Bend.
3. Mid-America Foundation for the Prevention and Treatment of Chemical Dependency, Hays.
4. Smoky Hill Foundation for Chemical Dependency, Hays.
5. Sunrise Inc., Larned.
6. Pawnee Mental Health Center, Manhattan.
7. Central Kansas Foundation for Alcohol and Chemical Dependency, Salina.

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