Approved Feb. 12, 1987
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

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

1:30 /~~/~~ a.m./p.m. on February 9, , 1987 in room 423-S of the Capitol.

All members were present except:

Chairman Littlejohn, Representative Hassler, both excused.

Committee staff present:

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

Conferees appearing before the committee:

Representative Susan Roenbaugh
Gary Colquette, Chief Ooperator of St. Joseph Memorial Hospital, Larned, Kansas
Dr. A. J. Yarmat, University of Kansas, Medical Center

Vice Chairman called meeting to order calling attention to hearings and briefings on various bills will be held this date.

Hearings began on HB 2141:

Representative Susan Roenbaugh gave hand-out to members, (see attachment No.1) for details. She spoke in favor of HB 2141. This bill speaks to the counting of practicing physicians in underserved areas. Statistics taken in 1985 indicate Pawnee County has 17 MD's and 1 DO or 1 physicians for every 450 persons. True counting show one Doctor is 65 years old, one an Iranian 54 year old physician who is difficult to understand, and one 75 year old D.O. that does not use the hospital. Two of these three could and might retire at any time. There are 22 physicians practicing at Larned State Hospital, but these do not serve the general public of 8100 persons. So, these figures indicate there is one physician for every 2700 people. HB 2141 speaks to having medical scholarships for students to serve in underserved areas such as Pawnee County, and when students check the statistics they determine that this area is NOT underserved. Language in HB 2141 will exclude the physicians employed full time at State Hospitals from being included in the counting of practicing physicians, therefore giving a more realistic count in determining whether or not an area is critically medically underserved.

Rep. Roenbaugh offered an amendment, (see Attachment No. 2), for details. This amendment reads, to amend HB 2141 page 4, line 148, to strike "statute book" and insert in lieu thereof "Kansas register". She then answered questions, i.e., would other hospitals i.e. Winfield be adversely affected by this change in counting of physicians, and it was determined there would not be any adverse affects. Ms. Correll stated when she checked with Health and Environment a year ago she was told that physicians were not counted at that time, (perhaps that has since changed). Further it was brought out, all State Hospitals were by definition underserved areas. Doctors at State Hospitals are State Employees and are not out to solicit private practice patients.

At this point the hearings on HB 2141 were stopped briefly so that Staff could brief committee members on HB 2096, HB 2166, and HB 2187.

Ms. Correll stated HB 2096 would create new legislation. She explained the bill in detail section by section. There were no questions.

Mr. Furse gave detailed briefing on HB 2166 and HB 2187. He answered questions from members of committee.

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S, Statehouse, at 1:30 /a.m./p.m. on February 9, 19 87

Hearings resumed on HB 2141.

Mr. Gary Colquette spoke in support of HB 2141, saying at present the statistics are inaccurate if the physicians at Larned State Hospital are included since they do not treat the general public. The count shown for their area is 14, yet there are only 3 practicing physicians to serve the entire area population. He said they need more accurate statistics, and he urged for favorable passage of HB 2141. see note:- late attm.

Dr. A. J. Yarmat, University of Kansas Medical Center, gave hand-out, see (Attachment No.3), for details. He stated the proposed legislation would have no fiscal consequences for administration of the scholarship program, or the preparation of the annual Medically Underserved Areas (MUA) Report, with the proviso that they receive from SRS updated rosters of physicians under their jurisdiction. He said they find it difficult to justify the inclusion of state hospital-based physicians in the report. These physicians are a special resource who provide minimal services outside the hospital setting, therefore, they believe it is inappropriate to include these physicians in the counting report made annually. He suggested a proposed amendment, i.e., lines 45 and 46 of HB 2141, changing language to read, "in preparing such a list the portion of time of the persons engage in practice of medicine and surgery at any institution who are full time employees of--. He then answered questions from members, i.e., yes, there would be a new report in about three weeks that would have more current information on medically underserved areas. He would be happy to provide that to members when it becomes available and he agreed to provide his proposed amendment along with said report.

Vice-Chairman Buehler closed hearings on HB 2141.

It was announced there is a report provided by Ms. Correll of Research that is shown as (Attachment NO. 4), and is memorandum on Medically Indigent Care Programs in other States.

Vice-Chairman called attention to HB 2018 and reviewed the bill briefly, it pertains to changing the registration of adult family homes from SRS to Health and Environment. Dr. Robert Harder had suggested amendments to this bill and discussion in regard to these changes were discussed, i.e., the staff that would be needed to provide administration of this change. Health and Environment Department states they will need 1.5 persons, and this is not allotted for in the current budget. Rep. Gatlin moved to strike sub section (d) on page 2, lines 60 through 74, seconded by Rep. Shallenburger. Discussion ensued, i.e., Mr. Furse indicated the bill would be workable if section (d) was deleted, the intent is not to delete 1½ persons from SRS staff or to transfer 1½ persons to Health and Environment. Vote taken, motion carried.

Rep. Harder moved to amend HB 2018 to change language to read on page 1, line 43, "of social and rehabilitation services which relate to the registration of adult family. Motion seconded by Rep. Green, motion carried.

Revisor Mr. Furse asked members to note another technical change might be necessary, i.e., Page 2, section (e) could/should be deleted. Discussion ensued. Rep. Green moved to delete section (e) page 2, seconded by Rep. Whiteman, motion carried.

Rep. Whiteman moved to pass HB 2018 favorably as amended, seconded by Rep. Harder. A discussion ensued, is there a great need to make this change? Some members of the Interim Committee fail to see a clear need for said change. Vote taken, division requested, show of hands indicated 11 for 4 against. Motion carried.

Vice-Chairman directed attention to HB 2014, and stated there were no conferees in opposition to this bill the day hearings were held. Rep. Green moved to pass HB 2014 favorable for passage, seconded by Rep. Cribbs. Discussion ensued, i.e., language in line 53 might tie hands to use Federal programs available. Mr. Furse advised committee on language changes.

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S Statehouse, at 1:30 ~~a.m.~~/p.m. on February 9, 19 87

Rep. Branson made a substitute motion to amend HB 2014 on page 2, line 53 to delete three words, "through existing programs;". Motion seconded by Rep. Neufeld, vote taken, motion carried.

Rep. Branson made a motion to pass HB 2014 favorably as amended, seconded by Rep. Neufeld, motion carried.

Meeting adjourned at 2:50 p.m.

Note: Attachment for 2/9/87 from Garrett E. Colquette, St. Joseph Memorial Hospital in Larned, Kansas is attached ~~without an attachment No. indicated~~. (Attachment 5)

GUEST REGISTER

DATE 2-9-01

HOUSE

PUBLIC HEALTH AND WELFARE

NAME	ORGANIZATION	ADDRESS
Janet Schalansky	SRS, Adult Services	Topeka
Rep. Presentation	Leg.	"
Terri Rosselot	Ks. State Nurses' Assoc.	Topeka

Thank you Mr. Chairman and Members of the Committee. I appreciate the opportunity to appear before you on HB 2141.

Pawnee County has for years, been listed in all statistics as being "over served" by physicians due to the counting of physicians practicing at Larned State Hospital. The statistic in 1985, showed Pawnee County with 17 MD's and 1 DO or 1 physician for every 450 persons. Fifteen to 20 years ago Pawnee Co. did have a maximum of 11 practicing physicians serving Pawnee Co. residents. However, their practicing physician numbers have gradually dwindled to 3 at the present time. One is (Dr. T. D. Ewing) over 65-years old, one is an Iranian (54-years, Dr. M. N. Shah) difficult to understand and Dr. V. R. Cade is a 75-year old D.O. that does not use the hospital. So you see, two of the 3 could easily retire at any time. An approximately 22 physicians practice at L.S.H., but do not serve the general public of approximately 8100 persons. So they have one physician for every 2700 people.

Medical scholarship students must agree to enter a full time practice in an underserved area for the numbers of years they obtained the scholarship in exchange for tuition and stipends. A number of students have been attracted to the Pawnee Co. area, but end up going somewhere else when they learn the area is not medically underserved.

I have visited at length with the Lt. Governor, Dr. Jack Walker, who has enthusiastically endorsed the direction of HB 2141 as the logical thing to do.

Dr. A. J. Yarmot, Director of the Center for Student Affairs and Educational Development at K.U. Med Center is aware of the situation and has been in contact with the Physician Recruitment Committee in Larned, St. Joseph Hospital in Larned, and myself. He feels that HB 2141 will give them the statutory mandate to do what they were considering doing by a methodology change because of necessity. Dr. Yarmot said and I quote:

> "We have been dubious as to the appropriateness of counting those physicians employeed at State Hospitals because they do not provide a meaningful measure of medical service to the community and this is extremely critical at Larned."

Mr. Chairman the bottom line of HB 2141 is simply to exclude those physicians employeed full time by state hospitals from being counted in determining whether or not an area is critically, medically underserved.

Health care is very important to each and every one of us, for our families, our communities, and our state. As Kansans, and legislators we would be remiss if we over looked such a simple soltuion to a problem that is growing larger each day.

Attm. #1
P&RW.
2-9-87.

Proposed Amendment to H.B.No 2141

Be Amended:

On page 4, in line 148, by striking "statute book" and inserting in lieu thereof "Kansas register"

P&HW
2-9-87
attm. # 2

The University of Kansas Medical Center

Center for Student Affairs
and Educational Development

February 9, 1987

MEMORANDUM

TO: Michael O'Keefe, Business Office

FROM: A. J. Yarmat, Ph.D., Director
Center for Student Affairs and Educational Development

RE: House Bill 2141

The proposed amendment to K.S.A. 1986 Supp. 76-375 would have no fiscal consequences for the administration of the Kansas Medical Scholarship program. Neither would it pose problems for the preparation of the annual Medically Underserved Areas (MUA) Report, with the proviso that we receive from SRS updated rosters of physicians under their jurisdiction.

The proposed amendment coincides with an overall review of the methodology for determining medically underserved areas in Kansas that we have initiated at the KU Medical Center. The item addressed in the amendment is especially pertinent. We find it very difficult to justify the inclusion of state hospital-based physicians in the determination of medically underserved areas. Physicians at state hospitals are a special resource who provide minimal service outside of the hospital. Therefore we believe that it is inappropriate to include their service within the state hospital when assessing medical services that are available to the general public.

There seem to be instances in which state hospital-based physicians provide occasional services outside of the hospital. There also may be instances in which community-based physicians may be contracted to provide services **at** a state hospital. In either instance, whatever the specialty involved, we believe that only that percentage of time in service to the **non-state hospital community** should be included in the determination of physician supply.

By applying these considerations to medical manpower data for 1986, two counties would be shifted from a designation of adequately served to critically medically underserved in primary care, namely, Pawnee and Norton counties. The status of several secondary care areas in the specialty of psychiatry also would be changed to underserved. Those counties so affected would have a better opportunity to recruit physicians from the pool of KU graduates with commitments to practice in underserved areas of Kansas.

AJY:mf

cc: Executive Vice Chancellor Clawson

Pawnee
Attm. #3
2-9-87

39th and Rainbow Blvd., Kansas City, Kansas 66103 • (913) 588-4698

MEMORANDUM

October 21, 1986

TO: Special Committee on Public Health and Welfare

FROM: Kansas Legislative Research Department

RE: Medically Indigent Care Programs in Other States

In 1985 the Intergovernmental Health Policy Project (IHPP) contacted each of the 50 states and the District of Columbia about programs for the medically indigent in the various states. A report was compiled by IHPP late in 1985 from information submitted by state personnel. This source appears to be the most comprehensive data source now available on state programs, and is the source for much of the information in the state-by-state summary which follows. Staff will followup on the programs of states that are of particular interest to the Committee.

General Summary

In 1985, 34 of the states either had some type of program for care of the medically indigent in place or had enacted legislation authorizing a program which was not yet implemented. Thirty programs were actually in operation in October of 1985. Arkansas, Oklahoma, South Carolina, and Texas had enacted legislation authorizing medically indigent assistance programs, but had not yet put such programs into place.

Eight states reported that they operated no programs that provide assistance to the medically indigent -- Delaware, Georgia, Kentucky, New Hampshire, North Carolina, North Dakota, Tennessee, and West Virginia. Several states have programs that serve only those populations located in a specific geographic area as noted below, and some states have only county-operated programs which vary in coverage and eligibility.

The most common form of assistance for the medically indigent in operation in 1985 was similar to the Kansas General Assistance medical program, i.e., MediKan. However, while Kansas included General Assistance Unrestricted (GAU), Transitional General Assistance (TGA), Aid to Pregnant Women (APW), Refugee GUA and Refugee TGA recipients as automatically eligible for MediKan, many states with state-funded medical assistance programs for recipients of cash assistance either require a separate application for medical assistance or are more restrictive in the persons covered by the program.

State-By-State Summary

Alabama has no state-operated medically indigent program. However, under a 1979 Health Care Responsibility Act, the individual counties in the state were made financially responsible for hospital treatment of the indigent

Attm. #4
2-9-87
pkw

within each county. The county of residence of an indigent is also financially responsible for the cost of hospitalization at a regional referral hospital.

Alaska operates a program of cash and medical assistance similar to the Kansas GUA and TGA programs, but known as General Relief in Alaska. Although the eligibility standards for the General Relief and General Relief-Medical programs are the same, an individual who is a recipient of General Relief cash assistance is not automatically eligible for General Relief-Medical and must make a specific application for the latter program.

Arizona, the only state that does not operate a traditional Medicaid Program, operates what is called the Arizona Health Care Cost Containment System (AHCCCS) under a waiver from the federal government that allows the state to exclude certain services otherwise required under Title XIX and which includes mandatory copayment for all services and a capitated, prepared delivery system. Under AHCCCS, the indigent component not eligible for Title XIX, is financed by state and county funds and makes up one of the membership groups covered by prepaid contractors. In categorizing this program, one could classify it as similar to the Kansas state-funded MediKan program although the operation of the system and the extent of coverage is quite different. However, in Arizona General Assistance recipients are not automatically eligible for AHCCCS; they must meet state eligibility standards.

Arkansas enacted legislation in 1985 that creates two funds and an Indigent Health Care Advisory Council. Pursuant to the 1985 legislation, the federal Medicaid rebate for fiscal year 1984 and any state appropriations were to be deposited in an Indigent Health Care Investment Trust Fund which is to be invested. Interest payments from the Trust Fund (and principal if necessary) may be transferred to an Indigent Health Care Fund which is to be used to finance medical care for the poor. The 1985 legislation sets out priorities in the expenditure of funds and directs the State Department of Human Services and the Advisory Council to establish policies and regulations that: define medical indigency; set utilization of preventive and primary care services as the highest priority; require hospitals to provide an established level of charity care as a condition of receiving indigent care funding; and coordinate care with existing public health and primary care services, with a priority being given to obstetrical and child health services.

California, in January of 1983, transferred the responsibility for providing health care to medically indigent adults (MIAs), defined as persons between 19 and 64 years of age with income no greater than 115 percent of the state's AFDC standard and not eligible for public assistance programs, back to the counties in California. The exception to the transfer of responsibility from the state to the counties were refugees, women with confirmed pregnancies, and adults residing in adult care homes. The latter remain eligible for Medi-Cal, California's name for Medicaid. (The state had assumed responsibility for MIAs in 1971 and included them as state-funded Medi-Cal recipients from 1972 to 1983.)

As a part of the transfer of responsibility to the counties, a state block grant program was created under which funds in amounts roughly equal to 70 percent of what the state would have spent for MIAs during calendar years 1980-82 are allocated to the counties on the basis of a formula set out in the

law. No matching county funds are required to receive a state allocation, but a county is prohibited from spending less in any fiscal year for persons not eligible for Medi-Cal than the county spent in fiscal year 1981-82. Counties under 300,000 population have an option of contracting with the state for the administration of the county MIA program.

Colorado has three major components in its Statewide Medically Indigent Program -- the University of Colorado Hospital, known as Colorado General; the University of Colorado medical faculty; and Denver General Hospital and other participating hospitals. The University of Colorado Health Sciences Center has sole administrative responsibility for the total program and establishes eligibility criteria and reimburses providers. Funding for Colorado General and the medical faculty is through state appropriations to the University of Colorado, and the funding for Denver General and other hospitals is through a separate appropriation.

The Colorado program provides inpatient hospital care, outpatient hospital services, hospital-based physician services, lab and X-ray, physician services, and prescription drugs for eligible individuals. Hospitals, associated physicians, HMOs, and clinics are providers under the program, and each provider has an obligation to provide a minimum of 3 percent of charity care of adjusted operating expenses based on the previous year.

Connecticut operates a General Assistance Medical Aid program which is jointly administered by the 169 towns in Connecticut and the State Department of Income Maintenance. Towns (there are no counties in Connecticut) are required to provide medically necessary services to persons who are eligible for General Assistance Financial Aid and to persons who are not eligible for General Assistance but who are unable to pay for medical treatment over a two-year period. The state share of the cost is 90 percent of the town's medical expenditures, except that medical expenditures for workfare participants are totally paid by the state. The state does not cost share in the town's administrative expenses. Recipients of General Assistance Financial Aid are automatically eligible for medical assistance. In categorizing this program, one could classify it as similar to the Kansas MediKan program and the medically needy component of the Kansas GA-Medical Assistance-Only program which was dropped in 1981.

Delaware does not have a state or state-county indigent care program.

Florida, by law, charges Florida counties with the responsibility of providing health care for their indigent citizens under the Florida Health Care Responsibility Act. The law also authorizes regional referral hospitals to be reimbursed by the county of residence of an indigent patient. County health departments, which deliver significant amounts of indigent care in some areas, receive about 70 percent of their funds from the state. In recent years and as a result of the passage of the Health Care Access Act of 1984, county health departments have become more responsive to state directives, and, in some areas, offer more comprehensive services.

The Health Care Access Act is a complex law that became effective in phases between its passage in 1984 and the beginning of 1986. The Act gave authority for the Florida Hospital Cost Containment Board to approve hospital budgets and rates of increase, expanded the Florida Medicaid program over a

two-year period, placed certain requirements on health insurers, authorized up to $10 million for the provision of primary care services to low-income Floridians through county health departments, required specified social studies to be carried out, created a tax on hospitals at the rate of 1 percent of net operating revenue the first year and 1.5 percent thereafter, created a separate Public Medical Assistance Trust Fund, and appropriated $20 million in state general revenues to the Fund, with half that amount earmarked for the new primary care program created by the Act.

Under the Florida Health Care Access Act, the State Department of Health and Rehabilitative Services follows a request-for-proposal procedure for the provision of comprehensive health services for indigent individuals who are not receiving care. In 1985, 33 counties of the 67 counties in Florida applied for funds and 18 were awarded funding. Care is free for those whose income is under 100 percent of the federal poverty level, while those with incomes ranging between 100 to 200 percent of the poverty level receive discounts of from 90 to 10 percent on the cost of services. A contracting county health department is required to offer comprehensive services, to linkup with other programs in the health department and with existing primary care providers, and to have arrangements for hospitalization and speciality care.

Georgia does not have a state or state-county indigent care program. Georgia did adopt a regulation under its Certificate-of-Need Program that requires parties purchasing or leasing a public hospital to provide an amount equal to 3 percent of the hospital's gross revenue in indigent care as a condition to the approval of the sale or lease of the hospital.

Hawaii operates what is called State-Only Medicaid under which individuals who receive General Assistance cash assistance are automatically eligible for State-Only Medicaid (all state-funded) and others may qualify as medically needy under spend-down provisions. The Hawaii program is similar to MediKan with the addition of the medical-only category discontinued by Kansas in 1981.

Idaho law mandates that counties must provide emergency medical assistance for indigents and authorizes counties to levy up to 5 mills in property tax for funding for medically indigent care. There is no statewide program with uniform benefits and eligibility criteria.

Illinois has two programs that address the needs of the medically indigent: the General Assistance Medical Program (GA-M), which is jointly administered by the state and counties or townships; and Aid to the Medically Indigent (AMI) which is a state program. Both programs offer six service components that are identified as the Basic Health Protection Plan although the GA-M plan has limited inpatient hospital payments in the past.

Counties and townships are mandated by law in Illinois to have a General Assistance cash assistance program. If a county wishes to receive state funding under the GA-M program, its eligibility criteria must conform to state set standards. If the county participates in a state funded GA-M program, General Assistance recipients are automatically eligible. If a county does

not participate in the state funding for a GA-M program, and most counties in Illinois do not, the program must be totally funded by the county.

The Aid to the Medically Indigent program is a uniform state-administered program for individuals who are not eligible for Medicaid or General Assistance. AMI is totally state funded in Illinois and could be categorized as similar to the discontinued MediKan Medical Only Program in Kansas.

Indiana implemented what is known as the Hospital Care for the Indigent program (HCI) in 1982. HCI is a county-only program in Indiana since it is county administered and county funded totally. However, the state establishes eligibility standards which are supposed to be uniform across the state. In fact, the various counties interpret the eligibility standards differently. HCI covers emergency services, including necessary medical and hospital care and transportation to the place of treatment.

Iowa law authorizes what is known as the State Papers Program which is an optional program in which counties may participate. (Iowa counties are legally responsible for providing medical care for indigent residents.) Under the State Papers program, each participating county is allowed a quota of indigent care patients who may be treated at the University of Iowa Hospital or Clinic without charge. The state appropriates funds to the University of Iowa Hospital for support of the State Papers program. The University of Iowa Hospital provides free care to county-certified indigents in a number equal to the county quota plus 10 percent. Certain indigents, i.e., obstetrical patients, newborns, orthopedic patients, who receive free care are not applied to the county's quota.

Kentucky does not have a state or state-county indigent care program. However, in 1985 appropriations in the amount of $7.4 million were appropriated to the University of Kentucky for charity care and educational expenses.

The state, the University of Louisville, Jefferson County, and the city of Louisville, and Humana Incorporated have entered into an agreement under which Humana leases the University of Louisville Hospital in return for a commitment to provide charity care and support for medical education and research. The agreement creates the Quality Care Trust to reimburse Humana for hospital care provided to indigents and the medically needy primarily in Jefferson County. The Trust is financed by the state, Jefferson County, and Louisville. Payments from the Trust are to reflect a 5 percent discount from Humana's normal charges when the case is an indigent or medically needy resident of Jefferson County.

Louisiana has operated a program for providing care to the medically indigent through a network of charity hospitals located throughout the state since the 1930s. The charity hospitals provide necessary inpatient and outpatient hospital services to the state's indigents and currently number nine. Eligibility standards are set by the state, and the program is 100 percent state funded.

Maine operates a General Assistance Medical program (GA-M) under which General Assistance recipients and the medically needy receive nonelective medical treatment when deemed necessary by a physician. The GA-M

program has two administrative components. Organized municipalities operate self-administered programs in which the state cost shares at the rate of 90 percent of the GA-M costs that exceed 0.03 percent of the municipality's property valuation. A state-administered GA-M program is operated for unorganized or unincorporated townships and is 100 percent state funded. In the case of the medically-needy component, the eligibility standards for the medically needy vary by municipality, but are uniform in the state-administered component. In general, the Maine program could be categorized as similar to MediKan, but including a medical only component similar to that discontinued in Kansas in 1981.

Maryland terms its indigent care program as State-Only Medicaid. General Public Assistance recipients are automatically eligible for State-Only Medicaid and several other groups are covered, i.e., Medicaid ineligible spouses and parents in an assistance unit with Title XIX eligible persons and persons aged 21 to 65 who are not eligible for Medicaid and not in a Title XIX assistance unit. This program is very similar to the Kansas MediKan program.

Massachusetts provides limited medical assistance to recipients of General Relief (General Assistance recipients). The Massachusetts program covers only ambulatory services, but covers a fairly extensive set of such services. The program is 100 percent state funded and state administered. The cost of charity care provided by Massachusetts hospitals, along with bad debts, are built into the hospital's maximum allowable cost ceiling under the Massachusetts hospital rate setting system.

Michigan law requires each county to provide hospitalization for its indigent residents; however, the state offers the option to counties to participate in the Resident County Hospitalization program (RCH). RCH covers inpatient hospital services only, including physician and dental services during the hospital stay and is restricted to hospitals that participate in the Medicaid program. For a participating county, the RCH program pays approximately 80 percent of the RCH program costs. The state payment is capped at $100 per day. Participating counties establish eligibility standards and determine eligibility.

Michigan also operates a General Assistance Medical (GA-M) program which is state-administered and state funded. Under the GA-M program, ambulatory care services are reimbursed for persons who are automatically eligible if they are General Assistance recipients. The latter program is similar to, but more limited than MediKan.

Minnesota law requires the counties to participate in a General Assistance Medical Care Program. Recipients of General Assistance are automatically eligible and others may become eligible when they meet spend-down requirements. Services covered under the GA Medical Care program are more limited than those made available under Medicaid. The state finances about 90 percent of the overall cost of the GA Medical Care program costs, although each county's share of costs varies with the number of resident recipients. The Minnesota program is very similar to the MediKan, with the addition of a medical-only component similar to the component discontinued in Kansas in 1981.

Mississippi funds medical care for the indigent under three separate programs: the State Hospital Commission; the Charity Hospital System; and an annual appropriation for indigent care made to the University of Mississippi Hospital and Medical Center.

The State Hospital Commission partially reimburses approved hospitals that provide inpatient care to county indigent individuals. The Commission allocates a maximum limit on the amount of state funds that may be used to reimburse hospitals for charity care based on the county's population. Each hospital that participates in the program sets its own eligibility standards, based on a scale of ability to pay, and does eligibility determinations. The state reimburses the hospital on the basis of claims submitted by the provider.

Mississippi also operates three charity hospitals, located in Meridian, Vicksburg, and Laurel, Mississippi. The Legislature makes annual appropriations to the hospitals to assist in financing medical treatment for the indigent.

Missouri operates a General Assistance program which is known as General Relief in Missouri. One component of this program is known as General Relief-Medical. General Relief cash recipients are automatically eligible for GR-Medical which is totally state funded and state administered. The present Missouri program is very similar to MediKan. For information on a new program proposed in Missouri see separate staff report.

Montana law authorizes counties to provide for the care of the indigent sick. The state has recently authorized an optional state program under which the state will administer the General Relief program and provide some state funding. Less than half the counties are participating in the state-administered program. Under state-administered General Relief, persons who qualify for cash assistance automatically qualify for medical services. The covered services are the same as services for the medical-only component of the Montana Medicaid program, but prior authorization is required except in an emergency. Under state-administered General Relief, the county must fund the equivalent of a 13.5 mill levy on property. The state funds any expense above the 13.5 mill levy equivalent or about 50 percent of the cost of medical care for the indigent. All counties that do not participate in state-administered General Relief administer and fund their own programs.

Nebraska does not have a statewide indigent care program, but county General Assistance programs provide emergency medical care for recipients of assistance. Benefits and eligibility standards vary by county.

Nevada, in 1985, enacted legislation which requires counties to create a "fund for medical assistance to indigent persons" and creates the Supplemental Fund for Medical Assistance to the Indigent. Both programs are totally funded by Nevada counties, but the Supplemental Fund is administered by a state board of trustees. The Supplemental Fund is financed by the counties remitting 3/10 of 1 cent per $100 of assessed property from the county indigent care ad valorem tax. The Fund is used to reimburse unpaid charges for hospital care in excess of $25,000 for any one person who has been certified as indigent by county commissioners and is only available if the county's

indigent care expenditures exceed the amount collected from the county indigent care ad valorem tax.

Nevada also has a program designed to assist counties when indigent's incur sizeable medical bills as the result of accidents. The Fund for Hospital Care for Indigent Persons is financed by imposing a levy of $.0075 per $100 of assessed valuation of taxable property in each county. The Fund reimburses hospitals and health care providers directly for costs incurred by indigents as the result of accidents that are in excess of $4,000.

New Hampshire does not have a state or state-county indigent care program.

New Jersey requires all municipalities to provide a General Assistance program, and all programs must use uniform eligibility standards and provide uniform benefits. Most counties in New Jersey participate in an optional State Match program which covers 99 percent of the municipal caseload. General Assistance recipients are automatically eligible for services that are similar to the state Medicaid Program. If a municipality participates in the State Match program, the state provides 75 percent of the expenditures. Nonparticipating counties pay the total cost of their programs.

New Jersey also operates an AFDC Nonfederal Medical program which covers eligible parents in families with children living with both natural or adoptive parents when the parents are not eligible under federal criteria. The program covers the same services and providers as the Medicaid program. The state establishes eligibility standards and processes claims; the counties determine eligibility. The program is 100 percent state funded.

New Mexico's Indigent Hospital Claims Act mandates a county program to provide necessary medical care to indigent residents and authorizes a county sales tax as a source of funding. While the state legislation mandates county programs except in Bernalillo County, only about one-third of the counties have created indigent care funds or operate a county hospital. There is no penalty for failure to comply with the Indigent Hospital Claims Act. Counties establish eligibility and process provider claims. Bernalillo County maintains its own county hospital in Alburquerque, and the state provides funds to the hospital for care provided to out-of-county patients.

New York recipients of Home Relief, the state-county General Assistance program, are automatically eligible for State-Only Medicaid. Persons who are eligible for Home Relief, but who choose not to receive a cash grant may also be eligible for State-Only Medicaid. Persons, who are not eligible under Title XIX and who have hospital bills which exceed the lesser of 25 percent of their net income or the difference between their net income and the public assistance standard of need, may also be eligible for State-Only Medicaid. Funding for the latter classes of eligible persons is 50 percent state and 50 percent local. The State-Only Medicaid Program is jointly administered by the state and county governments. The state sets eligibility standards and processes claims and counties determine eligibility. The New York program is similar to MediKan with the addition of a medically needy component similar to that dropped by Kansas in 1981.

North Carolina does not have a state or state-county indigent care program.

North Dakota does not have a state or state-county indigent care program.

Ohio has a General Relief program operated by the counties under state law which mandates both General Relief and a medical component of General Relief. Although certain services are required by state law, counties may limit the amount and duration of these services or may add services. Recipients of General Relief are automatically eligible for the medical component. General Relief-Medical is jointly administered by the state and counties, with the state setting eligibility criteria and the counties certifying eligibility and reimbursing providers. The state funds 75 percent of the cost, and the county share is 25 percent, except that low-income counties can receive a greater state share under a state-determined formula.

Oklahoma enacted the Oklahoma Indigent Care Act in 1984. The Act creates an optional state program that is to be jointly funded and administered by the state and participating counties. In order to participate, a county must create a county indigent health care trust board and a county indigent health care fund financed by an ad valorem tax levy of 3.5 mills on assessed property value.

Because counties in Oklahoma are constitutionally prohibited from raising more than 2 mills on the property valuation, a constitutional amendment was submitted to the voters to authorize a county ad valorem tax of 3.5 mills solely to finance indigent health care. The referendum failed, and the 1985 Legislature eliminated the requirement that counties participating in the Oklahoma Indigent Health Care Program must contribute an amount equal to 3.5 mills on taxable property in the county. The 1985 legislation also authorized a check-off for donating part of an individual's state tax refund to the Indigent Health Care Fund.

Under the 1984 act as amended in 1985, only hospitals are eligible to receive reimbursement from the state and county payments. For a hospital to participate, the hospital must be located in a participating county, must determine whether the patient is eligible under the definition of indigent contained in the state law, and must supply the county trust board with documentation of the recipient's eligibility and the services provided.

Oregon operates a General Assistance Medical Program under which General Assistance recipients automatically qualify and certain aged, blind, and disabled individuals may qualify. The General Assistance Medical Program is a state-administered program and is similar to the Kansas MediKan Program.

Pennsylvania provides medical care under the state-administered General Assistance Program. Under the Pennsylvania program recipients of General Assistance are automatically eligible for GA-Medical, and the medically needy who meet spend-down provisions may become eligible. Under the GA-Medical program operated by the state of Pennsylvania, the program also provides specified services for recipients of the State Blind Pension program. In general, the Pennsylvania program is similar to the MediKan except for the inclusion of the medically needy who were dropped from the Kansas program in 1981.

Rhode Island operates an optional General Assistance Medical Program in which all cities and towns participate, which in effect makes the program a statewide program. General Assistance recipients and low-income families with dependent children who are not eligible for Medicaid are automatically eligible for GA-Medical. The program is jointly administered by the state and cities, with the state establishing eligibility criteria and the city determining eligibility and processing claims. The GA-Medical Program is totally state funded. The Rhode Island program is generally similar to MediKan.

South Carolina was to implement the Medically Indigent Assistance Fund on January 1, 1986. The Fund is financed by an assessment on general hospitals and an assessment on counties. Both assessments must contribute the same amount of money which for 1986 is a total of $15 million. The annual assessment on each general hospital is based on the hospital's ratio of net to gross patient revenue, multiplied by the total number of patient days. The county assessment is based on a formula that weighs county property value, per capita income, and net taxable sales equally. If a county has a public charity hospital which provides medical care to the indigent, the contributions from the hospital are credited against the county assessment. The General Assembly determines the total amount to be assessed annually.

Money deposited in the Medically Indigent Assistance Fund may be used only to compensate general hospitals for providing medical care to medically indigent persons. The program is administered by a state agency which determines the procedures to be followed in determining eligibility, the population to be served, the health care services covered, a prospective payment system, and a procedure for paying claims. The legislation which creates the Fund defines the term, medically indigent.

South Dakota created the Catastrophic County Poor Relief Fund in 1984 to become effective on January 1, 1985. The Fund received a one-time, "startup" appropriation of $500,000. Future funding is to come solely from the participating counties and is limited to replacing the portion of the initial reserve expended during the previous year. If the Fund is in danger of being depleted, an assessment, based on a formula set out in the legislation, may be made against participating counties. Participating counties may draw from the Fund when an individual who is eligible for county poor relief incurs hospital or medical expenses in excess of $20,000. The county will be reimbursed from the Fund for 90 percent of costs in excess of $20,000.

A key provision in the South Dakota law required that at least 50 of the 66 South Dakota counties agree to participate in the Fund before November 1, 1984, for the law to go into effect. The requirement was met. If, at the end of any calendar year, fewer than 35 counties elect to remain in the Fund, a final assessment will be made, the Fund will be discontinued, and the reserve will revert to the State General Fund.

Tennessee does not have a state or state-county indigent care program.

Texas adopted a series of laws in 1985 which clarified governmental responsibility for treating medically indigent persons. Four major pieces of legislation include: the Indigent Health Care and Treatment Act; the Primary

Health Care Services Act; the Maternal and Infant Health Improvement Act; and a bill which amends the hospital licensure law.

The Indigent Health Care Treatment Act clarifies county responsibility for providing medical care to indigent residents, setting different requirements for counties based on whether the county supports a public hospital, is located within a hospital district, or has neither a public hospital nor hospital district. Although the state establishes eligibility standards under the act, a county is permitted to adopt less restrictive standards. Each county must provide the same services that are mandated under the medically needy component of the Texas Medicaid program with the exception of EPSDT services and a requirement to provide prescription drugs. A county's payment liability for each recipient is limited to 30 days of hospitalization or in a skilled nursing home, or a maximum total payment of $30,000 per recipient, whichever occurs first. State financial assistance is available for counties that expend at least 10 percent of their general levy to provide mandatory medical services to eligible recipients. The state assistance is limited to 80 percent of the payment for medical services after the 10 percent requirement is met. Counties operating a public hospital are required to provide sufficient funding to the hospital to provide health care assistance to the indigent (inpatient and outpatient services). A county supporting a public hospital has the same payment standards and maximum as counties without a hospital. Counties were not required to provide health care assistance until September, 1986 under the Indigent Health Care Treatment Act.

The Primary Health Services Act of 1985 authorizes the state to create a primary health care services program for the indigent. The Texas Board of Health has broad authority to establish the program. A long-range plan was to be submitted to the Texas Legislature and Governor by January 1, 1986, and no services were to be provided until January 1, 1986.

The Maternal and Infant Health Improvement Act of 1985 authorizes the Texas Board of Health to establish a program for the delivery of comprehensive maternal and infant health services for eligible women and infants, defined as children under 12 months of age. Applicants for the program must be referred to the program by a health care provider or other source.

Texas amended its hospital licensing law to include minimum standards governing the transfer of patients for nonmedical reasons.

Utah makes county governments responsible for providing the medical care needed by low-income persons who are not covered by other state or federal programs and who are unable to pay for the cost of medical care. The state makes an optional indigent care program, known as the Indigent Medical Assistance Program (IMAP), available to counties. IMAP is state administered but financed by both the state and participating counties. To participate, a county must contribute a .25 mill levy on the county's total assessed property value to IMAP. The state sets uniform eligibility standards, certifies eligibility, and reimburses providers. The state finances all costs over the participating county's assessment. There is no automatic eligibility. Eligibility is based solely on income and assets, and only five covered services are included in the program.

Vermont has a limited medical assistance program for individuals receiving State General Assistance payments. The program reimburses only for emergency treatment and only for physician and dental services, vision care, prescribed drugs and certain medical supplies and equipment, and certain ambulance services. The program is totally state funded. The Vermont program, except for its restrictive nature, is similar to MediKan.

Virginia has four major programs that provide some type of medical care to the indigent.

The State and Local Hospitalization Program (SLH) is an optional program under which participating counties or cities provide inpatient hospital care. Although the state recommends income eligibility guidelines, the participating city or county has the option of establishing more stringent or more liberal eligibility standards. Only inpatient and outpatient hospital services and outpatient health department clinic services are covered under SLH, which is funded overall at the rate of 75 percent state funds. The state match is based on population.

The General Relief-Ongoing Medical Assistance Program (GR-Medical Assistance) in Virginia covers ambulatory services (nonhospital) and is limited to $500 in medical expenditures per recipient per month. Recipients of Ongoing General Relief cash payments are eligible for the medical component if the medical component is included in the local jurisdiction's plan. A local GR-Medical Assistance program may cover up to six services and may impose limitations on coverage such as prior authorization requirements. The state provides 62.5 percent of the funding for GR-Medical Assistance up to the $500 monthly limit. Any expenditure over that amount must come from local funds. With the exception of limitations and local administration, GR-Medical Assistance is similar to MediKan.

Virginia also cost shares in optional General Relief-Emergency Medical Assistance programs operated by local units. The services covered are selected by the locality and may include those covered under GR-Medical Assistance plus nursing home care. The programs are administered by participating counties which determine eligibility, set eligibility standards, and process provider claims. The state provides 62.5 percent of the funding for GR-Emergency Medical Assistance up to a $500 per person per month limit.

Virginia also appropriates funds to the Medical College of Virginia in Richmond and the University of Virginia in Charlottesville to provide medical care to indigents who do not qualify for categorical medical care programs or whose benefits have been exhausted. Services are limited to inpatient and outpatient hospital services. The Eastern Virginia Medical Authority has also received indigent care funds since 1978.

Washington has two indigent care programs: the medical services component of the General Assistance - Unemployable Program (GA-U); and the Limited Casualty-Medically Indigent Program. The GA-U program is state administered cash assistance and medical services program that covers adults who have an emotional, physical, or mental impairment that precludes employment and certain pregnant women who are not eligible for AFDC. Recipients of GA-U are automatically eligible for medical care. The GA-U Medical Assistance Program is nearly identical to MediKan.

The Limited Casualty Program-Medically Indigent (LCP) is the medically indigent component of LCP which is similar to the medically needy program under Medicaid. The program covers medical care for certain persons who are not eligible for any other program. Indigents must spend-down any excess income and resources and pay a deductible of $500 per year. Care is limited to acute and emergency conditions.

West Virginia does not have a state or state-county indigent care program.

Wisconsin reimburses counties and municipalities for a percentage of General Relief medical claims. General Relief recipients are automatically eligible for medical services in most jurisdictions in Wisconsin, although there may be some exceptions since eligibility standards are established by local jurisdictions. The local jurisdiction decides which services to cover and which providers to reimburse for indigent care. Prior to July, 1983, no state funding was available for the General Relief Program in Wisconsin. Because of increasing costs, the state began reimbursing local jurisdictions for a part of the medical costs of General Relief in fiscal year 1983. In 1985, the state reimbursed local jurisdictions for 10 percent of the portion of GR medical claims between $500 and $5,000 and for 50 percent of claims over $5,000. To receive state funds, the local jurisdiction must: prior authorize medical services, develop a cost containment plan, and use a state form when submitting claims. With the exception of the location of responsibility for administration, the Wisconsin General Relief Program medical component is not unlike MediKan.

Wyoming provides state funds to counties for medical expenses incurred under the county General Assistance Program. Recipients of SSI, AFDC-FC, and licensed sheltered care are automatically eligible for Wyoming's Minimum Medical Program (MMP). Each county also has the option to extend medical services to individuals or families with sufficient income to meet maintenance needs, but not to meet medical needs, i.e., the medically needy. The state sets eligibility standards, determines eligibility, and processes provider claims for the MMP, which is 100 percent state funded.

Other

Many of the states have special assistance programs for special populations as Kansas does in providing assistance to those who suffer from hemophilia. Such special programs include high-risk maternity patients; soldiers, sailors, and marines; perinatal intensive care patients; pharmaceutical assistance; blind pensioners; special needs of the seriously ill; sickle cell anemia patients; kidney disease patients; and needy Indians.

CC86-265/EC

HOUSE BILL 2141
PUBLIC HEALTH AND WELFARE COMMITTEE
TESTIMONY
February 9, 1987

FEB 16 1987

Mr. Chairman, members of committee and guests, my name is Garrett E. Colquette, Chief Operating Officer, St. Joseph Memorial Hospital, Larned, Kansas.

Before I start my testimony, I would like to express my appreciation to our representative, Susan Roenbaugh. She recognized our problem, found a solution and took decisive and direct action without solicitation. I want to publicly thank her for her efforts.

Obviously, I am speaking in favor of House Bill 2141. Statistics used to determine underserved areas are not true and accurate because they include doctors who do not severe the general public. In Larned, for example, the statistics include those doctors under contract at the Larned State Hospital and that contract states that they can only serve the contracting agency.

1985 statistics show 17 primary care physicians in Pawnee County. Six of these were physicians treating the general public; 11 must be state employed physicians. With 17 doctors in our county, we could not be considered and underserved area.

Today, using the same statistics, there would be 14 primary care physicians in Pawnee County, three of these treating the general public with the same 11 state employed physicians. With 14 doctors in our area, we still would not be considered an underserved area, yet with the three actual physicians, we would be considered critically underserved.

The Kansas University Center for Student Affairs and Educational Development has been very helpful. Dr. Yarmat hopes to help us with this problem soon.

All in all, I believe this bill will benefit not only Pawnee County but the entire state. We need statistics which accurately represent the physician distribution throughout Kansas.

We need accurate statistics so those communities in trouble can receive the assistance they need and physicians can accurately locate practice opportunities. I believe this bill will help reach this goal.

Thank you for your consideration.

Garrett E. Colquette
Chief Operating Officer

Note! - Late Attm. for minutes of 2/9/87.
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Public Health + Welfare
Attachment 5
2/9/87