Approved 1-29-87
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Marvin L. Littlejohn at
Chairperson

1:30 ~~a.m.~~/p.m. on January 26, 1987 in room 423-S of the Capitol.

All members were present except:

Representative O'Neal, excused.

Committee staff present:
Emalene Correll, Research
Bill Wolff, Research
Norman Furse, Revisor
Sue Hill, Committee Secretary

Conferees appearing before the committee:
Representative Kathryn Sughrue
Representative Frank Buehler
Tom Bell, Kansas Hospital Association
Dr. Robert C. Harder, Secy. Department of Social Rehabiltation Services
Lila Paslay, Chairperson of Assoc. for Retarded Citizens of Kansas, Inc. (ARC)
Yo Bestgen, Kansas Association of Rehabilitation Facilities (KARF)

Chairman called meeting to order asking members to direct their attention to HB 2054 in the blue bill books. He invited Rep. Sughrue to speak to this bill.

Hearings began on HB 2054:

Representative Sughrue called attention to hand-out, (see Attachment NO. 1) which will indicate her testimony comments. She explained this legislation had been requested early last year, and it suggested the procedure to itemize hospital bills be mandatory. That legislation was not formalized. She explained that HB 2054 will speak to the problem patients have who have coverage by more than one health insurance policy and see a need to furnish an itemized account on the cost of service and equipment, supplies, medication, x-rays, etc. during their hospital stays. If they request an itemized accounting of charges, the hospital will be required to furnish same. She spoke to procedures other states have in this regard. She asked committee favorably consider this legislation. She answered questions, i.e., just how would itemized be defined, could language in line 22 saying costs be changed to charges, what time restraints should be placed on the hospital to comply.

Representative Buehler spoke to HB 2054, saying he disliked the mandatory itemizing, so had authored HB 2054 this Session, to have itemizing done by hospitals on request by the patient. He cited cases where people in his district had been at a disadvantage because the Insurance Company refused to settle claims until they received an itemized statement for charges by the hospital. He felt this legislation would speak to this problem. He felt the hospitals should have adequate time to make this statement available, and said if it could not be done at time of discharge of patient, then a day or so, or a period of 6 to 12 months would be permitted. He answered questions from members, i.e., no, Insurance Companies were not contacted, yes, it is more difficult for smaller hospitals that do not have access to computers to compile these statements. He urged for favorable consideration of HB 2054.

Tom Bell, Kansas Hospital Association spoke to members on HB 2054, giving hand-outs (see Attachments No. 2-A and 2-B). Mr. Bell called attention to page 3 of Rights and Responsibilties of Patients (Attachment 2-A), Hospital Charges already indicate the patient has a right to request and receive itemized detailed explanation of his total bill for services rendered in the hospital. He further called attention Ks. Medicaid Medikan manual, where it indicates as a result of an accident, bills should not be released to the recipient without authorization from the SRS Medical Subrogation Unit.
After noting these items, he stated their Association is not against HB 2054 in principle, but feels there are several factors that would need to be taken into consideration before this bill is enacted. He answered questions from members, i.e., yes he certainly agrees that patients have the right to know how they spend their money for hospital care and supplies, yes, you can call State Medicaid hotline to see if the itemized information could be released. This is a State policy and not a hospital policy he pointed out.

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S, Statehouse, at 1: 30 a.m./p.m. on January 26, 19 87

Hearings temporarily ended on HB 2054.

Chairman noted he will contact Insurance carriers to see if they choose to testify on HB 2054.

Chair directed attention to HB 2019.

Dr. Robert C. Harder, SRS gave handout to members, see (Attachment No.3). He gave background of the bill, and stated SRS recommends that HB 2019 be amended to allow for an appeal committee to waive the waiting list requirement, and that the count of clients be done on the same base year as is used for the hold harmless provision. He urged for these minor changes in the form of amendments, (1) the creation of an appeal committee to review emergency and special cases regarding clients moving off the waiting list; and (2) matching the year of the client count with the year upon which the hold harmless provision is based. With these proposed changes, he urged for committee's support.

He then answered numerous questions from committee and several were answered by Dr. Gerald Hannah, Commissioner of Mental Health & Retardation Services. Questions, i.e., no, this isn't a way to get around the single list, it is insuring that if there is extenuating circumstances there is a way to handle it, there would still be the 69 clients, and there will remain that number. There is no new money, but the money is there to continue to implement the program. If there are 5 slots of persons who have moved on to different programs, then those 5 slots will be filled on a first come first serve basis, and the same money would apply to the same 69 positions. Revisor asked for some clarification on the language in the amendment proposed and this was cleared up.

Lila Pasley, Assoc. for Retarded Citizens of Kansas gave hand-out to members, see (Attachment No. 4), and spoke in behalf of HB 2019. She addressed the waiting list segment in Sec. 1, (b), and they feel the ultimate decision of moving persons up on the list should rest with the governing boards of the facilities since they are in contact with families and have ability to determine genuine emergencies which often cause placement of the retarded into adult services programs necessary. Their Association supports the single waiting list. She answered questions, i.e., the make up of the governing committee would be the President of their Association should name a person to be on that committee. At this point Rep. Blumenthal inquired if the balloon (See Attachment No. 5 for details), amendment offered would speak to the problem?. He said that Association for Retarded Citizens (ARC) had asked be drafted and he went to Revisor's to have it done. Rep. Blumenthal asked how the local and institutional groups could be merged. There was lengthy discussion on this point and consequently it was determined that a cooperative effort for a new balloon that would speak to this cooperation would be drafted.

Yo Bestgen, Ks. Association of Rehabilitation Facilities (KARF), gave hand-out to members, see (Attachment NO.6). She recommended that the hold harmless clause be sustained for the life of the Bill, and in regard to single waiting list, support the opportunity for all Kansas citizens who are mentally retarded/developmentally delayed to have equal access to community based services. She supports the technical amendments proposed by SRS.

After questions from committee Dr. Harder proposed the SRS offer a new balloon which would indicate changes that would be acceptable to SRS, ARC, and KARF that would read, "provided the exception is agreed to by the local ARC, local KARP and a representative of SRS." Concensus was this would provide a clean amendment and should be done.

Hearings closed on HB 2019.

Meeting adjourned.

GUEST REGISTER

HOUSE

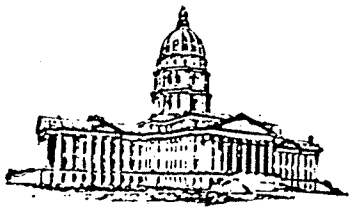
PUBLIC HEALTH AND WELFARE COMMITTEE

Date 1-26-1987

NAME	ORGANIZATION	ADDRESS
Dr. Robert C. Harder	SRS	Topeka
Dr. Gerald T. Hannah	SRS	Topeka
Lila Paslay	ARC/Kansas	Topeka
Dean + Carol Snodgrass		Dodge City
Jo Bastajian	KARF	Newton
Theresa Shively	Kansas NARAL	Topeka
Belva Ott	Planned Parenthood of KS	Wichita
Keith R. Landis	Christian Science Committee on Publication for Kansas	Topeka
Tom Bell	Ks. Hosp. Assn.	Topeka
Nancy Bramwell	Ks Medical Society	Topeka
Marilyn Bradt	KINH	Lawrence
Mark Intermill	KCOA	Topeka
Mary Ellen Conlee	St. Francis Reg. Med Center	Wichita

STATE OF KANSAS

KATHRYN SUGHRUE
REPRESENTATIVE 116TH DISTRICT
FORD COUNTY
1809 LA MESA DRIVE
DODGE CITY KANSAS 67801



TOPEKA

COMMITTEE ASSIGNMENTS
MEMBER FEDERAL AND STATE AFFAIRS
ENERGY AND NATURAL RESOURCES
GOVERNMENTAL ORGANIZATION

HOUSE OF
REPRESENTATIVES

January 26, 1987

Mr. Chairman and members of the Public Health and Welfare Committee.

Approval of H.B. 2054 will be helpful for many Kansans who have encountered difficulty in securing an itemized bill at the time of their discharge from the hospital.

Persons who have coverage by more than one health insurance policy often find that they need to furnish an itemized account on the cost of service equipment, supplies, medication, X-rays, etc.

With H.B. 2054 the patient must request an itemized bill. Since requests will probably be limited, the burden will not be excessive for hospitals.

A limited poll of hospital administrators done in 1985, showed that about 1 out of 3 hospitals provide detailed bills to patients on a routine basis. However, all those polled said that they would provide a detailed bill on request by the patient.

Legislation in other states (1985) - New Hampshire, Massachusetts, & Tennessee have laws that require hospital bills to be itemized.

The Nevada law requires that hospitals itemize hospital bills including the cost of supplies and medication, and do so at no additional cost to the patient, they must also answer any questions the patients

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may have as to items on the bill.

Maine enacted legislation in 1983 that requires that hospitals inform all patients in writing at the time of the patients discharge that it will provide an itemized bill upon the request of the patient. The request for an itemized bill maybe made at the time of the discharge or at anytime within 7 years after discharge.

I urge your favorable consideration of H.B. 2054

Rights and Responsibilities Of Patients

The basic rights of human beings for independence of expression, decision, and action, and concern for personal dignity and human relationships are always of great importance. During sickness, however, their presence or absence becomes a vital, deciding factor in survival and recovery. Thus it becomes a prime responsibility for hospitals to endeavor to assure that these rights are preserved for their patients.

In providing care, hospitals have the right to expect behavior on the part of patients and their relatives and friends, which, considering the nature of their illness, is reasonable and responsible.

This statement does not presume to be all-inclusive. It is intended to convey JCAH's concern about the relationship between hospitals and patients and to emphasize the need for the observance of the rights and responsibilities of patients.

The following basic rights and responsibilities of patients are considered reasonably applicable to all hospitals.

Patient Rights

Access to Care

Individuals shall be accorded impartial access to treatment or accommodations that are available or medically indicated, regardless of race, creed, sex, national origin, or sources of payment for care.

Respect and Dignity

The patient has the right to considerate, respectful care at all times and under all circumstances, with recognition of his personal dignity.

Privacy and Confidentiality

The patient has the right, within the law, to personal and informational privacy, as manifested by the following rights:

- To refuse to talk with or see anyone not officially connected with the hospital, including visitors, or persons officially connected with the hospital but not directly involved in his care.

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- To wear appropriate personal clothing and religious or other symbolic items, as long as they do not interfere with diagnostic procedures or treatment.
- To be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy. This includes the right to have a person of one's own sex present during certain parts of a physical examination, treatment, or procedure performed by a health professional of the opposite sex and the right not to remain disrobed any longer than is required for accomplishing the medical purpose for which the patient was asked to disrobe.
- To expect that any discussion or consultation involving his case will be conducted discreetly and that individuals not directly involved in his care will not be present without his permission.
- To have his medical record read only by individuals directly involved in his treatment or in the monitoring of its quality and by other individuals only on his written authorization or that of his legally authorized representative.
- To expect all communications and other records pertaining to his care, including the source of payment for treatment, to be treated as confidential.
- To request a transfer to another room if another patient or a visitor in the room is unreasonably disturbing him by smoking or by other actions.
- To be placed in protective privacy when considered necessary for personal safety.

Personal Safety

The patient has the right to expect reasonable safety insofar as the hospital practices and environment are concerned.

Identity

The patient has the right to know the identity and professional status of individuals providing service to him and to know which physician or other practitioner is primarily responsible for his care. This includes the patient's right to know of the existence of any professional relationship among individuals who are treating him, as well as the relationship to any other health care or educational institutions involved in his care. Participation by patients in clinical training programs or in the gathering of data for research purposes should be voluntary.

Information

The patient has the right to obtain, from the practitioner responsible for coordinating his care, complete and current information concerning his diagnosis (to the degree known), treatment, and any known prognosis. This information should be communicated in terms the patient can reasonably be expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to a legally authorized individual.

Communication

The patient has the right of access to people outside the hospital by means of visitors, and by verbal and written communication.

When the patient does not speak or understand the predominant language of the community, he should have access to an interpreter. This is particularly true where language barriers are a continuing problem.

Consent

The patient has the right to reasonable informed participation in decisions involving his health care. To the degree possible, this should be based on a clear, concise explanation of his condition and of all proposed technical procedures, including the possibilities of any risk of mortality or serious side effects, problems related to recuperation, and probability of success. The patient should not be subjected to any procedure without his voluntary, competent, and understanding consent or that of his legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed.

The patient has the right to know who is responsible for authorizing and performing the procedures or treatment.

The patient shall be informed if the hospital proposes to engage in or perform human experimentation or other research/educational projects affecting his care or treatment, and the patient has the right to refuse to participate in any such activity.

Consultation

The patient, at his own request and expense, has the right to consult with a specialist.

Refusal of Treatment

The patient may refuse treatment to the extent permitted by law. When refusal of treatment by the patient or his legally authorized representative prevents the provision of appropriate care in accordance with professional standards, the relationship with the patient may be terminated upon reasonable notice.

Transfer and Continuity of Care

A patient may not be transferred to another facility unless he has received a complete explanation of the need for the transfer and of the alternatives to such a transfer and unless the transfer is acceptable to the other facility. The patient has the right to be informed by the practitioner responsible for his care, or his delegate, of any continuing health care requirements following discharge from the hospital.

Hospital Charges

Regardless of the source of payment for his care, the patient has the right to request and receive an itemized and detailed explanation of his total bill for services rendered in the hospital. The patient has the right to timely notice prior to termination of his eligibility for reimbursement by any third-party payer for the cost of his care.

Hospital Rules and Regulations

The patient should be informed of the hospital rules and regulations applicable to his conduct as a patient. Patients are entitled to information about the hospital's mechanism for the initiation, review, and resolution of patient complaints.

Patient Responsibilities

Provision of Information

A patient has the responsibility to provide, to the best of his knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his health. He has the responsibility to report unexpected changes in his condition to the responsible practitioner. A patient is responsible for making it known whether he clearly comprehends a contemplated course of action and what is expected of him.

Compliance with Instructions

A patient is responsible for following the treatment plan recommended by the practitioner primarily responsible for his care. This may include following the instructions of nurses and allied health personnel as they carry out the coordinated plan of care and implement the responsible practitioner's orders, and as they enforce the applicable hospital rules and regulations. The patient is responsible for keeping appointments and, when he is unable to do so for any reason, for notifying the responsible practitioner or the hospital.

Refusal of Treatment

The patient is responsible for his actions if he refuses treatment or does not follow the practitioner's instructions.

Hospital Charges

The patient is responsible for assuring that the financial obligations of his health care are fulfilled as promptly as possible.

Hospital Rules and Regulations

The patient is responsible for following hospital rules and regulations affecting patient care and conduct.

Respect and Consideration

The patient is responsible for being considerate of the rights of other patients and hospital personnel and for assisting in the control of noise, smoking, and the number of visitors. The patient is responsible for being respectful of the property of other persons and of the hospital.

Circle One

MA.1.4.3 The establishment of departments/services necessary for the effective and efficient functioning of the hospital. 1 2 3 4 5 NA

MA.1.4.4 The implementation of effective communication mechanisms between and among hospital departments/services, the medical staff, the administration, and the governing body.* 1 2 3 4 5 NA

MA.1.4.5 The establishment of internal controls to safeguard physical, financial, and human resources. 1 2 3 4 5 NA

MA.1.4.6 Monitoring of the accuracy and reliability of financial data. 1 2 3 4 5 NA

MA.1.4.7 The control of inventories and purchasing procedures. 1 2 3 4 5 NA

MA.1.4.8 The implementation of a comprehensive management reporting system to account to the governing body. 1 2 3 4 5 NA

MA.1.4.9 The coordination of hospital services with the identified needs of the patient population served. 1 2 3 4 5 NA

MA.1.4.10 A hospitalwide policy on patients' rights and responsibilities. 1 2 3 4 5 NA

MA.1.4.11 Except in hospitals that have psychiatric/ substance abuse departments/services or except in hospitals that provide only psychiatric/substance abuse services, the development of a written plan for the care and/or appropriate referral of patients who are emotionally ill, who become emotionally ill while in the hospital, or who suffer the results of alcoholism or drug abuse. 1 2 3 4 5 NA

MA.1.4.11.1 The role of the medical staff is clearly defined in the written plan. 1 2 3 4 5 NA

MA.1.4.12 The spiritual needs of patients, either through hospital resources or through arrangement with appropriate community resources. 1 2 3 4 5 NA

MA.1.5 The chief executive officer, through the management and administrative staff, provides for personnel policies and practices that pertain to at least the following:

MA.1.5.1 The employment of personnel, without regard to sex, race, creed, or national origin, whose qualifications are commensurate with anticipated job responsibilities;* 1 2 3 4 5 NA

MA.1.5.2 The orientation of all new employees to the hospital and to hospital and personnel policies; 1 2 3 4 5 NA

MA.1.5.3 The maintenance of an accurate, current, and complete personnel record for each hospital employee; 1 2 3 4 5 NA

MA.1.5.4 The verification of all applicable current licensure/certification;* 1 2 3 4 5 NA

MA.1.5.5 A periodic performance evaluation, based on a job description, of each employee; and 1 2 3 4 5 NA

MA.1.5.6 The provision of employee health services, in consultation with the medical staff. 1 2 3 4 5 NA

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page ix.

TYPICAL ACCIDENT SITUATIONS

Often accident situations present difficulties to the provider in determining liability. However, there are situations where another party is liable and should be billed first. Some common examples include:

a. A recipient is a pedestrian hit by a car driven by a person with auto insurance.
b. A recipient who is employed is injured in a work related accident.
c. A recipient falls in a store and the store accepts liability.

The above list is not intended to be all inclusive, but rather to provide examples of cases where a responsible party should be billed first.

After receiving payment from the liable party a claim may then be submitted to Medicaid/MediKan for any unpaid charges for eligible services within 6 months or service. The payment by the other insurance company should be indicated on the claim in the same manner as those claims filed with other health insurance payment.

Likewise there are accidents where Medicaid/MediKan may be primary because no other insurance offers coverage and should be billed first; e.g., an accident (i.e., contusion, laceration) is self inflicted at home.

However, there are many accidents where there is possible liability, but a final determination will not be made until long after the accident. Claims for services rendered should be billed directly to Medicaid clearly stating thedetails of the accident giving any information available about the liability of other parties and possible insurance resources. These claims will be processed for payment by Medicaid and recovery sought on a post-payment basis.

RECIPIENT REQUESTS FOR BILLS

Frequently a Medicaid recipient who has been involved in a accident will return to the providers office at some point after the accident and request bills. If the services rendered as a result of the accident have been billed to Medicaid, then these bills should not be released to the recipient without authorization from the SRS Medical Subrogation Unit. The provider should obtain authorization from the SRS Medical Subrogation Unit in writing at the following address:

SRS Medical Subrogation Unit
State Office Building, 5th Floor
Topeka, Kansas 66612

or, by calling:

913/296-2476

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STATE DEPARTMENT OF SOCIAL & REHABILITATION SERVICES

Statement Regarding H.B. 2019

1) Title - This is a bill concerning the Kansas community mental retardation centers; amending K.S.A. 1986 Supp. 65-4411, 65-4413, and 65-4414.

2) Purpose - HB 2019 continues the authority for the Kansas Community Mental Retardation Facilities System Act until July 1, 1990. In addition, the Bill states that a client shall constitute a full-time equivalent status for the purpose of reimbursement when the client has been served from the top of the center's waiting list.

3) Background - During the 1986 Legislature, a long standing formula grant program (called 649) created in 1975 was changed by the passage of legislation, HB:3127. During the Summer of 1986, a Special Committee on Public Health and Welfare was created to consider ways to reduce the waiting lists for community facilities for the mentally retarded. The committee recommended that the statute be amended to allow for state financial assistance to community facilities only if clients were served on a first-come, first-serve basis.

4) Proposed Amendments - SRS recommends that the Bill be amended to allow for an appeal committee to waive the waiting list requirement. SRS further recommends that the Bill be amended to require that the count of clients be done on the same base year as is used for the hold harmless provision. Without the proposed SRS amendment, this legislation would not allow a center to be reimbursed for clients not at the top of the waiting list if the client were served on an emergency basis. The same problem could occur if the client at the top of the list needed services that were not available, while at the same time a different array of services were available to another client further down the list. An example of this situation would be if the client at the top of the list needed residential services, but the current residential program at a Community facility were at capacity. If at the same time there was a client further down the list that only needed day treatment services, the facility would be penalized for providing day treatment services ahead of the client who needed residential services that were not available. The other proposed SRS amendment would match the year upon which the number of clients is counted with the year upon which the hold harmless funding level is based. The current

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statute penalizes community facilities that have expanded their programs between 1983 and 1987.

5) Effect of Passage - Passage of this legislation without some minor changes would create problems for the community centers. The Department suggests two amendments: (1) the creation of an appeal committee to review emergency and special cases regarding clients moving off the waiting list; and (2) matching the year of the client count with the year upon which the hold harmless provision is based.

6) SRS Recommendation - The Department of Social and Rehabilitation Services supports this legislation in with the amendments as proposed above.

Robert C. Harder, Secretary
Social & Rehabilitation Services
296-3271

HOUSE BILL No. 2019

By Special Committee on Public Health and Welfare

Re Proposal No. 25

12-15

AN ACT concerning the Kansas community mental retardation facilities assistance act; amending K.S.A. 1986 Supp. 65-4411, 65-4413 and 65-4414 and repealing the existing sections.

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

Section 1. K.S.A. 1986 Supp. 65-4411 is hereby amended to read as follows: 65-4411. (a) K.S.A. 1986 Supp. 65-4411 to 65-4415, inclusive, and amendments thereto shall be known and may be cited as the Kansas community mental retardation facilities assistance act.

(b) K.S.A. 1986 Supp. 65-4411 to 65-4415, inclusive, and amendments thereto shall expire on July 1, ~~1987~~ *1990*.

Sec. 2. K.S.A. 1986 Supp. 65-4413 is hereby amended to read as follows: 65-4413. (a) For the purpose of insuring that adequate community mental retardation services are available to all inhabitants of Kansas, the state shall participate in the financing of community mental retardation facilities in the manner provided by this section.

(b) Subject to the provisions of appropriations acts and the provisions of K.S.A. 1986 Supp. 65-4414 *and amendments thereto*, the secretary shall make grants to community mental retardation facilities based on full-time equivalent clients served and per diem amounts per client as provided in this section. The secretary shall adopt rules and regulations (1) defining full-time equivalent clients and prescribing the method of computing full-time equivalent clients and (2) establishing statewide per diem amounts per client for the purposes of determining grants to community mental retardation facilities. *A client accepted by a facility on and after July 1, 1987, shall constitute a full-time*

Exceptions to the first-come, first-serve basis may be granted when heard before an appeal committee to be comprised of the Secretary, a representative of the Kansas Association of Rehabilitation Facilities, and a representative of the Kansas Association of Retarded Citizens.

equivalent client only if the client was accepted by the facility on a first-come, first-serve basis in order of the time at which an application for admission was made to such facility on behalf of the client.

(c) The secretary shall make grant payments each calendar quarter which shall be based upon the adjusted payments for the additional actual clients served during the ~~previous~~ calendar year *immediately preceding the year in which such grant payments are to be made*, subject to the provisions of K.S.A. 1986 Supp. 65-4414 *and amendments thereto*. In the event that sufficient moneys to pay to all community mental retardation facilities the full amount of grant payments determined in accordance with the number of actual clients served thereby and the current per diem amounts per client for any calendar quarter have not been appropriated or are not available, the entire amount available such calendar quarter for grant payments shall be prorated by the secretary among all the community mental retardation facilities applying for such grant payments in proportion to the amount each such community mental retardation facility would have received if sufficient moneys had been appropriated and available therefor, subject to the provisions of K.S.A. 1986 Supp. 65-4414 *and amendments thereto.*

When ~~Then~~ compared to the number of clients served during the year upon which the minimum grant amounts in K.S.A. 1986 Supp. 65-4414 and amendments thereto are based. These payments shall be

(d) The secretary shall adopt rules and regulations for the administration of the provisions of the Kansas community mental retardation facilities assistance act.

Sec. 3. K.S.A. 1986 Supp. 65-4414 is hereby amended to read as follows: 65-4414. During each fiscal year commencing after June 30, 1986, each community mental retardation facility which was eligible for grant payments under K.S.A. 1986 Supp. 65-4413 *and amendments thereto* and which received assistance under the provisions of K.S.A. 65-4401 to 65-4408, inclusive, *and amendments thereto* for the fiscal year ending June 30, 1986, shall receive a total amount of grant payments under K.S.A. 1986 Supp. 65-4413 *and amendments thereto* for such fiscal year in an amount which is not less than the total amount of assistance earned by such community mental retardation facility under the provisions of K.S.A. 65-4401 to 65-4408, inclusive, *and amend-*

ments thereto for the fiscal year ending June 30, 1986. In the event that sufficient funds are not appropriated to pay all such community mental retardation facilities, which are applying for grants, the minimum amounts which such facilities are eligible to receive under this section, the secretary shall prorate the entire amount appropriated for grants among those community mental retardation facilities which are applying for grants and which are eligible under this section, in proportion to the amount each such community mental retardation facility received during the base year ending June 30, 1986. *This section shall expire on July 1, 1989.*

Sec. 4. K.S.A. 1986 Supp. 65-4411, 65-4413 and 65-4414 are hereby repealed.

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

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THE ASSOCIATION FOR
RETARDED CITIZENS OF KANSAS, INC.

11111 W. 59th TERRACE
SHAWNEE, KANSAS 66203 • (913) 268-8200

Hope through understanding

January 26, 1987

To: Rep. Marvin Littlejohn, Chairman
Members House Public Health and
Welfare Committee

From: Lila Paslay, Chairperson
Legislative Affairs

Re: HB 2019

I am speaking to you today on behalf of the Association for Retarded Citizens of Kansas and in support of the concept of HB 2019.

We do want the extention of the Kansas Community Mental Retardation Facilities Act and we do support the continuation of the hold harmless provision of that Act.

We would, however, like to address the waiting list segment in Section 1(b), line 0043 which states, "A client accepted by a facility on and after July 1, 1987, shall constitute a full time equivalent client only if the client was accepted by a facility on a first-come, first-serve basis in order of the time at which an application for admisstion was made to such a facility on behalf of the client."

Representing primarily parents of persons with mental retardation I can assure you we have no difficulty philosophically with that section. We do support the single waiting list. The reality is a different matter.

If this were to become law, there would be no opportunity for a facility to deal with an emergency or crisis situation. No opportunity to address family needs and there impact upon the person with retardation.

Consider the possibility of an adult living at home with his or her parents. The individual may be three or four on the waiting list. The caregiver during the day becomes ill and is no longer able to provide supervision. Would it not be better for that individual to be accepted into a vocational program ahead of number one on the list rather than have the person with retardation enter a day program for the elderly or become a resident at a state institution or other inappropriate program?

We also have questions about how the waiting lists are developed. There is no single method used by all facilities. I recently heard of a mother

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who placed her daughter, 14 years of age, on a waiting list for adult services because the waiting list was so great. Other facilities only place individuals who meet the criteria for eligibility for the facility on the waiting list when the individual is 21 years of age.

We understand the concern of the interim committee as they looked for solutions to the waiting list problem. We understand their concern for fairness but we do feel that somehow the ultimate decision should rest with the governing boards of the facilities. They are in contact with families and have the ability to determine genuine emergencies.

equivalent client only if the client was accepted by the facility on a first-come, first-serve basis in order of the time at which an application for admission was made to such facility on behalf of the client.

(c) The secretary shall make grant payments each calendar quarter which shall be based upon the adjusted payments for the actual clients served during the ~~previous~~ calendar year *immediately preceding the year in which such grant payments are to be made*, subject to the provisions of K.S.A. 1986 Supp. 65-4414 *and amendments thereto*. In the event that sufficient moneys to pay to all community mental retardation facilities the full amount of grant payments determined in accordance with the number of actual clients served thereby and the current per diem amounts per client for any calendar quarter have not been appropriated or are not available, the entire amount available such calendar quarter for grant payments shall be prorated by the secretary among all the community mental retardation facilities applying for such grant payments in proportion to the amount each such community mental retardation facility would have received if sufficient moneys had been appropriated and available therefor, subject to the provisions of K.S.A. 1986 Supp. 65-4414 *and amendments thereto*.

(d) The secretary shall adopt rules and regulations for the administration of the provisions of the Kansas community mental retardation facilities assistance act.

Sec. 3. K.S.A. 1986 Supp. 65-4414 is hereby amended to read as follows: 65-4414. During each fiscal year commencing after June 30, 1986, each community mental retardation facility which was eligible for grant payments under K.S.A. 1986 Supp. 65-4413 *and amendments thereto* and which received assistance under the provisions of K.S.A. 65-4401 to 65-4408, inclusive, *and amendments thereto* for the fiscal year ending June 30, 1986, shall receive a total amount of grant payments under K.S.A. 1986 Supp. 65-4413 *and amendments thereto* for such fiscal year in an amount which is not less than the total amount of assistance earned by such community mental retardation facility under the provisions of K.S.A. 65-4401 to 65-4408, inclusive, *and amend-*

Attachment 5
1/26/87

[, except that in instances of family crises or emergency a client may be accepted by a facility on other than a first-come, first-serve basis if the board of directors of the facility approves the admission of the client to the facility

Attm. #5
PHRW
1-26-87

Kansas Association of Rehabilitation Facilities

TownCenter Building 120 West Sixth, Suite 110
Newton, KS 67114 316-284-2330

TO: HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

FROM: KANSAS ASSOCIATION OF REHABILITATION FACILITIES (KARF)

RE: HB 2019 - AN ACT CONCERNING KANSAS COMMUNITY MENTAL RETARDATION FACILITIES ASSISTANCE ACT

DATE: JANUARY 26, 1987

Recommendations:

-That the hold harmless clause be sustained for the life of the Bill.

-Single waiting list - support the opportunity for all Kansas citizens who are mentally retarded/developmentally delayed to have equal access to community based services.

-Support technical amendments proposed by SRS.

Attm. # 6
Joe Bertin
PH&W
1-26-87