Approved Feb-5, 1987
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Vice-Chairman, FRANK BUEHLER at
Chairperson

1:30 ~~a.m./~~p.m. on February 3, 1987 in room 423-S of the Capitol.

All members were present except:

Chairman Marvin Littlejohn, escused.

Committee staff present:

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

Conferees appearing before the committee:

Jerry Slaughter, Kansas Medical Society
Representative Branson
Michael Byington, Ks. Association for Blind and Visually Impaired
Representative Melvin Neufeld

Vice-Chairman Frank Buehler called meeting to order when quorum was present, calling attention to announcements. He recommended that committee members refer to the Interim Report, pages 451 through 461, especially top of page 461, there is a good explanation of how the committee perceived HB 2017 and HB 2018.

Vice-Chair then made a comment in regard to questions after bill requests. He urged members to limit their questions to the requests specifically since the issue will be debated on hearing date and those types of questions could be dealt with at that hearing.

Vice-Chair then invited those present who had bill requests to begin.

Jerry Slaughter, Kansas Medical Center had requests for two bills. These bills are related to each other he explained and gave hand-outs to members, (see Attachments 1 and 2) for details. A new law requests that smoking be regulated, (not prohibit, but regulate) smoking in public places. The intention is to provide laws to store owners that some place be set aside, (well ventilated) for non smokers. There is also a prohibition of smoking in all health care institutions as they feel there should be one place in society you can be free of smoke, and the health care providers offices and medical care facilities. He explained the entire proposed legislation in detail. The other request would prohibit the sale of cigarettes or tobacco products in any health care institution. He explained in detail the definition of health care institutions. He answered questions, i.e., yes there perhaps needs to be an amendment to clean up the problem of the health care providers who would be in private homes, as there intent does not plan to include private homes.

Representative Blumenthal made a motion to introduce both these bill requests with the modifications that Mr. Slaughter has agreed to make and have these bills returned to this committe, motion seconded by Representative Neufeld. Motion carried.

Representative Branson had a bill request in regard to legislation that would speak to Beverly Enterprises. She said in view of the problem of the number of nursing homes in Kansas owned by this Company, (they are far ahead of any other chain that operates nursing homes, she said), this bill would limit the percentage of homes that any individual or Company could own in Kansas. She and Mr. Furse are presently working on language for this bill draft, and she asked that she might present the request at a later date. Vice-Chairman agreed.

Michael J. Byington, Kansas Association for the Blind and Visually Impaired, Inc., gave hand-out to members of a draft of proposed legislation. (See Attachment NO.3), for details. He explained there are two proposals in this hand-out, and he detailed each, i.e., one relates to descrimination against blind, visually handicapped, and persons otherwise disabled, and the bill would assure that trained dog guides for the blind may accompany their owners into virtually every place into which the public is invited. The second request would be to have SB 529 from last year be heard again since the Legislature ran out of time before the bill could be finalized. (It would of course be under new numbering.) This bill speaks to the process that insurance discrimination against the blind, only because they are blind, would be unlawful.

Discussion ensued after Mr. Byington's requests that it is likely that the proposal that seeks to eliminate insurance discrimination against the blind could already have been requested in the package of bill requests by the Insurance Commissioner. This fact will be checked on, and dealt with accordingly.

Rep. Gatlin made a motion to have these bills introduced and referred back to this committee, if, they have not been previously introduced. Motion seconded by Rep. Harder, motion carried.

Representative Neufeld gave hand-out to members, (see Attachment No. 4), for details of his bill draft. He explained the request is due to a concern at Fort Dodge Soldier's Home, i.e, resident of the home if he is a convicted felon. They would like this legislation to give the Veterans Commission the authority to admit such persons if they are sufficiently rehabilitated, to stay on as a resident of the Soldier's Home.

Rep. Neufeld made a motion this bill be requested and referred back to this committe, motion seconded by Rep. Blumenthal, motion carried.

Vice-Chairman noted the next order of business would be a refresher course on Credentialing by Staff members, Ms. Correll and Mr. Furse.

Ms. Correll gave a very comprehensive briefing on the process of Credentialing. She noted this year we will be dealing with bills that speak to the Dietitians and Counselors. She explained Registration means the exclusive right to use a title. Licensure is the exclusive right to practice a particular type of health care. The Statewide Health Coordinating Council (SHICC) appoints a technical committee who then has the right to review the need for credentialing. They forward their report and recommendations back to SHICC who in turn makes its own report and recommendations. She answered questions.

Mr. Furse then reviewed statutory aspects of the Credentialing process, and gave hand-out information to members. He reviewed the statutes 65-5006 and 65-5007 as defined in Attachment NO.5 and statutes 65-5001 as defined in Attachment NO.6. He answered numerous questions, i.e., it takes different periods of time for different processes in credentialing and licensing, and yes, he could provide a list of Health Care Providers that indicates who is registered and who is licensed. The fee of $1,000 is an application fee. He asked members to take note that he would refer to (Gumbhir vs. State Board of Pharmacy) during some hearing proceedings. This case will determine authority on whether person is eligible to be licensed, and he wanted members to become familiar with this term.

Vice Chairman thanked Staff for their comprehensive remarks on Credentialing, and their efforts in preparing for it on short notice.

Vice-Chair announced he would like members to re-lay announcements to members who are not present so all will be aware of all committee activity. He called attention to (Attachment NO.7), an extremely good article on, "CARING FOR THE MEDICALLY INDIGENT: WHO WILL PAY THE BILL?", and urged members to study it before hearings on HB 2014. Further, he thanked Representative Flottman for her efforts in arranging to send card and flowers to Chairman Littlejohn in behalf of committee members and staff, and it was learned that Chairman Littlejohn is improving nicely after surgery in Wesley Medical Center in Wichita.

Meeting adjourned 2:30 p.m.

GUEST REGISTER

HOUSE

PUBLIC HEALTH AND WELFARE COMMITTEE

Date 2-3-1987

NAME	ORGANIZATION	ADDRESS
Jerry Slaughter	KS MEDICAL SOC.	TOPEKA
John Myers	Ks Dietetic Assoc.	Topeka
Dal Liddle	Hutchinson News	Hutchinson
SUSAN TANNENWALD-MIRINOFF	KS State Nurses Assn	Topeka
Michael Byington	Ks. Ass. FIT & Blind and Visually Impaired	P. O. Box 292, Topeka 66601
Tom Bell	KS. Hosp. Assn.	Topeka
John Peterson	Ks Dietetic Assn	Topeka
Marilyn Bradt	Kansans for Improvement of Nursing Homes	
Theresa Shively	KANSAS NARAL	Topeka
KEITH R. LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS	"
John Grace	KS Homes for Aging	Topeka
Gary Robbins	Ks Optometric Assn	Topeka

BILL NO. _____

AN ACT regulating the smoking of tobacco products in public places and at public meetings, and prohibiting the use of tobacco products in health care institutions.

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

Section 1. Definitions. As used in this Act: (a) "Public place" means enclosed indoor areas open to the public or used by the general public including but not limited to: restaurants, retail stores, public means of mass transportation, passenger elevators, health care institutions, educational facilities, libraries, courtrooms, state, county or municipal buildings, restrooms, grocery stores, school buses, museums, theaters, auditoriums, arenas, recreational facilities, and state buildings.

(b) "Public meeting" includes all meetings open to the public.

(c) "Smoking" means possession of a lighted cigarette, cigar, pipe or any other lighted smoking equipment.

(d) "Health care institution" means any office of a health care provider as defined by K.S.A. 40-3401, any medical care facility as defined by K.S.A. 65-425, private and state psychiatric hospitals, private and state institutions for the mentally retarded, and any other place where health care services are provided to the public.

Section 2. (a) No person shall smoke in a public place or at a public meeting except in designated smoking areas. (b) Smoking areas may be designated by proprietors or other persons in charge of public places, except in health care institutions, passenger elevators, school buses, public means of mass trans portation and any other place in which smoking is prohibited by the fire marshal or by other law, ordinance or regulation. (c) Where smoking areas are designated, existing physical barriers and ventilation systems shall be used to minimize the toxic effect of smoke in adjacent nonsmoking areas.

Section 3. In each room or area in which smoking is prohibited by this Act, the proprietor or other person in charge of the premises shall post or cause to be posted in a conspicious place signs clearly stating that smoking is prohibited by state law. The person in charge of the premises shall also post or cause to be posted in any room or area designated as a smoking area, signs stating that smoking is permitted in such room or area. The proprietor or person in charge of the public place shall have the authority to establish the percentage of area in the public place which shall be posted and designated as a smoking area.

Section 4. Smoking is hereby prohibited in all health care institutions.

Section 5. Any person found guilty of smoking in violation of this act is guilty of public offense, punishable by a fine of not more than $20.00 for each violation. All fines shall inure to the benefit of the county conducting the prosecution. Any person found guilty of failing to post signs as required by this act, is guilty of a public offense, punishable by a fine of not more than $50.00. All such fines shall inure to the benefit of the county conducting the prosecution. In addition, the Kansas Department of Health and Environment, or local department of health may institute an action in any court of competent jurisdiction to enjoin repeated violations of this act.

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Section 6. Nothing in this act shall prevent any town, city or county from adopting ordinances to regulate smoking within its boundaries, provided that the provisions of such ordinances are at least as stringent as those imposed by this act. In such cases the more stringent local ordinances shall control to the extent of any inconsistency between them and this act.

Section 7. If any provision of this act or the application thereof to any person, thing or circumstance is held invalid, such invalidity shall not affect the provisions of application of this act that can be given effect without the invalid provision or application, and to this end the provisions of the act are declared to be severable.

Section 8. This act shall take effect and be in force after its publication in the statute book.

BILL NO. _____

An Act amending K.S.A. 79-3321 regarding unlawful acts related to cigarettes and tobacco products and repealing the existing section.

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

Section 1. K.S.A. 79-3321 is amended to read as follows:

It shall be unlawful for any person: (a) To possess, except as otherwise specifically provided by this act, more than two hundred (200) cigarettes without the required tax indicia being affixed as herein provided.

(b) To mutilate or attach to any indiviual package of cigarettes any stamp that has in any manner been mutilated or that has been heretofore attached to a different individual package of cigarettes or to have in possession any stamps so mutilated.

(c) To prevent the director or any officer or agent authorized by law, to make a full inspection for the purpose of this act, of any place of business and all premises connected thereto where cigarettes are or may be manufactured, sold, distributed, or given away.

(d) To use any artful device or deceptive practice to conceal any violation of this act or to mislead the said director or officer or agent authorized by law in the enforcement of this act.

(e) Who is a dealer to fail to produce on demand of the said director or any officer or agent authorized by law any records or invoices required to be kept by said person.

(f) Knowingly to make, use, or present to said director or agent thereof any falsified invoice or falsely state the nature or quantity of the goods therein invoiced.

(g) Who is a dealer to fail or refuse to keep and preserve for the time and in the manner required herein all the records required by this act to be kept and preserved.

(h) To wholesale cigarettes to any person, other than a duly licensed manufacturer's salesman, retail dealer or wholesaler.

(i) To have in his or her possession any evidence of tax indicia provided for herein not purchased from the director.

(j) To fail or refuse to permit the director or any officer or agent authorized by law to inspect a carrier transporting cigarettes.

(k) To vend small cigars, or any products so wrapped as to be confused with cigarettes, from a machine vending cigarettes, nor shall a vending machine be so built to vend cigars or products that may be confused with cigarettes, be attached to a cigarette vending machine.

(l) To sell cigarettes to any person under eighteen (18) years of age.

(m) For any person under eighteen (18) years of age to purchase cigarettes.

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2-3-7

(n) To sell cigarettes to a retailer or at retail that do not bear Kansas tax indicia or upon which the Kansas cigarette tax has not been paid.

(o) To sell cigarettes without having a license for such sale as provided herein.

(p) To sell cigarette vending machines without having a license as provided herein for sale of vending machines.

(q) To sell cigarettes or tobacco products in any health care institution. For the purposes of this section health care institution means: any office of a health care provider as defined by K.S.A. 40-3401, any medical care facility as defined by K.S.A. 65-425, private and state psychiatric hospitals, private and state institutions for the mentally retarded, and any other place where health care services are provided to the public.

Section 2. K.S.A. 79-3321 is hereby repealed.

Section 3. This statute shall take effect and be in force after its publication in the statute books.

Kansas Association for the Blind and Visually Impaired, Inc.

February 2, 1987

TO: House Public Health and Welfare

FROM: Michael J. Byington, Registered Kansas Lobbyist

SUBJECT: Bill Requests

The Kansas Association for the Blind and Visually Impaired Inc., the oldest and largest all volunteer advocacy organization for and of the blind and visually impaired in the State of Kansas, requests the following two bills.

NON DISCRIMINATION IN HOUSING FOR DOG GUIDE USERS

K.S.A. 39-1101-1102 assures non discrimination against blind, visually handicapped, and persons who are otherwise physically disabled, and these sections also assure that trained dog guides for the blind may accompany their owners into virtually every place into which the public is invited. K.S.A. 39-1101 in fact offers a list of such places where the blind, visually handicapped, or persons who are otherwise physically disabled must be admitted. Over the years, the Legislature has added more and more specifics to this list to the point that now the list is quite comprehensive. K.S.A. 39-1102 essentially states that dog guides for the blind may go into all of the places listed in K.S.A. 39-1101.

The list in K.S.A. 39-1101 covers virtually everything except rental and sale housing. K.S.A. 39-1107 prohibits housing discrimination against deaf persons who use specially trained hearing ear dogs, but there is no legal protection with reference to housing discrimination as it relates to blind people who use specially trained dog guides.

It is the intent of the Kansas Association for the Blind and Visually Impaired Inc. to request that a bill be introduced which would afford blind people using dog guides for the blind the same protections with reference to housing as currently are offered in the law to deaf people who use specially trained hearing ear dogs. This seems quite logical and appropriate as dog guides for the blind have actually been used as independent living aids successfully for a far greater period of time than have hearing ear dogs. Below shall be provided our rationale for the wording our organization would like in the bill.

Our organization attempted to achieve above described legislative result and overall effect over the past two years through the introduction in 1985 of SB 292. This bill simply added the words "rental and sale housing" to the list in K.S.A. 39-1101. This wording received opposition from landlord organizations which was completely

PH&W
Attm. #3
2-3-7

out of proportion. The landlords seemed to feel that the addition of the words in this section would potentially require them to make housing accessible to the physically disabled because 39-1101 refers to protection of the rights of the blind, visually handicapped, and persons who are otherwise physically disabled. Although staff assured the Senate Committee reviewing the bill and the landlords that this was not the anticipated intent or effect of the bill, confusion over the issue caused the bill to be reported unfavorably. It seems the bill had become confused with last years HB 2018 which was much broader and which was assigned to this House Public Health and Welfare Committee. At the time the bill was killed, several Senators, and several lobbyists for landlord interests told this author that, it they could be assured that the bill only covered dog guides for the blind, there would be no problem. Thus, this year we are requesting more narrow wording. We are requesting that the rental and sale housing reference be added to K.S.A. 39-1102 instead of 1101. This would satisfy the concerns expressed last year as 1102 relates only to blind people using dog guides. We want to start the bill on the House side this time. The proposed bill would make K.S.A. 39-1102 read as follows:

"Same; use of guide dogs; liability. Every totally or partially blind person shall have the right to be accompanied by a guide dog, especially trained for the purpose, in or upon any of the places listed in K.S.A.39-1101 and in the acquisition and use of rental residential housing or in the purchase and use of such residential housing without being required to pay an extra charge for the guide dog: provided that such person shall be liable for any damage done to the premises or facilities by such dog."

NON DISCRIMINATION IN INSURANCE FOR THE BLIND

Last year, SB 529 was reported favorably out of the Senate Committee on Financial Institutions and Insurance. It simply did not have time to get all the way through the legislative process. We would like to introduce the same bill again, and this year it will have two years to attempt to wonder through the process. The bill simply prohibits insurance discrimination against the blind. In other words, it states that blindness alone in and of itself can not be a reason for charging higher insurance rates. The wording used by the Revisor of Statutes last year would be acceptable to our organization. This bill probably will not remain in Public Health and Welfare, but as this Committee has in recent years spent so much time in study of issues related to discrimination against disabled individuals, it seemed an appropriate place for introduction, certainly as appropriate as an insurance related committee.

7 RS 0176

HOUSE BILL NO. _____

By

AN ACT concerning the Kansas soldiers' home; relating to admission thereto; amending K.S.A. 76-1908 and repealing the existing section.

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

Section 1. K.S.A. 76-1908 is hereby amended to read as follows: 76-1908. (a) The following, subject to the rules and regulations that may be adopted by the Kansas veterans' commission for the management and government of the Kansas soldiers' home shall be eligible to admission to the Kansas soldiers' home:

(1) Any person who served in the active military or naval service of the United States during any period of the war with Spain, Philippine insurrection, Boxer uprising, world war I, world war II, Korean emergency or Viet Nam emergency, and who ~~shall have~~ has been discharged or relieved therefrom under conditions other than dishonorable, who may be disabled by disease, wounds, old age, or otherwise disabled, and who has no adequate means of support, and who, by reason of such disability, is incapacitated from earning a living, and who would otherwise be dependent upon public or private assistance, together with such members of the family as are dependent upon ~~him or her~~ such person for support.

(2) The widow, mother, widower, father or minor child of any person who served in the active military or naval service of the United States during any period in time of any war of the United States, including the Korean emergency and Viet Nam emergency, and who ~~shall have~~ has been discharged or relieved therefrom under conditions other than dishonorable, if such widow, mother, widower, father or minor child is incapable of

PA&C attm. #4 2-3-7

self-support because of physical disability and is without adequate means of support.

(b) No person shall be admitted to the soldiers' home except upon application to the commission and approval of the application by the commission. No applicant shall be admitted to the soldiers' home who has not been an actual resident of the state of Kansas for at least two ~~(2)~~ years next preceding the date of application, except that any applicant who at the time of entering service in a Kansas unit was a resident of Kansas and served in a Kansas unit during the war with Spain, Philippine insurrection, Boxer uprising, world war I or world war II ~~or~~, Korean emergency or Viet Nam emergency, and who ~~shall--have~~ has been discharged or relieved from such services under conditions other than dishonorable, shall be admitted regardless of place of residence.

(c) No person shall be admitted to or retained in the soldiers' home:

(1) Who is a mentally ill person ~~or~~;

(2) who has been convicted of a felony, unless the commission finds that such person has been adequately rehabilitated and is not dangerous to oneself or to the person or property of others; or

(3) who is an habitual drunkard ~~shall--be--admitted-or retained-as-a-member-of-the-soldiers'-home~~.

(d) No child shall be admitted to or retained in the soldiers' home who is ~~sixteen--(16)~~ 16 years of age or over, unless such child is incapable of ~~earning-his-or-her-own--support by-his-or-her-own-labor~~ supporting oneself.

(e) No child properly a member of the home shall be discharged under ~~sixteen-(16)~~ 16 years of age.

(f) The Kansas veterans' commission shall have authority by resolution to discharge any member from the soldiers' home on a showing that the member has gained admittance into ~~said~~ the soldiers' home by misrepresentation of ~~his-or--her~~ the member's financial or physical condition, or a showing that the financial

or physical condition of such member has been so altered since admittance ~~as--not-to-justify~~ so that the further maintenance of the member in the soldiers' home is not justified. No such member shall be discharged without notice and opportunity to be heard by the commission.

(g) The rules and regulations for admission of members to the Kansas soldiers' home shall require that an applicant for admission ~~shall~~ be given priority over patients transferred from state institutions under the provisions of K.S.A. 76-1936 and 76-1937 and amendments to these statutes.

Sec. 2. K.S.A. 76-1908 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the Kansas register.

include the reports of the technical committee and the council in the final report prepared for submission to the legislature. The secretary need not be bound by the recommendations of a technical committee or of the council.

(b) If the secretary determines after consideration of the reports of the technical committee and the council and the evidence and testimony presented to the technical committee that all criteria established by law or by rules and regulations for credentialing have not been met and that credentialing is not appropriate, the secretary shall recommend that no legislative action be taken on a credentialing application. If the secretary determines that clear and convincing evidence which was more than hypothetical examples or testimonials was presented to the technical committee that the applicant occupational or professional group of health care personnel should be credentialed by the state, that the applicant occupational or professional group of health care personnel has met all the criteria established by law or by rules and regulations for credentialing and that credentialing by the state is appropriate, the secretary shall recommend that the occupational or professional group of health care personnel be credentialed. If the secretary recommends that an occupational or professional group of health care personnel be credentialed, the secretary shall recommend: (1) The level or levels of credentialing, and such recommendation shall be based upon a finding by the secretary, stated in the report, that all criteria established by law or by rules and regulations concerning the recommended level or levels of credentialing have been met; (2) an agency to be responsible for the credentialing process and the level or levels of credentialing; and (3) such matters as the secretary deems appropriate for possible inclusion in legislation relating to the recommendation for credentialing.

(c) No group of health care personnel shall be credentialed except by an act of the legislature. The final report of the secretary and the reports and recommendations of the technical committee and the council shall constitute recommendations to the legislature and shall not be binding upon the legislature. The legislature may dispose of such recommendations and reports as it deems appropriate.

History: L. 1980, ch. 181, § 5; L. 1986, ch. 246, § 5; April 24.

65-5006. Same; credentialing criteria. (a) The technical committee appointed pursuant to K.S.A. 65-5003 and amendments thereto, the council and the secretary shall apply the following criteria to each credentialing application:

(1) The unregulated practice of the occupation or profession can harm or endanger the health, safety or welfare of the public and the potential for such harm is recognizable and not remote;

(2) the practice of the occupation or profession requires an identifiable body of knowledge or proficiency in procedures, or both, acquired through a formal period of advanced study or training, and the public needs and will benefit by assurances of initial and continuing occupational or professional ability;

(3) if the practice of the occupation or profession is performed, for the most part, under the direction of other health care personnel or inpatient facilities providing health care services, such arrangement is not adequate to protect the public from persons performing noncredentialed functions and procedures;

(4) the public is not effectively protected from harm by certification of members of the occupation or profession or by means other than credentialing;

(5) the effect of credentialing of the occupation or profession on the cost of health care to the public is minimal;

(6) the effect of credentialing of the occupation or profession on the availability of health care personnel providing services provided by such occupation or profession is minimal;

(7) the scope of practice of the occupation or profession is identifiable;

(8) the effect of credentialing of the occupation or profession on the scope of practice of other health care personnel, whether or not credentialed under state law, is minimal; and

(9) nationally recognized standards of education or training exist for the practice of the occupation or profession and are identifiable.

(b) Reports of the technical committee, the council and the secretary shall include specific findings on the criteria set forth in

PHRW attm. #5
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subsection (a). No report of the technical committee, the council or the secretary shall recommend credentialing of any occupational or professional group of health care personnel unless all the criteria set forth in subsection (a) have been met.

History: L. 1980, ch. 181, § 6; L. 1986, ch. 246, § 6; April 24.

65-5007. Same; criteria applicable to levels of credentialing regulation. (a) All recommendations of the technical committee, the council and the secretary which relate to the level or levels of credentialing regulation of a particular group of health care personnel shall be consistent with the policy that the least regulatory means of assuring the protection of the public is preferred and shall be based on alternatives which include, from least regulatory to most regulatory, the following:

(1) Statutory regulation, other than registration or licensure, by the creation or extension of statutory causes of civil action, the creation or extension of criminal prohibitions or the creation or extension of injunctive remedies is the appropriate level when this level will adequately protect the public's health, safety or welfare.

(2) Registration is the appropriate level when statutory regulation under paragraph (a)(1) is not adequate to protect the public's health, safety or welfare and when registration will adequately protect the public health, safety or welfare by identifying practitioners who possess certain minimum occupational or professional skills so that members of the public may have a substantial basis for relying on the services of such practitioners.

(3) Licensure is the appropriate level when statutory regulation under paragraph (a)(1) and registration under paragraph (a)(2) is not adequate to protect the public's health, safety or welfare and when the occupational or professional groups of health care personnel to be licensed perform functions not ordinarily performed by persons in other occupations or professions.

(b) Reports of the technical committee, the council and the secretary shall include specific findings on the criteria set forth in subsection (a). No report of the technical committee, the council or the secretary shall recommend the level or levels of credentialing of any occupational or professional group of health care personnel unless all the criteria set forth in subsection (a) for the recommended level or levels of credentialing have been met.

History: L. 1980, ch. 181, § 7; L. 1986, ch. 246, § 7; April 24.

65-5009. Same; records; duties of secretary; rules and regulations; compensation of members of technical committee. (a) The secretary shall provide all necessary professional and clerical services to the technical committee and to the council. Records of all official actions and minutes of all business coming before the technical committee and the council shall be kept. The secretary shall be the custodian of all records, documents and other property of the technical committee and the council.

(b) The council shall advise and consult with the secretary on the administration of the provisions of this act and the adoption of rules and regulations. The secretary shall adopt rules and regulations necessary to implement the provisions of this act including, but not limited to, rules and regulations establishing the policies and procedures to be followed by the technical committee and the council in the consideration of credentialing applications under this act.

(c) Members of the technical committee appointed pursuant to K.S.A. 65-5003 and amendments thereto shall be paid subsistence allowances, mileage and other expenses as provided in K.S.A. 75-3223 and amendments thereto when in attendance at a meeting of the technical committee authorized by the council.

History: L. 1980, ch. 181, § 9; L. 1986, ch. 246, § 8; April 24.

65-5011. Application of act to certain credentialing applications. Except as otherwise provided in this act, the review of an application for credentialing commenced prior to the effective date of this act shall be governed by the provisions of this act which apply to that part of the review of such application which was not completed prior to the effective date of this act. The secretary shall authorize an original application for credentialing filed prior to the effective date of this act, to be amended to address the standards and criteria established under this act. Nothing in this section shall be

ployee. If the aggrieved employee substantially prevails on any of the allegations contained in the pleadings in an action allowed by this section, the court, in its discretion, may allow the employee reasonable attorney fees as part of the costs.

History: L. 1986, ch. 229, § 9; July 1.

65-4929. Purpose of risk management programs; status of entities conducting programs; antitrust immunity. (a) The legislature of the state of Kansas recognizes the importance and necessity of providing and regulating certain aspects of health care delivery in order to protect the public's general health, safety and welfare. Implementation of risk management plans and reporting systems as required by K.S.A. 1986 Supp. 65-4922, 65-4923 and 65-4924 and peer review pursuant to K.S.A. 65-4915 and amendments thereto effectuate this policy.

(b) Health care providers and review, executive or impaired provider committees performing their duties under K.S.A. 1986 Supp. 65-4922, 65-4923 and 65-4924 and peer review pursuant to K.S.A. 65-4915 and amendments thereto for the purposes expressed in subsection (a) and 65-4915 and amendments thereto shall be considered to be state officers engaged in a discretionary function and all immunity of the state shall be extended to such health care providers and committees, including that from the federal and state antitrust laws.

(c) Nothing in this section shall be construed to require health care providers or review, executive or impaired provider committees to be subject to or comply with any other law relating to or regulating state agencies, officers or employees.

History: L. 1986, ch. 229, § 10; July 1.

65-4930. Act supplemental to existing law. The provisions of K.S.A. 1986 Supp. 65-4921 through 65-4929 shall be supplemental to K.S.A. 65-28,121, 65-28,122 and 65-4909, and amendments thereto, and shall not be construed to repeal or modify those sections.

History: L. 1986, ch. 229, § 11; July 1.

Article 50.—CREDENTIALING

65-5001. Credentialing health care personnel; definitions. As used in this act unless the context requires otherwise, the following words and phrases shall have the meanings respectively ascribed to them herein:

(a) "Credentialing" or "credentialed" means the formal recognition of professional or technical competence through the process of registration, licensure or other statutory regulation.

(b) "Certification" means the process by which a nongovernmental agency or association or the federal government grants recognition to an individual who has met certain predetermined qualifications specified by the nongovernmental agency or association or the federal government.

(c) "Registration" means the process by which the state identifies and lists on an official roster those persons who meet predetermined qualifications and who will be the only persons permitted to use a designated title.

(d) "Licensure" means a method of regulation by which the state grants permission to persons who meet predetermined qualifications to engage in an occupation or profession, and that to engage in such occupation or profession without a license is unlawful.

(e) "Health care personnel" means those persons whose principal functions, customarily performed for remuneration, are to render services, directly or indirectly, to individuals for the purpose of:

(1) Preventing physical, mental or emotional illness;

(2) detecting, diagnosing and treating illness;

(3) facilitating recovery from illness; or

(4) providing rehabilitative or continuing care following illness;

and who are qualified by training, education or experience to do so.

(f) "Council" means the statewide health coordinating council created by K.S.A. 65-4705 and amendments thereto.

(g) "Secretary" means the secretary of health and environment.

History: L. 1980, ch. 181, § 1; L. 1986, ch. 246, § 1; April 24.

65-5002. Same; credentialing applications; fees. (a) Health care personnel seeking to be credentialed by the state shall submit a credentialing application to the secretary upon forms approved by the secretary. The application shall be accompa-

PH+W, attm # 6 2-3-7

Ralph Turner
S-308 Windsor Place
Lawrence, Kansas 66044
February 1, 1987

The Honorable Marvin Littlejohn
Chairman, House Public Health and Welfare Committee
Room 425-S, State Capitol
Topeka, Kansas 66612

Dear Representative Littlejohn:

Attached is an article, "Caring for the medically indigent: Who will pay the bill?" This article is from the January 1987 issue of Trustee magazine.

I note that the House Public Health and Welfare Committee will hold a hearing on HB 2014 at 1:30 PM on Wednesday, February 4, 1987.

I am presently serving on the Board of Trustees of Lawrence Memorial Hospital and see all the time that the problem of the medically indigent is currently with us and is growing more serious all the time.

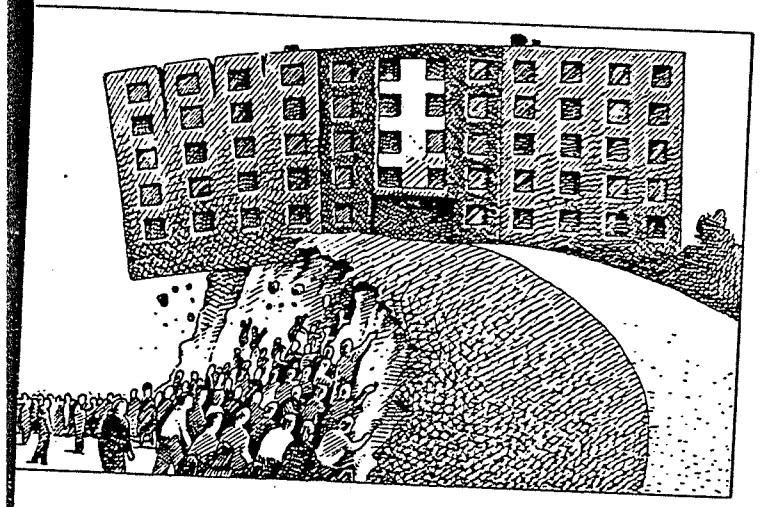
This is one of the better articles that I have seen on this problem and am passing it on to you for your information.

Sincerely,

Ralph Turner

P&HW
Attm. #1
2-3-7

Caring for the medically indigent: Who will pay the bill?



by David Hitt

One of the most urgent problems facing society today is finding adequate resources to fund health care services for the indigent and medically indigent. In this article, the author describes the magnitude of the problem and suggests how trustees can participate in the search for a solution.

Except for the most affluent, a major illness can quickly deplete the assets of anyone without good insurance. The cost of health care is a problem not only for those living in poverty who are ineligible for assistance through public programs, but also for persons who are medically indigent.

The term "medically indigent" describes individuals who can manage their other living requirements but cannot afford needed medical care. This includes both the working poor and a huge and growing number of individuals whose health insurance coverage is too limited for a catastrophic illness. Even well-insured persons are potentially at risk because a catastrophic illness can lead to disability, loss of employment and employer-sponsored benefits, and disqualification for other coverage.

Public expectations

The public apparently believes that everyone should receive needed care regardless of their ability to pay. News of a hospital's refusal to admit a poor patient, especially in an emergency, arouses indignation. Simplistic publicity on "patient dumping" conveys the impression that hospitals could meet the health needs of the poor if they would extend credit, share the load equitably, and manage more efficiently.

Yet the average citizen, unaware that vast numbers cannot pay, probably assumes that indigent care is well funded by taxes or provided through a local public hospital. Medicaid programs may be publicized as a drain on state budgets, but their limitations go unnoticed, as does the fact that more than three quarters of Medicaid funds are used to serve Medicare patients.

In reality, the already large gap between indigent care needs and funding is widening. Since 1978, tax funds for indigent care have steadily diminished while the number of very poor and medically indigent has multiplied. The number of people living below federal poverty levels has increased from 25 million to 35 million. Of these, 20 million have no insurance or public coverage for health care. Medicaid eligibility for those under 65 years of age, or who are blind or disabled, has declined from 76% to 38%, and in some states is less than 20%.

For those living above the poverty level, a rapidly growing number lack insurance coverage. In 1983, nearly 13 million working poor had no insurance and at least another 17 million had inadequate coverage. When combined with the 20 million in poverty without insurance or eligibility for public assistance, the number of people affected by the funding gap totals 50 million.

David H. Hitt chaired the AHA's Special Committee on Care for the Indigent. He is president and chief executive officer, Methodist Hospitals, Dallas.

Attempts to force hospitals to absorb higher and higher losses could ultimately force the closure of public, inner-city, and rural facilities that serve the poor

A "Robin Hood" system

Traditionally, hospitals and physicians financed indigent care through a "Robin Hood" system of higher charges to other payers. Charity/bad debts or "uncompensated care" provisions were the major or entire source of funding in many communities.

U.S. hospitals recorded $6.9 billion in uncompensated care costs in 1984. Only 16 percent ($1.2 billion) was offset by state and local tax appropriations. The other $5.7 billion, doubled since 1980, was absorbed by hospitals or passed on to private payers as an average 10.6% "hidden tax" on charges for hospital services. "Private payers" include employers and insurance companies, and a growing number of individuals who pay their own bills. Self-pay patients must also pay the higher deductibles and copayments which have become common in employee coverage.

The cost of uncompensated care is spread unevenly among hospitals and payers. The impact is heaviest on hospitals serving the poor and payers who use those facilities. In many hospitals located near high concentrations of low income populations, charity/bad debt allocations are 20% or more of non-Medicare revenues. As that percentage rises, compounding occurs and a higher charge is required for each dollar needed. Thus, the rapidly growing number of patients unable to pay for care causes severe problems for the hospitals most affected and clouds future reliance on the subsidy system.

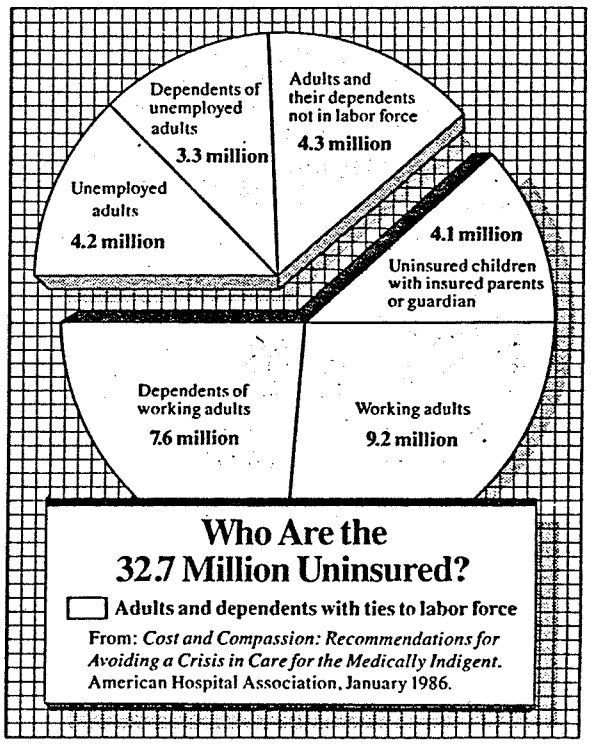
The subsidy approach is also threatened by the new competition among providers and third-party payers. Hospitals face stiffening payer resistance to increased charges, along with revenue losses from declining inpatient utilization and narrowing Medicare payments. Institutions with high uncompensated care costs are less able to compete, especially for volume contracts. Health maintenance organizations (HMOs) and other contract payers now demand discounts that reduce their participation in uncompensated care.

Equitable financing

All indigent care is either directly or indirectly paid by the public. Attempts to force hospitals to absorb higher and higher losses could ultimately force the closure of public, inner-city, and rural facilities that serve the poor. Many hospitals cannot afford to serve larger numbers of needy patients or even to sustain the present level.

Unfortunately, current pressure on federal, state, and local budgets is heavy and new taxes are unpopular. This impedes consideration of new, adequately financed public assistance programs. Even so, taxes are the ideal long-term funding source and the federal government is the most logical level of taxation. Funding through federal taxes would distribute the costs most equitably, and would formalize the financing of indigent care as a public responsibility.

For federal financing to be manageable, the number of individuals requiring public assistance must be limited to those who are otherwise uninsurable. Counting workers and their dependents, more than half the 33 million uninsured could potentially be insured through employers. Many employed individuals lack good coverage simply because they work in service industries, agriculture, or other seasonal or unstable vocations, small firms, or part-time and temporary jobs. Insurance for a



small employee group is hard to find at a reasonable cost, and coverage for high-risk individuals is generally unavailable. Potential solutions include multi-employer groups or high-risk pools. Employers should be encouraged, through appropriate incentives, to purchase coverage for employees and their dependents, and to continue coverage for a specified period after a layoff.

Many of the uninsured are "between jobs" and could be covered through expanded unemployment benefits and public welfare programs that finance food stamps, housing, and general assistance. However, the narrow definition of eligibility under welfare programs is an obstacle; federal poverty standards, which are higher than many state standards, exclude a large number of poor persons.

If indigent care is society's goal, the cost is society's responsibility, and should be spread equitably over as broad a base as possible

While the nation moves slowly toward nationally equitable financing and higher minimum levels of Medicaid coverage in all states, several measures are needed in the interim to improve local circumstances, achieve gradual changes, and most of all, avoid loss of status. The public must be educated on the nature and extent of the indigent care problem. And until other more rational and reliable methods are available, insurers and employers must be pressured to continue to share in indigent care costs.

A social policy

When assigning responsibility for indigent care, public policy must be defined. For example, to what degree does society view health care as a necessity? Is it considered a privilege reserved for those who can afford it? As noted earlier, the public reacts negatively to any denial of care but seems unconcerned about the problems produced by open admission policies. Liability awards against hospitals and physicians when a patient suffers an adverse result after being transferred or denied admission are an expression of public policy, but the courts rarely consider the full impact or ultimate consequences of that policy.

The public's advocacy of access to health care for all who need it is empty rhetoric unless entitlement is defined as public policy and formally reinforced with appropriate means to make it possible. The American Hospital Association's report on care for the medically indigent[1] defined four major goals for a social policy on health care: access, adequacy of financing, equity of financing, and efficiency. The report concludes that:

- Care should be accessible to both indigent and nonindigent patients based on their individual needs and circumstances and in accordance with contemporary standards of medical practice.
- Financing should be adequate for the amount of care society expects to be delivered.
- Equitable financing systems are essential for full access to be realized. If indigent care is society's goal, the cost is society's responsibility, and should be spread equitably over as broad a base as possible. By contrast, the present system unfairly distributes to private payers the full burden of the net cost of uncompensated care. To self-pay patients, the system is an extreme form of "sick tax." The inequity escalates as volume purchasers use their power to avoid their share of the cost through discounted payments. Cities and states that impose higher taxes to provide indigent care for citizens attract the poor from other places with scant programs and lower taxes.
- Measures to control abuse and promote efficient use of resources must be included in any valid proposal for access and adequate financing of indigent care. The runaway demand-pull inflation experience of Medicare must be anticipated and avoided.

Survival of the fittest

With encouragement from business and government, the hospital industry has adopted competition as its new regulating mechanism. But by its very nature, competition is a "survival of the fittest" system that excludes the poor and hospitals serving the poor. If it expects care for the poor to continue, and if competition is to be an acceptable regulatory approach, society must overcome the negative effects of competition.

Public misunderstanding of the indigent care problem is a major obstacle to solving it. Yet, in explaining indigent care as a community responsibility, hospital representatives are likely to be perceived as self-serving. But the public needs to understand that hospitals do not actually bear the present cost of charity care. Costs borne by hospitals are either

sh[illegible]to those who pay hospital bills or are made up by underfunding other patient services. The message must be communicated in a way that projects a sense of responsibility and concern for both the poor and the community at large.

As a minimum, hospitals must ensure that the immediate needs of emergency patients are met and that arrangements are in place for the safe and orderly transfer of patients to other facilities when necessary. For nonemergency care, the hospital's obligations must be balanced with its resources and its obligations to nonindigent patients and the community.

The balancing of these interests requires careful and continuous attention by the hospital's governing board, management, and medical staff, taking into consideration the needs of the local community, the availability of alternatives in the community, and the hospital's mission, legal requirements, and public accountability.[1]

Hospitals, government, civic, and business forces must exercise enlightened, long-term self-interest and work together to find publicly acceptable answers. Hospitals should join with other hospitals, employers, insurers and group purchasers, governmental officials, and the public to promote access to quality and quantity of care, adequacy of financing, equitable sharing of the cost, and efficient use of resources.

Hospital trustees are in a unique position to help. They represent the community in making policies for the hospital; they represent the hospital among peers in the business and civic community; and they exert influence in government. Their participation can be invaluable in sorting out the local options and devising state and national patterns to meet the need and to preserve a balance while the search for solutions continues. Few other services to the public are as meaningful.

Reference

1. *Cost and Compassion: Recommendations for Avoiding a Crisis in Care for the Medically Indigent*. American Hospital Association, January 1986.


Clarke


Gephardt


O'Leary


Wesbury


McCann

over their September 30, 1986, prices.

This increase is better than many industry observers had expected. Nonetheless, "it is well below what is needed to provide quality care," Owen asserts. The cost of hospital care for Medicare patients will increase by more than 4 percent in 1987. Consequently, the projected add-on will not cover 1987 expenditures, let alone previous losses. "We need at least a 4 percent increase—3 percent for 1986 and a one percent makeup for what was taken away in 1985," Owen says.

Prospective pricing also will "grind down" on capital, says Owen. Medicare capital outlays will be reduced by $1 billion over three years: 3.5 percent in 1987, 7 percent in 1988, and 10 percent in 1989. Moreover, Congress, working with the health care industry, will make a concerted effort to fold capital into the fixed-price prospective pricing system during its next session, Owen predicts.

In the short term, these changes may mean less access to care. To make up for payment shortfalls, hospitals will be more inclined to discontinue a service than lower the quality of care. "If hospitals cut a service because they can no longer afford to offer it, access to care becomes a real problem," Owen says. Medicare recipients aren't the only ones who will suffer. The rest of the community will also be without "access to the service," he says.

Over the long term, this may result in a deterioration of bricks and mortar. To respond to reduced capital payments, hospitals may have to forestall future facilities planning, according to Richard Clarke, president of the Healthcare Financial Management Association (HFMA). "Because payment is compressed, hospitals will not have the cash to replace the physical plant and equipment. Hospitals also will not have as good a credit rating as they otherwise would have and that will affect the cost of the money they borrow. The net result," Clarke adds, "will be a disincentive to make investments in plant and equipment."

Cash flow

Hospitals will have to pay particular attention to cash flow, Clarke contends, because of growing pressure from a number of sources, including their own competitive strategies, government actions, and insurance problems.

The Health Care Financing Administration's elimination of periodic interim payments (PIP) for most hospitals, beginning July 1, 1987, will have the most obvious effect on cash flow. According to Clarke, elimination of PIP "could add some 30 days of receivables for the Medicare population and amount to a deferral somewhere in the neighborhood of $1 million for an average-sized hospital."

Diversification and other start-up operations will also affect cash flow. "Diversification especially requires substantial cash flow to begin and maintain and therefore drains the hospital's cash resources," Clarke notes.

As insurance companies shift more responsibility for payment to the patient, "hospitals' exposure to bad debt increases," Clarke says, adding, "the increasing number of uninsured or underinsured individuals treated by the hospital places an extreme cash flow burden on the institution."

Uncompensated care

Industry experts agree that uncompensated care (including bad debt and charity care) will be the "front-burner" issue for 1987. The statistics are staggering: Because they cannot afford it, every year at least one million Americans do not receive needed health care and another four million do not even seek it, according to estimates of the Robert Wood Johnson Foundation.

The hospital's duty to the medically indigent is undermined by the enormous costs. Unsponsored care more than doubled between 1980 and 1984, jumping from $2.8 billion to $5.7 billion and totaling 4.6 percent of total hospital expenses.

Legislators are beginning to take note. Last October, Rep. Richard Gephardt (D-MO) called for a tax credit, tax deduction, or an expansion of the Medicaid program to fund care for the indigent, and high-risk insurance pools for the uninsured are being discussed at state and federal government levels. And, as new chairman of the Labor and Human Resources Committee, Sen. Edward Kennedy (D-MA) is expected to make access to health care services for the medically indigent one of his priorities in 1987.

Quality

Quality will continue to be an issue, but unlike previous years, it will begin to take on definition in 1987. To a great extent, "quality is in the eye of the beholder," acknowledges Dennis O'Leary, M.D., president of the Joint Commission on Accreditation of Hospitals. Increasingly, "quality is [being] equated with clinical performance" on the part of Congress, the Executive Branch, state governments, the private sector, and business, says O'Leary.

JCAH is embarking on a "major new initiative that will look at clinical performance