Approved 3-24-87
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by SENATOR ROY M. EHRLICH at
Chairperson

10:00 a.m./p.m. on March 18, 1987 in room 526-S of the Capitol.

All members were present except:

Committee staff present:
Emalene Correll, Legislative Research
Bill Wolff, Legislative Research
Norman Furse, Revisor of Statutes Office
Clarene Wilms, Committee Secretary

Conferees appearing before the committee:
Paul Klotz, Executive Director, Mental Health Centers of Kansas
Dwight Young, President, Community Mental Health Centers of Kansas
Representative Jessie Branson
Rita Wolf, KDHE
Don Wilson, President, Kansas Hospital Association
Suellen Weber, Department On Aging
Carla Nakota for Dr. Harder, SRS
Elizabeth Taylor, Associations of Local Health Departments
Stewart Frager, Kansas Coalition for Mental Health of Shawnee County
Gail Hamilton, Kansas NOW
Ralph Wright, AARP
Oscar Haugh, AARP
Written testimony by Sister Ann Marita Loosen, SCL, President, St. Francis Hospital and Medical Center, Topeka, KS
Written information submitted by James A. Power, Acting Director of Environment

3/18

Others attending: see attached list

Staff spoke concerning SB-326 stating that it was clean up legislation. This bill was amended twice in past years and sections were not combined. This bill would combine the sections. Two sections that now exist would amend the one and repeal the other one so the new language on page 2 would bring in the language that is in the section that would be repealed.

SB-329 is essentially the same situation as SB-326. This bill combines two sections and on page 2 (g) the language from the repealed sections has been inserted.

Senator Francisco made the motion to report SB-326 and SB-329 favorable for passage and be placed on the consent calendar. Senator Hayden seconded the motion. The motion carried.

Senator Hayden's pages, Jennifer Cutter and Susan Morris from Hugoton and Greg Newham from Topeka, were welcomed.

Paul Klotz spoke in support of SB-316. Mr. Klotz stated that SB-316 was designed to close out the Kansas Community Mental Health Centers Assistance Act." It was stated that this bill involves the issue of continuing need for the state to be involved in funding community based services. (attachment 1)

Dwight Young presented testimony in support of SB-316. Mr. Young stated that his organization supported the concept of closing out the formula grant funding program in favor of a base grant approach. He also spoke concerning the proposed amendment to SB-316 which would replace the 3 year averaging with a compromise distribution adopted by the majority of the community mental health centers and is a part of his testimony. (attachment 2)

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

Written testimony from the department of SRS with a balloon to SB-316 was presented to committee members stating that SRS would support the bill with the SRS amendment. (attachment 3)

Senator Riley moved that the committee request SB-316 be sent to the Senate Ways and Means Committee. Senator Hayden seconded the motion. The motion carried.

Chairman Ehrlich told the committee that SB-319 had been sent to the Juciciary Committee March 17, 1987 and this bill was removed from the books.

Narda S. McClindon spoke in support of HB-2014 stating that there are growing numbers of medically indigent both locally and nationally. A patient of St. Vincent's Clinic told the committee of the difficulty faced in obtaining needed health care. (attachment 4) Ms. McClindon stated the need is immediate and help is needed now.

Representative Jessie Branson spoke in support of HB-2014. Representative Branson stated she felt the fiscal note which originally had been suggested is excessive. (attachment 5)

Rita Wolf spoke in favor of HB-2014 stating that the greatest benefit of this bill would be its potential to research and design the most efficient, cost-effective method of addressing the medical indigency crisis in Kansas. (attachment 6)

Don Wilson spoke in support of HB-2014 stating Kansas hospitals are providing increasing amounts of uncompensated care at a time when Kansas hospitals' revenues have actually decreased. (attachment 7)

Suellen Weber spoke in support of HB-2014 stating that the state must examine the issues surrounding the medically indigent and the homeless. (attachment 8)

Carla Nakata spoke about the number of changes on both federal and state levels which have eliminated access to medical services. Cuts have also been initiated due to budget cut backs. Ms. Nakata stated that SB-2014 is certainly needed. The committee was also reminded that the emergency assistance program will close March 20 as there is no more funding available. (attachment 9)

Ralph Wright presented testimony from James Behan, Chairman, AARP and spoke in support of HB-2014 stating that the health care system is not functioning for vulnerable portions of our population. (attachment 10)

Elizabeth Taylor spoke in support of HB-2014 and its provisions saying that a way to help the medically indigent is badly needed.

Stewart Frager spoke in support of HB-2014 stating that this commission on access to services is much needed.

Gail Hamilton appeared before the committee asking that they support HB-2014. Ms. Hamilton stated that many of those in need of help are women between 45 and 65. (attachment 11)

Oscar Haugh spoke in support of HB-2014 and presented a position paper from AARP. (attachment 12)

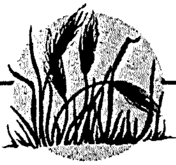
Written testimony by Sister Ann Marita Loosen in support of HB-2014 was presented to the committee. (attachment 13)

James A. Powers presented to members of the committee, copies of the Safe Water Drinking Act amendments of 1986. (attachment 14)

The meeting adjourned at 11:00 a.m. and will meet March 19, 1987.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE 3/18/87

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Dee Roberts	The Center, Great Bend
Dwight Young	Assn. Com. MH Centers Ks.
Rosalie Seover	KNI
Julia Jolliffe	K.N.I.
Carla Nakata	SRS
Stuart Frager	Ks. Coal. for Mental Health of Shawnee Co.
Ralph Wright	AARP
Oscar M. Haugh	AARP State Legislative Committee
James H. Nickel	AARP
Etta Blancke Dahlgren	AARP Leg. Comm.
Elizabeth Johnson	Saint Vincent Clinic 422 Walnut Leavenworth, Ks.
Lori Willey	Saint Vincent Clinic 422 Walnut Leav. Ks
Narda McClandon	Saint Vincent Clinic 422 Walnut Leav. KS. 66048
Keith R Landis	Christian Science Committee on Publication for Kansas
Gail J. Hamilton	KS NOW Lawrence
Marilyn Bradt	KINH Lawrence
Rita Wolf	KDHE
Shelley Weber	KDOA
Gerald T. Hannah	SRS / MHRS
Don Wilson	KHA
Melissa Hungerford	KHA
John O. Miller	AARP State Leg Comm.
Madeline Miller	
Melissa Ness	Sen. Werts



Association of Community Mental Health Centers of Kansas
835 S.W. Topeka Ave., Suite B/Topeka, Kansas 66612/913 234-4773
Paul M. Klotz, Executive Director

March 1987

TESTIMONY ON:
COMMUNITY MENTAL
HEALTH CENTERS OF KANSAS FUNDING

Paul M. Klotz, Executive Director

The Association of Community Mental Health Centers of Kansas, Inc., has two major funding issues before the 1987 Session of the Legislature.

The first issue involves SB 316. This bill is designed to close out the "Kansas Community Mental Health Centers Assistance Act." The State leadership and some centers have come to realize that this program, while it has been very useful in the past in providing an incentive in generating local dollars and forging a partnership between the community and the State, is no longer a viable program with which to fund centers. Among several, two basic reasons for the closure of this program are given: (1) The program is open-ended and particularly in this time of tight budgets is no longer acceptable; and (2) the program does not allow the State to directly carry out its own priorities. Finally, many centers believe that the program does not permit an "equitable" distribution of the funding, particularly to poor and/or populous counties. We earlier proposed a bill requiring about $1 million in new funding to close out the program. This bill would have held all centers "harmless" and would have made a one-time adjustment on the issue of "equity." Since new funding was not available, this bill did not produce legislative or gubernatorial support. The bill that has been introduced by Senate Ways and Means would simply close out the twelve year old program, using an average of the last three fiscal years; allowing for future inflationary increases; future increases would be shared on a prorata basis; and finally, allows the State to appropriate special purpose funding to meet its own priorities and goals.

Some centers and the Association itself continue to search for a distribution formula that will allow for an "equity" adjustment. If such formula is found to be reasonable and definable, we will seek to amend SB 316 with such a formula. However, since any such shifting of existing dollars may cause some centers to lose additional 1986-1987 dollars; these centers may want to make their own case.

SPH&W
3-18-87
attachment 1

(over)

Dwight Young
President

Kermit George
President Elect

John Randolph
Vice President

Larry W. Nikkel
Past President

Paul Thomas
Treasurer

Steven J. Solomon
Secretary

Gene Jacks
Bd. Memb. at Large

The second issue involves the continuing need for the State to be involved in funding community based services, either in terms of the new base grant or future special purpose grants.

These needs for State funding now and into the future are highlighted as follows:

(1) Centers provide the vast majority of public and private mental health services in the state. Nearly 97 percent of those seeking public mental health care are seen at the centers.

(2) Thirty licensed centers provide services in every county of the state.

(3) Centers saw 81,225 patients in FY 1986.

(4) Centers provide direct and continuing services to well over 4,000 chronic/long-term patients.

(5) Centers provide over 6,500 man days of professional time in consultation and educational services to their communities.

(6) In 1986, centers received and served over 1,988 patients discharged from State Hospitals.

(7) Eighty-six percent of the long-term patients seen by mental health centers are unemployed. A majority of all our patients are near or below the poverty level.

(8) Recent MH/MRS trend data (based on the first five months) shows that average monthly State Hospital, adult, psychiatric admissions are declining in FY 1987 at a rate of about 10 percent as compared to the previous year. Over the last several years the number of adults being readmitted to State Hospitals has been reduced.

(9) Centers directly receive about 15 percent of their total funding from the State general fund.

(10) Current national research* shows, on a per capita basis, that Kansas ranked 51st, in the nation and three territories, in terms of state support for community programs. Another national study showed that Kansas community centers ranked near the top in terms of quality services and programs; particularly in terms of programs for the chronic patient. Kansas, nationally, also ranks near the top in terms of local support when determined on a per capita basis.

Thank you!

*National Institute of Mental Health

COMMUNITY BASED MENTAL HEALTH SERVICES

1987

Association of Community Mental Health Centers of Kansas, Inc.

835 S.W. Topeka Avenue/Suite B
Topeka, Kansas 66612

(913) 234-4773

1-2

WHAT IS COMMUNITY MENTAL HEALTH?

- Under K.S.A. 19-4001 et. seq., 30 licensed community mental health centers (CMHCs) currently operate in the state. These centers have a combined staff of over 1,300 providing mental health services in every county of the state. Together they form an integral part of the total mental health system in Kansas. Federal support was drastically reduced a few years ago at a time when the number of patients seeking treatment increased dramatically. These two factors continue to pose a very real threat to the continued delivery of some of the services provided by these centers. Additionally, CMHCs are concerned regarding recent cuts in the Medicaid Program.

WHO NEEDS IT AND WHO USES IT?

- Between 367,500 (15 percent) to 490,000 (20 percent) of the Kansas population are suffering from varying degrees of mental disabilities that require treatment. The combined private and public sectors of mental health treatment are not reaching all of those needing service.
- Demand for community based mental health care has grown by 41 percent during the past ten years. During times of economic distress, the need for mental health services typically rise dramatically.
- The primary goal of CMHC's is to provide quality care, treatment and rehabilitation to the mentally disabled in the least restrictive environment. We try to provide services to all those needing it, regardless of economic level, age, or type of illness. Many arguments can be advanced for treatment at the community level, chief of which is to keep individuals functioning in their own homes and communities, at a considerably reduced cost to them, third party payors and/or the taxpayer. The following table represents what service modality and diagnostic group for which clients were seen at CMHC's during FY 85:

FY 85 Community Mental Health Center Book Population
By Diagnostic Group and Service Modality*

Services	Inpatient Modality %	Outpatient Modality %	Partial Hospital %	Percent Totals	Total Numbers
Children Services					
Behavior Problems	.6	51.6	0	52.2	3,594
Emotional Problems	.2	10.6	0	10.8	742
Disoriented & Confused	.1	.5	0	.6	40
**Multiple Problems	.3	36.0	.1	36.4	2,506
Totals	1.2	98.7	.1	100	6,882
Adult Services					
Dangerous to Self	.7	5.0	.1	5.8	2,114
Dangerous to Others	.7	35.2	.1	36.0	2,027
Disoriented & Confused	.8	5.0	.3	6.1	12,541
**Multiple Problems	1.7	50.3	.1	52.1	18,170
Totals	3.9	95.5	.6	100	34,852
Substance Abuse Services					
Alcoholics	.3	9.2	0	9.5	3,293
Drug Users	.1	2.5	0	2.6	913
**Multiple Problems	3.6	83.7	.6	87.9	30,646
Totals	4.0	95.4***	.6	100	34,852

*These data include those cases opened during FY 85 and meet selected diagnostic criteria
**Multiple Problems—Alcohol, Sexual Deviance, Other Psychotic
Addendum to Report to the Legislature on Mental Health and Retardation September, 1985.

***The average cost per year for 1985 for outpatient treatment at CMHC's was $200.00. If the early intervention (outpatient services) were not offered by CMHCs a sizeable number would find their condition deteriorating and eventually need hospitalization at a much higher expense.

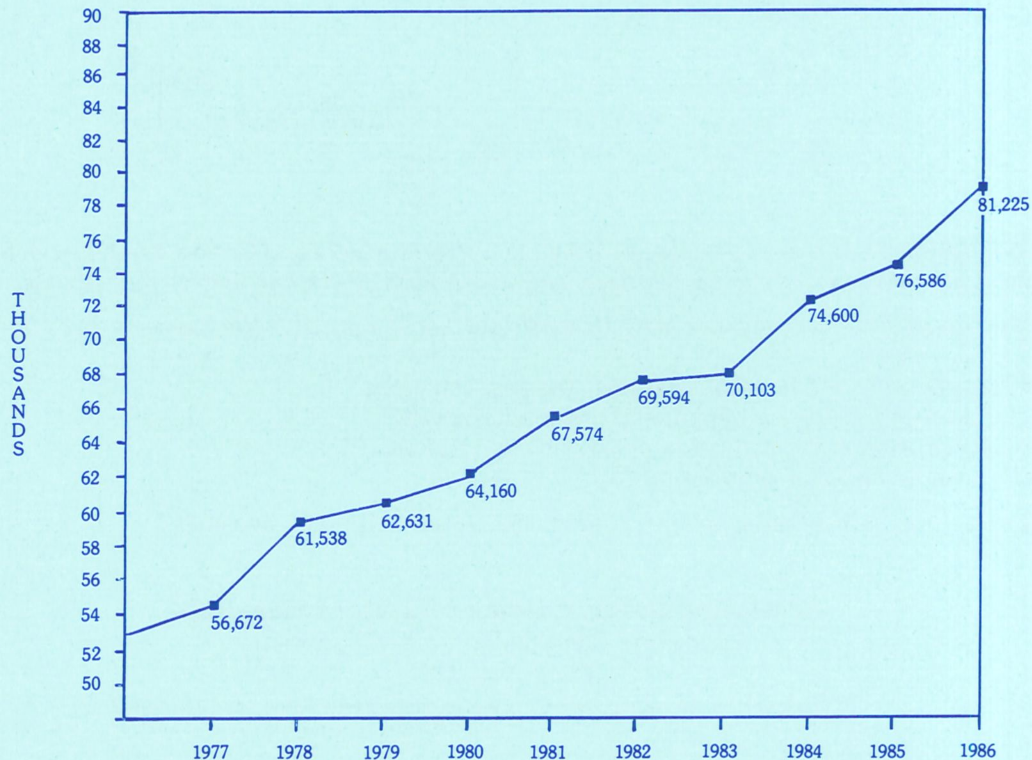
- CMHCs were primarily, if not exclusively, established to provide preventative short-term treatment and care. In the past five years, centers have dramatically shifted toward more costly, public long-term treatment and care. As a result of this rather dramatic shift in funding, some of the prevention and early intervention programs have been cut back. In order for CMHCs to continue providing quality services to citizens at all levels of need, new and/or separate public funding must be forthcoming for the long-term client.
- In 1986, Kansas CMHCs provided care to over 80,000 Kansas citizens. In addition to these direct services, CMHCs provided over 6,500 man days of professional time in consultation and educational services. Patient loads have generally doubled over the past eight to ten years largely as a result of deinstitutionalization. During the period from 1969-79, the state hospital average daily census declined by more than half. Many of these former hospital patients now rely on CMHCs for mental health services to maintain their ability to live in their own community. There is a desperate need to support CMHCs in developing separate ongoing programs for the chronically mentally ill. Cost of service for this population is generally much higher than other groups. Private funding for the long-term patient generally does not exist.

Client Growth In Mental Health Programs

Fiscal Year 1977 thru Fiscal Year 1986

Kansas Citizens Receiving Mental Health Care

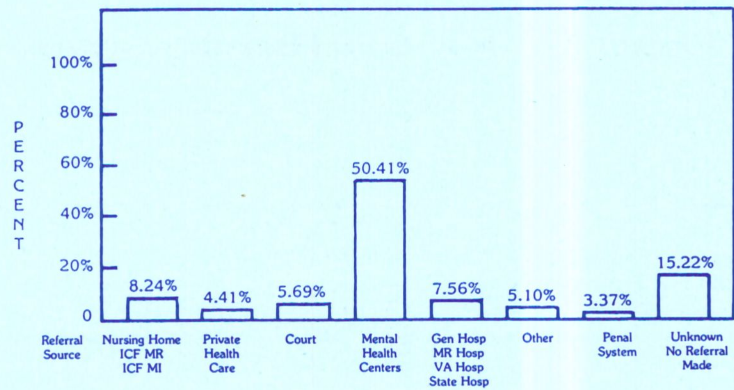
Source: Mental Health Center Caseload Reports. S.R.S. Research and Statistics



- Of the total patients in the public sector having diagnoses of psychotic conditions (severely disabled), over 57 percent are being served by CMHCs.
- In Kansas, more than 95 percent of all citizens seeking public mental health care are seen at community health centers. However, over 30 percent of the patients seen in CMHCs pay their own way.
- The major national and state trend in mental health care over the last 15 to 20 years has been the shift from institutional care to community based care.

- An estimated 3,630 of the CMHC clientele are chronic patients who require ongoing care and treatment. Only recently, have centers been asked to serve this client. Growth in this type of service has been quite rapid over the past five years to the point that centers are now seeing most of the chronically mentally ill seeking service. Without CMHCs, many chronically mentally ill would have no services available to them, or they would be confined to a hospital.
- Based on the population at the State Hospitals, there were 861 long term mentally disturbed patients discharged during fiscal year 1985. This population was defined as: (1) having had one previous admission to a state hospital and (2) having a diagnoses in one of the following categories: Schizophrenia, Affective Disorder, Paranoid Disorder, Personality Disorder. The question is often asked who is treating this population upon discharge from the state hospitals? The following graph represents where these patients are referred upon discharge from state hospitals:

Discharge Referral Source From State Hospitals
Long Term Mentally Disturbed Population
Fiscal Year 1985

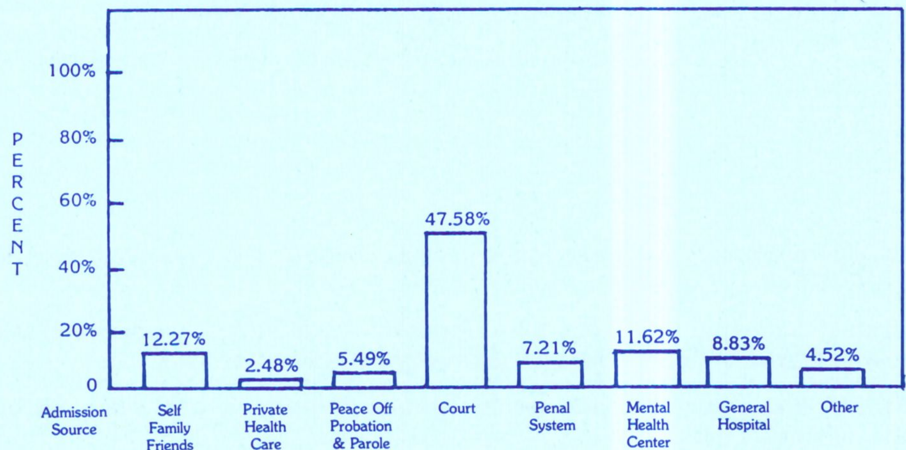


Of the above population, 86.08% are unemployed. If it were not for the State and County Aid received by Centers, this population would not be served at the current level and would probably be readmitted to hospitals.

- Another question often asked; why are state hospitals still above capacity? We believe it is a combination of the following:
  — Drastic reduction of state hospital beds over the past ten years.
  — Lack of consistent funding for community based alternatives.
  — Lack of coordination at the admission point to state hospitals.
  — Use of Psychiatric Beds for other purposes.

The following graph represents how long-term patients are admitted to state hospitals:

Admission Referral Source To State Hospitals
Long Term Mentally Disturbed Population
Fiscal Year 1985

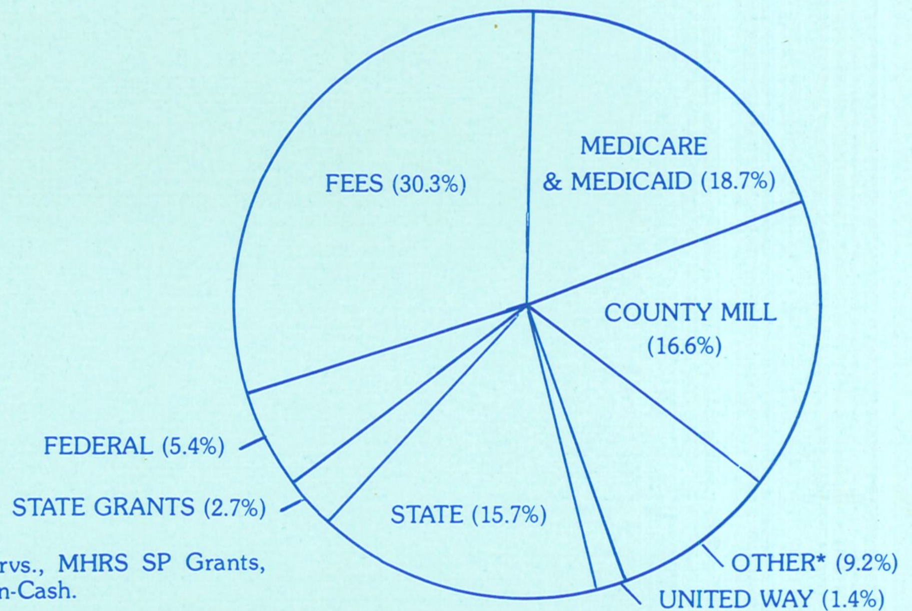


WHO PAYS FOR IT?

- No person, by law, can be denied community mental health care because of the inability to pay; consequently, public support is required. Over 50.43 percent of families served for fiscal year 1986 by CMHCs had gross family incomes of less than $15,000. Poverty level for a family of four is $11,000.
- In 1986, county mill levies provided CMHCs with $8.2 million. County funding is the single largest direct source of public support. Counties currently provide not only mill levy support, but other substantive funding as well. Mill levy support alone averages $3.18 per capita on a statewide basis. County funding may be jeopardized by the loss of Federal General Revenue Sharing.
- In 1986, direct state support for CMHCs was $7.8 million. Nationwide, the average state contribution to CMHCs as a percentage of total budget, is over 30 percent. In Kansas, about 15 cents of every CMHC dollar is directly provided by the State. **A current national research study shows, on a per capita basis, Kansas ranked 51st in terms of state support for community programming, among the 50 states and three territories.**
- The majority of CMHC costs were paid from community sources, with the single largest share coming from the patient.

CMHC REVENUE

TOTAL 1986 BUDGET ESTIMATE $50,048,229

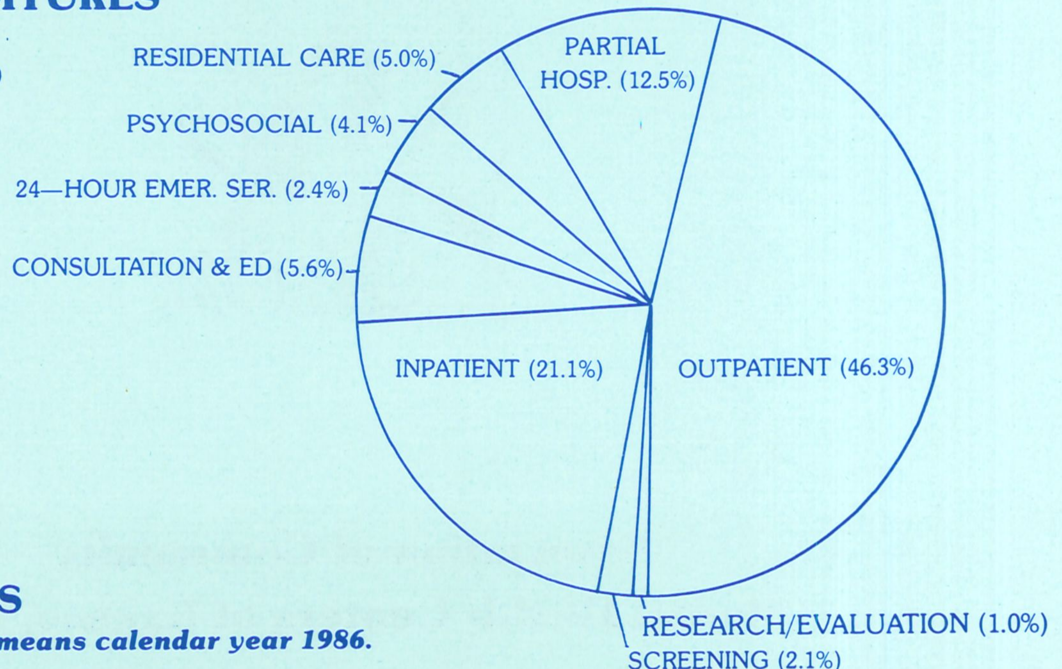


*Other

Title XX, Voc. Rehab., Fees—Prof. Servs., MHRS SP Grants, Sheltered Workshop, Rec Bad Debts, Non-Cash.

CMHC EXPENDITURES

TOTAL 1986 BUDGET ESTIMATE $48,745,550



BUDGET NOTES

- ***"1986 Budget Year" means calendar year 1986.***

Association of Community
Mental Health Centers of Kansas, Inc.

Association of Community
Mental Health Centers of Kansas
835 S.W. Topeka Ave., Suite B/Topeka, Kansas 66612/913 234-4773

Paul M. Klotz, Executive Director

Presentation to the Senate Public Health and Welfare
Committee regarding SB 316
Kansas Community Mental Health Centers Assistance Act
by
Dwight L. Young, M.S.
President

March 18, 1987

The current method of distribution of State aid does not meet the needs of the State, S.R.S. or the mental health centers.

Since 1974 mental health centers have been receiving fund pursuant to KSA 65-4401 et seq which provides for state-aid not to exceed 50% of a center's eligible income. The term "eligible income" means total income of the facility after deduction of the following: (1) income received from state or federal sources; (2) income to be used for capital expenditures; (3) governmental third party payments; (4) professional personnel salaries in excess of state salaries for comparable positions; (5) income received from other community facilities; and (6) income used to provide services other than those specifically designated by statute.

Funds have never been appropriated at the maximum 50% match (FY '87 = 42.7%). The current amount of the state formula-aide to community mental health centers is $7.9 million with the Governors Budget recommending $8,034,447 for FY'88. The method of distribution of this money has become a matter of concern for both S.R.S. and the mental health centers.

The current formula grant produces pressure to increase the allocation for this program in order to maintain the match against increasing local income, therefore, it has fallen into disfavor with many legislators. It does not meet the needs of S.R.S. because the act is designed to offer assistance in local programs, so S.R.S. has no control in directing the money into programs or locations where there are special needs. The mental health centers are in need of a stable base to help meet the State licensing requirements and there is concern regarding the fluctuations in funding that can take place with the formula grant as well as the distribution of the funds in the program.

SPH&W
3-18-87
attachment 2

Dwight Young, President | Kermit George, President Elect | John Randolph, Vice President | Larry W. Nikkel, Past President
Paul Thomas, Treasurer | Steven J. Solomon, Secretary | Gene Jacks, Bd. Memb. at Large

The ACMHCK supports the concept of "closing out" the formula grant funding program in favor of a base grant approach.

SB 316 accomplishes this by averaging three years of funding for each center to establish that center's base grant which would be the State's support for local programing. Assuming the allocation for this act would remain stable, the mental health centers could count on these funds to assist them in maintaining the programs which are necessary for licensing as a community mental health center which answers the concerns of the mental health centers. Any additional funds can be awarded through S.R.S. as special project grants thus meeting the needs of that agency and the growth in the program is completely controlled by the legislature.

The ACMHCK recommends an amendment to SB 316 which replaces the 3 year average with a compromise distribution adopted by the majority of the community mental health centers.

In anticipation of legislation for this year, the ACMHCK and S.R.S. developed a funding program which called for a redistribution of existing funds taking into account the variables of population, poverty and geography. The proposal also "held harmless" each center as compared to that centers three year average. This was unanimously adopted by all the centers, however, it required $912,000 in new monies to implement. When it became clear that these monies would not be available, a series of negotiations within the ACMHCK resulted in the distribution ratio offered as an amendment. Since the negotiations resulted in calculations that require 19 steps it was considered impractical to write this process into law, and it is the hope of the ACMHCK that the legislature will accept placing the final results into the law by way of this amendment.

Session of 1987

SENATE BILL No. 316

By Committee on Ways and Means

2-24

0017 AN ACT enacting the Kansas community mental health centers
0018 assistance act; authorizing state financial assistance for com-
0019 munity mental health centers; prescribing powers, duties and
0020 functions for the secretary of social and rehabilitation ser-
0021 vices; repealing K.S.A. 1986 Supp. 65-4401 to 65-4408, inclu-
0022 sive.

0023 *Be it enacted by the Legislature of the State of Kansas:*
0024 Section 1. This act shall be known and may be cited as the
0025 Kansas community mental health centers assistance act.
0026 Sec. 2. (a) "Mental health center" means any community
0027 mental health center organized pursuant to the provisions of
0028 K.S.A. 19-4001 to 19-4015, inclusive, and amendments thereto, or
0029 mental health clinics organized pursuant to the provisions of
0030 K.S.A. 65-211 to 65-215, inclusive, and amendments thereto, and
0031 licensed in accordance with the provisions of K.S.A. 75-3307b
0032 and amendments thereto.
0033 (b) "Secretary" means the secretary of social and rehabilita-
0034 tion services.
0035 Sec. 3. For the purpose of insuring that adequate mental
0036 health services are available to all inhabitants of Kansas, the state
0037 shall participate in the financing of mental health centers in the
0038 manner provided by this act.
0039 Sec. 4. (a) Subject to the provisions of appropriation acts and
0040 the provisions of section 5, the secretary shall make grants to
0041 mental health centers as provided in this section.
0042 ~~(b) For the first fiscal year commencing after June 30, 1987,~~
0043 ~~the secretary shall make grants to each mental health center~~
0044 ~~equal to the amount that center's average grant would have been~~
0045 under the Kansas community mental health assistance ~~act for the~~
0046 fiscal years ending on ~~June 30, 1986, June 30, 1987, and June 30,~~

Line 0042

New Sec. 4, (b) For the first fiscal year commencing after June 30, 1987 the secretary shall make grants to each mental health center according to the following proportional distribution: Area MHC, 0.044777; Bert Nash MHC, 0.024787; Ctr for Counseling, 0.028065; Central Kansas MHC, 0.026631; Cherokee Co MHC, 0.005457; Cowley Co MHC, 0.009446; Crawford Co MHC, 0.009902; Four Co MHC, 0.020072; Franklin Co MHC, 0.006791; High Plans MHC, 0.082319; Horizons MHC, 0.060561; Iroquois, 0.009365; Johnson Co MHC, 0.076206; Kanza MHC, 0.013984; Labette Co MHC, 0.007580; MHC East Cent Ks, 0.030176; Miami Co MHC, 0.005706; Northeast Ks MHC, 0.021662; Pawnee Comm MHC, 0.056360; Prairie View MHC, 0.086291; Sedgwick Co Dept MH, 0.150953; Shawnee Comm MHC, 0.114267; South Central MHC, 0.018149; Southeast Ks MHC, 0.023807; SW Guidance Ctr, 0.012866; Sumner Co MHC, 0.008624; and Wyandot, 0.045193.

The sum of such grants shall equal the total appropriations for the Kansas Community Mental Health Centers Assistance Act for fiscal year 1988.

0047 ~~1988, if such act had not been repealed and if appropriations for~~
0048 ~~the fiscal year ending June 30, 1988, to finance grants under such~~
0049 ~~act had remained constant from the previous fiscal year plus each~~
0050 ~~mental health center's pro rata share of any increase in moneys,~~
0051 ~~including any inflation adjustments, appropriated for such pur-~~
0052 ~~pose. If appropriations have been reduced from the previous~~
0053 ~~fiscal year, the secretary shall prorate the available moneys~~
0054 ~~based upon the center's average grant for such three fiscal years~~
0055 ~~as computed under this subsection (b).~~
0056 (c) For subsequent fiscal years, the secretary shall make
0057 grants to mental health centers based upon the grant payments
0058 received by each mental health center for the previous fiscal year
0059 plus each mental health center's pro rata share of any increase in
0060 moneys, including any inflation adjustments, appropriated for
0061 such purpose. If appropriations have been reduced from the
0062 previous fiscal year, the secretary shall prorate the available
0063 moneys based upon the grant payments each center received
0064 during such fiscal year.
0065 (d) At the beginning of each fiscal year, the secretary shall
0066 determine the amount of state funds due under this section to
0067 each mental health center which has applied for such funds. The
0068 secretary, with the consent of the governing board of a mental
0069 health center, may withhold funds that would otherwise be
0070 allocated to the mental health center and use the funds to match
0071 other funds for the purchase of services for the mental health
0072 center. Any funds withheld that are not used to purchase services
0073 in the various mental health centers shall be allocated to the
0074 mental health center from which such funds were originally
0075 withheld.
0076 (e) The state funds due under this section to each mental
0077 health center applying therefor shall be paid in four quarterly
0078 installments. The moneys received in any quarter may be used at
0079 any time during the year. Installments shall be paid as follows:
0080 (1) On July 1st for the quarter beginning July 1 and ending
0081 September 30; (2) on October 1st for the quarter beginning
0082 October 1 and ending December 31; (3) on January 1st for the
0083 quarter beginning January 1 and ending March 31; and (4) on

0084 April 1st for the quarter beginning April 1 and ending June 30.
0085 Sec. 5. In the event that a mental health center becomes
0086 defunct and no other mental health center assumes responsibil-
0087 ity for providing services to the geographic area formerly served
0088 by the defunct center, the secretary may use those quarterly
0089 installments that would otherwise be paid to such defunct center
0090 for the purpose of making special purpose grants under this
0091 section.
0092 Sec. 6. (a) In the event any mental health center is paid more
0093 than it is entitled to receive under any distribution made under
0094 this act, the secretary shall notify the governing board of the
0095 mental health center of the amount of such overpayment and
0096 such governing board shall remit the same to the secretary. The
0097 secretary shall remit any moneys so received to the state trea-
0098 surer, and the state treasurer shall deposit the entire amount of
0099 such remittance in the state treasury. If any such governing
0100 board fails so to remit, the secretary shall deduct the excess
0101 amount so paid from future payments becoming due to such
0102 mental health center.
0103 (b) In the event any mental health center is paid less than the
0104 amount to which it is entitled under any distribution made under
0105 this act, the secretary shall pay the additional amount due at any
0106 time within the fiscal year in which the underpayment was made
0107 or within 60 days after the end of such fiscal year.
0108 Sec. 7. The secretary shall provide consultative staff services
0109 to mental health centers to assist in ascertaining local needs, in
0110 obtaining federal funds and assistance and in the delivery of
0111 mental health services at the local level.
0112 Sec. 8. The governing board of any mental health center may
0113 apply for assistance provided under section 4 by submitting
0114 annually to the secretary a budget showing the estimated re-
0115 ceipts and intended disbursements for the calendar year imme-
0116 diately following the date the budget is submitted and a report
0117 detailing the income received and disbursements made during
0118 the calendar year just preceding the date the report is submitted.
0119 Sec. 9. The secretary shall review the budgets and expendi-
0120 tures of the mental health centers, from time to time during the

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Statement Regarding Senate Bill No. 316

I. Title of Bill: An act concerning state financial assistance for community mental health centers; authorizing certain grants; prescribing powers, duties and functions for the secretary of social and rehabilitation services; repealing K.S.A. 1986 Supp. 65-4401 TO 65-4408, Inclusive.

II. Purpose

The intent of this legislation is to propose a new funding methodology as a replacement for the Kansas Community Facilities for Mental Health and Mental Retardation Assistance Act (K.S.A. 64-4401 et seq). This plan was arrived at in a collaborative effort between the Kansas Department of Social and Rehabilitation Services (SRS) and the Association of Community Mental Health Centers of Kansas (ACMHCK).

III. Background

In 1974, the Legislature initiated state formula-aid to community mental health centers organized pursuant to KSA 19-4001 et seq. The legislation, known as the Kansas Community Facilities for Mental Health and Mental Retardation Assistance Act, provides for state-aid not to exceed 50% of a centers' eligible income. State-aid for the centers can, by statute, be as much as 50 percent of eligible income. However, funds have not been appropriated up to that maximum (FY '87 is 35.2%). In Fiscal Year 1987, the total in state formula-aid to community mental health centers if $7.9 million. Since 1974, increase in state-aid can be attributed to the combined effect of: growth in the amount of eligible income matched by the state; and (3) growth in the per-cent of match.

IV. Effect of Passage

This plan for a new funding methodology would establish a base grant to assure ongoing support of established community mental health programs. For several years, SRS and ACMHCK have worked jointly to develop these programs which meet critical local needs.

The other major source of state funding of mental health programs is special purpose grants. Program priorities for special purpose grants are established by SRS/MH&RS to address the needs of particularly vulnerable groups of Kansans such as severely emotionally disturbed children and adults, individuals impacted by the current rural economic

SPH&W
attachment 3

crisis, and others. State funds dedicated to special purpose grants will be directed by SRS, in consultation with interested provider and advocacy groups to programs for these priority populations.

V. SRS Position

The Kansas Department of Social and Rehabilitation Services supports Senate Bill No. 316 with the Department's amendment. The amendment being offered by the department (See Page 3, New Section V), allows the state to determine critical needs of difficult to serve populations such as rural families, psychiatrically disabled individuals, etc. This agency has worked closely with interested provider and advocacy groups over the past several years to develop appropriate mental health services. Senate Bill No. 316 with the Department's amendment would assure ongoing support of these services and, therefore, has the strong support of SRS.

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

Session of 1987

SENATE BILL No. 316

By Committee on Ways and Means

2-24

0017 AN ACT enacting the Kansas community mental health centers
0018 assistance act; authorizing state financial assistance for com-
0019 munity mental health centers; prescribing powers, duties and
0020 functions for the secretary of social and rehabilitation ser-
0021 vices; repealing K.S.A. 1986 Supp. 65-4401 to 65-4408, inclu-
0022 sive.

0023 *Be it enacted by the Legislature of the State of Kansas:*
0024 Section 1. This act shall be known and may be cited as the
0025 Kansas community mental health centers assistance act.
0026 Sec. 2. (a) "Mental health center" means any community
0027 mental health center organized pursuant to the provisions of
0028 K.S.A. 19-4001 to 19-4015, inclusive, and amendments thereto, or
0029 mental health clinics organized pursuant to the provisions of
0030 K.S.A. 65-211 to 65-215, inclusive, and amendments thereto, and
0031 licensed in accordance with the provisions of K.S.A. 75-3307b
0032 and amendments thereto.
0033 (b) "Secretary" means the secretary of social and rehabilita-
0034 tion services.
0035 Sec. 3. For the purpose of insuring that adequate mental
0036 health services are available to all inhabitants of Kansas, the state
0037 shall participate in the financing of mental health centers in the
0038 manner provided by this act.
0039 Sec. 4. (a) Subject to the provisions of appropriation acts and
0040 the provisions of section 5, the secretary shall make grants to
0041 mental health centers as provided in this section.
0042 (b) For the first fiscal year commencing after June 30, 1987,
0043 the secretary shall make grants to each mental health center
0044 equal to the amount that center's average grant would have been
0045 under the Kansas community mental health assistance act for the
0046 fiscal years ending on June 30, 1986, June 30, 1987, and June 30,

3-4

0047 1988, if such act had not been repealed and if appropriations for
0048 the fiscal year ending June 30, 1988, to finance grants under such
0049 act had remained constant from the previous fiscal year plus each
0050 mental health center's pro rata share of any increase in moneys,
0051 including any inflation adjustments, appropriated for such pur-
0052 pose. If appropriations have been reduced from the previous
0053 fiscal year, the secretary shall prorate the available moneys
0054 based upon the center's average grant for such three fiscal years
0055 as computed under this subsection (b).
0056 (c) For subsequent fiscal years, the secretary shall make
0057 grants to mental health centers based upon the grant payments
0058 received by each mental health center for the previous fiscal year
0059 plus each mental health center's pro rata share of any increase in
0060 moneys, including any inflation adjustments, appropriated for
0061 such purpose. If appropriations have been reduced from the
0062 previous fiscal year, the secretary shall prorate the available
0063 moneys based upon the grant payments each center received
0064 during such fiscal year.
0065 (d) At the beginning of each fiscal year, the secretary shall
0066 determine the amount of state funds due under this section to
0067 each mental health center which has applied for such funds. The
0068 secretary, with the consent of the governing board of a mental
0069 health center, may withhold funds that would otherwise be
0070 allocated to the mental health center and use the funds to match
0071 other funds for the purchase of services for the mental health
0072 center. Any funds withheld that are not used to purchase services
0073 in the various mental health centers shall be allocated to the
0074 mental health center from which such funds were originally
0075 withheld.
0076 (e) The state funds due under this section to each mental
0077 health center applying therefor shall be paid in four quarterly
0078 installments. The moneys received in any quarter may be used at
0079 any time during the year. Installments shall be paid as follows:
0080 (1) On July 1st for the quarter beginning July 1 and ending
0081 September 30; (2) on October 1st for the quarter beginning
0082 October 1 and ending December 31; (3) on January 1st for the
0083 quarter beginning January 1 and ending March 31; and (4) on

0084 April 1st for the quarter beginning April 1 and ending June 30.

Sec. 5. Any moneys appropriated to fund grants under the Kansas community mental health assistance act and not designated to fund grants pursuant to section 4 shall be distributed as special purpose grants to individual mental health centers at the discretion of the secretary to establish priority services.

6 0085 Sec. ~~5~~. In the event that a mental health center becomes 0086 defunct and no other mental health center assumes responsibil- 0087 ity for providing services to the geographic area formerly served 0088 by the defunct center, the secretary may use those quarterly 0089 installments that would otherwise be paid to such defunct center 0090 for the purpose of making special purpose grants under this 0091 section.

7 0092 Sec. ~~6~~. (a) In the event any mental health center is paid more 0093 than it is entitled to receive under any distribution made under 0094 this act, the secretary shall notify the governing board of the 0095 mental health center of the amount of such overpayment and 0096 such governing board shall remit the same to the secretary. The 0097 secretary shall remit any moneys so received to the state trea- 0098 surer, and the state treasurer shall deposit the entire amount of 0099 such remittance in the state treasury. If any such governing 0100 board fails so to remit, the secretary shall deduct the excess 0101 amount so paid from future payments becoming due to such 0102 mental health center.

0103 (b) In the event any mental health center is paid less than the 0104 amount to which it is entitled under any distribution made under 0105 this act, the secretary shall pay the additional amount due at any 0106 time within the fiscal year in which the underpayment was made 0107 or within 60 days after the end of such fiscal year.

8 0108 Sec. ~~7~~. The secretary shall provide consultative staff services 0109 to mental health centers to assist in ascertaining local needs, in 0110 obtaining federal funds and assistance and in the delivery of 0111 mental health services at the local level.

9 0112 Sec. ~~8~~. The governing board of any mental health center may 0113 apply for assistance provided under section 4 by submitting 0114 annually to the secretary a budget showing the estimated re- 0115 ceipts and intended disbursements for the calendar year imme- 0116 diately following the date the budget is submitted and a report 0117 detailing the income received and disbursements made during 0118 the calendar year just preceding the date the report is submitted.

10 0119 Sec. ~~9~~. The secretary shall review the budgets and expendi- 0120 tures of the mental health centers, from time to time during the

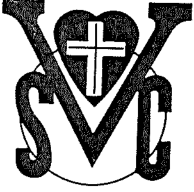
0121 fiscal year, and may withdraw funds from any facility which is
0122 not being administered substantially in accordance with the
0123 provisions of the annual budget submitted to the secretary.

11 0124 Sec. ~~10~~. As a prerequisite for receiving assistance provided
0125 under this act, each mental health center shall agree to provide
0126 the secretary with at least 45 days' notice prior to initiating a new
0127 program. If the secretary determines that such program dupli-
0128 cates a program which is adequately serving the geographic area
0129 served by such mental health center, the secretary may subse-
0130 quently withdraw assistance provided under this act equal to the
0131 net loss, if any, generated by the program in the previous calen-
0132 dar year unless the mental health center agrees to purchase the
0133 service from or otherwise cooperate with such other program.

12 0134 Sec. ~~11~~. The secretary shall adopt rules and regulations for
0135 the administration of the provisions of this act, including the
0136 content of budgets, reports and the criteria for the awarding of
0137 special purpose grants, determining program duplication and the
0138 redistribution of moneys if a new mental health center is created
0139 or if the geographic area served by a mental health center is
0140 added to or subtracted from.

13 0141 Sec. ~~12~~. K.S.A. 1986 Supp. 65-4401 to 65-4408, inclusive, are
0142 hereby repealed.

14 0143 Sec. ~~13~~. This act shall take effect and be in force from and
0144 after its publication in the statute book.



Saint Vincent Clinic
P.O. Box 2426
422 Walnut Suite C
Leavenworth, Kansas 66048
(913) 651-8860

Saint Vincent Clinic Testimony Regarding House Bill #2014

Packet Contents:

1. Position statement regarding House Bill #2014.
2. Position statement on health care for the medically indigent also presented to Senator Dole's Field Representative December 1986.
3. A segment of, The Medical Indigency Crisis in Kansas: A White Paper . The entire report can be ordered by contacting the Statewide Health Coordinating Council.
4. "Human Impact of Proposed SRS Budget Cuts FY 1987".
5. Saint Vincent Clinic Introduction Sheet.
6. Saint Vincent Clinic brochures.

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Saint Vincent Clinic

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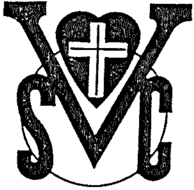
Position Statement Regarding

House Bill #2014

The numbers of persons identified as medically indigent are growing both locally and nationally. These are individuals and families, usually employed, who cannot afford private health insurance and do not qualify for public health benefits. Over 500,000 Kansans, or one fourth the state population of our state, have been identified as medically indigent. Across the United States 21.8 million people are without the resources to obtain basic health care services.

More and more, the medically indigent are denied access to health care services. Physicians cannot distinguish between patients who will not pay and those who cannot. As a result, office systems are designed to accept patients with insurance or those who can pay fees in full. Hospitals, operating now from business models, no longer have the vehicles to treat patients who cannot pay for their care. Public and private social agencies face budget cuts at the federal, state, and local levels and at the same time find there are fewer alternate resources for the money required to finance primary health care for the uninsured poor.

Saint Vincent Clinic is in favor of House Bill #2014. The staff requests to be informed of any action on the bill. We are also interested in cooperating, on any level we can, with the proposed commission as it meets its objectives.



Saint Vincent Clinic
P.O. Box 2426
422 Walnut Suite C
Leavenworth, Kansas 66048
(913) 651-8860

Position Statement
Health Care for the Medically Poor

Saint Vincent Clinic provides health care services to the medically indigent; that is to low income persons and families who are without public or private health insurance benefits.

Because each day we are acutely aware of the fact that if we did not exist, some 11,000 persons without health insurance in Leavenworth County would have nowhere to turn for primary health care services nor for dental care or eye care, and that the consequences of this lack of access could threaten the health, employability, optimum life span, and perhaps the very life of these persons, and because we are also aware of the limited number of clinics such as ours in the nation, we urge legislators to consider the following:

1. 21.8 million people across the United States are medically indigent. 11.6 million of these people live below the poverty level and are not eligible for Medicaid.

2. Over 500,000 Kansans, that is one-quarter of the population, are medically indigent.

3. Children represent the primary population of the medically indigent of Kansas.

4. The unemployed, the underemployed, the migrant farm worker, the employee who is not offered health care benefits, the employee who cannot afford health insurance even if offered because he/she cannot afford the employee share, are characteristics of the uninsured poor.

Position:

1. A national health care policy needs to be developed which gives all people access to primary health care as well as hospitalization.

2. The above should be made a priority before a national health care policy is in effect which relates to catastrophic illness and affects relatively fewer persons in comparison.

3. A comprehensive health care policy which assures a variety of health services from basic primary care, dental care, and eye care to hospitalization to home health to long term care and catastrophic illness protection is an ideal the nation should work toward. Many industrialized nations are far ahead of our own country in providing health care for all their citizens. It is a scandal that a nation so rich in resources as ours cannot meet the basic health needs of its citizens.

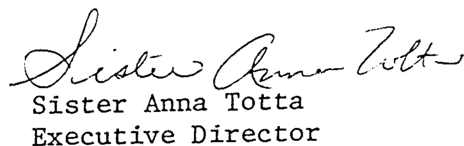
4. A poll taken by the Kansas Hospital Association in 1986 demonstrates that the public is in favor of providing health care for the medically poor.

5. The nation's resources are drained by a defense budget which questionably adds to the nation's security. Meanwhile, the sufferings of the poor are ignored by legislation and the present administration. Indeed, Medicaid cutbacks are one of the significant causes of medical indigence.

6. The recent tax reforms predict significant reductions for the wealthy while there is strong evidence that the poor will be burdened with increased taxes. Taxes must be equitable, and the wealthy can bear more easily an increase of taxes which could be used for health care services. Increasing taxes to provide health care is a morally tenable position for Congress.

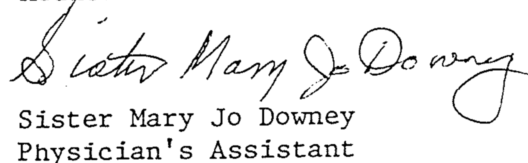
7. The Catholic Bishops economic pastoral published in 1986 includes health care as a basic human right for all citizens along with food, shelter, clothing, and education. They urge all of us to advocate for these basic rights.

Sincerely,

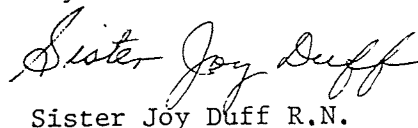


Sister Anna Totta
Executive Director

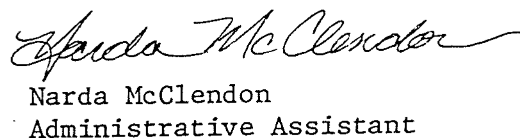
Sister Mary Rardin, M.D.
Medical Director



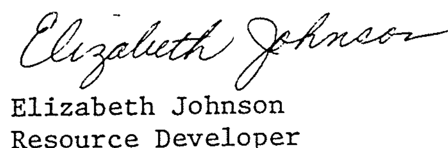
Sister Mary Jo Downey
Physician's Assistant



Sister Joy Duff R.N.



Narda McClendon
Administrative Assistant



Elizabeth Johnson
Resource Developer

THE MEDICAL INDIGENCY CRISIS IN KANSAS

A WHITE PAPER

Statewide Health Coordinating Council

and

Office of Health and Environmental Planning

Division of Policy and Planning

Kansas Department of Health and Environment

(Barbara J. Sabol, Secretary)

July, 1986

EXECUTIVE SUMMARY

PREFACE

In a land as bountiful as the United States, it is shameful that many of our young, older, as well as productive citizens are unprotected by the ravishment of illnesses simply because they are impoverished, poor and beyond the extended hands of those wanting to assist.

One health issue that has reached a critical state in the U.S. and in Kansas is access to health care for the medically indigent, or those individuals who do not have the financial resources to pay for their own health care and are not covered by private or public (Medicare, Medicaid) insurance. The Statewide Health Coordinating Council (SHCC) believes that all Kansans are entitled to equal access to health care regardless of their economic status, age, race or nationality.

The uninsured and underinsured poor are generally in poorer health and are more likely to have low birthweight babies, hypertension and other ills than higher income persons of comparable age. In addition, those without insurance use the health system less frequently, and when they are ill and seek medical care, the most frequently used services are maternity and infant care, trauma, alcohol and drug abuse and psychiatric care. Since the poor have greater health problems and use fewer health services, when services are finally sought, care is likely to be at a more intensive and costly level since pre-existing conditions have not been diagnosed and treated.

OVERVIEW OF THE MEDICALLY INDIGENT POPULATION AND SPECIFIC HIGH RISK GROUPS IN KANSAS

In Kansas, based upon 1985 census population figures and national statistics, 581,000 persons were either uninsured (all or part of the year) or underinsured. Three major subgroups comprise the population lacking adequate private or public insurance. They are the unemployed, individuals who cannot acquire insurance due to health or occupational reasons (the uninsurable) and individuals employed in firms offering no medical benefits (the premium indigent). In addition to and/or included within the major subgroups, Kansas has specific high risk populations that are either medically indigent or at risk of indigency:

1. Older adults between the ages of 60 to 64 who are not employed, cannot afford to purchase adequate coverage and are ineligible for Medicare;

2. Mid-life women between the ages of 45 to 65 in which many are either not in the work force or in low paying jobs, have had a change in marital status and find cost to be the main deterrent in purchasing adequate health insurance;

3. Black Kansans which, as a group, experience higher rates of poverty, unemployment, infant death rates and various illnesses far exceeding the White population;

4. Migrant and seasonal farm workers in which the majority are Hispanic. They do not have the financial resources to pay for adequate health care and suffer from a number of health problems far exceeding the general population as well as language, transportation and other barriers;

5. The homeless in which an increasing number appear to be women and children, young people, minorities and mentally ill persons; and

6. Displaced farmers who have experienced farm losses due to the declining farm economy and cannot afford to maintain medical insurance and do not qualify for public assistance.

STATISTICAL INDICATORS AND CAUSATIVE FACTORS/TRENDS OF MEDICAL INDIGENCY

A major cause of the increase of medical indigency is the reduction of Medicaid funds. The Kansas Department of Social and Rehabilitation Services (SRS) reported that between FY 1981 and FY 1982, there was an 11.4 percent decrease in the number of families served. In 1982, the ADC caseload decreased from 26,936 to 21,603 persons which was a 19.8 percent decrease. In addition, the Kansas Legislature in FY 1982 eliminated medical coverage for the General Assistance/Medical Care only recipients, affecting 2,675 participants. Medicaid payments to hospitals have also decreased by 2 percent between 1983 and 1984.

The severity of medical indigency is indicated by the amount of uncompensated care provided by Kansas hospitals. Survey results from the Kansas Hospital Association (KHA) covering data from 1982 to 1984 indicates that hospitals have provided $75 million in uncompensated care. Another issue that relates to uncompensated care is the reduction of Hill-Burton obligations from hospitals and other health care facilities. Of the 74 facilities in Kansas that originally received Hill-Burton funds, 53 of them are obligated to provide uncompensated care services. This amount totaled approximately $3.6 million in 1983 which would have little or no impact on the uncompensated care costs.

Other major factors related to the increase in medical indigency are cost containment approaches and competition in the health care market. Medicare, Medicaid, Blue Cross/Blue Shield of Kansas, HMOs and PPOs have within the last few years taken steps to reduce their future financial liabilities by introducing fixed payments. Such payment plans prevent hospitals from distributing the costs among all payers and users thereby placing the full financial burden on the uninsured and underinsured.

PROGRAMS OTHER STATES HAVE IMPLEMENTED TO ADDRESS THE UNCOMPENSATED/INDIGENT CARE CRISIS

A number of states have successfully implemented various programs that either:

1. Target providers in which hospitals could be compensated directly by factoring the costs of uncompensated care into the routine reimbursement for services, or indirectly by granting a lump sum determined by need and taken from a pool of funds.

2. Target individuals who are likely to generate uncompensated care. These individuals could, for example, be provided with catastrophic insurance, unemployment insurance, medical vouchers, etc.

If a program for the medically indigent is to be established in Kansas, public policy makers must consider the types of taxes that would be used to support additional expenditures. Examples of what some states have done to finance their indigent care programs include:

1. Direct appropriations of state funds;

2. Earmarking state lottery funds;

3. Increasing general sales taxes or special purpose excise taxes on goods, such as alcohol or tobacco;

4. Tax deductible contributions to an uncompensated care fund;

5. Passage of a tax on all or some hospitals to develop a revenue pool;

6. Passage of a tax on health insurance premiums; and

7. Passage of a tax on all health services.

RECOMMENDATIONS OF THE STATEWIDE HEALTH COORDINATING COUNCIL

The Statewide Health Coordinating Council (SHCC) recommends that the legislature establish an interim committee to further study medical indigency in summer 1986.* This would give the issue of medical indigency a high degree of visibility and focus as well as providing an opportunity for a number of providers, consumers, agencies and organizations to voice their concerns.

The SHCC also recommends that following the interim study, a special task force or commission be appointed. The purpose of this group is to study the issue in more detail and develop specific financial recommendations for funding a program for the medically indigent. Members of the task force, as well as Kansas legislators should examine a number of policy issues prior to the development of a specific program(s) for the medically indigent. The task force should have representation from a number of agencies, groups, various levels of government and consumers.

*This recommendation has already been accomplished. An interim study on "Access to Health Care for the Medically Indigent" was assigned to the committee on Public Health and Welfare in June, 1986.

INTRODUCTION

In the past several years, health planning has spent a significant amount of time on issues surrounding health care cost containment. However, other concerns also need to be addressed. One concern that has reached a critical stage in the U.S. and in Kansas is access to health care for the medically indigent, or those individuals who do not have the financial resources to pay for their own health care and are not covered by private or public (Medicare, Medicaid) insurance.

In March 1983, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research released its report, Securing Access To Health Care, in three volumes, representing the culmination of several years of effort. The report indicates that access to health care is an important subject area and will continue to grow in importance with time. The Commission concluded that "society has a moral obligation to ensure that everyone has access to adequate care without being subject to excessive burdens." (President's Commission 1983, P.22). The Statewide Health Coordinating Council is in concurrence with this philosophy and strongly believes that all Kansans are entitled to equal access to health care regardless of their economic status, age, race or nationality.

The equality in access to health care for all Americans is a concept that has grown over the decades, nourished by the development of employment related insurance for the working and middle classes and by the introduction, in 1965, of the federal Medicare and Medicaid programs for the elderly and various sectors of the poor. However, in our current era, the health care system is guided by a different set of forces which appear to contradict the theme of "equality of care" of the 1960's.

The theme of the 1980's is "health care cost containment" and "competition." Prospective pricing and other changes in the delivery and financing systems as well as reductions in federal, state and local budgets has severely affected not only the ability to shift costs to payers but creates an ever-increasing dilemma for those who are indigent and have little or no resources to purchase adequate care. In Kansas, those individuals that are extremely vulnerable are the unemployed, the working poor, the uninsurable, the elderly, women in their mid-life years, Blacks, migrants and seasonal farm workers, the homeless and the farming community.

In this paper, only a portion of the financial issue of access as it relates to the medically indigent is addressed. Information is provided as to the characteristics of the indigent population, changes in public and private payment mechanisms as well as federal and state budget changes. The paper also briefly discusses financial options various states have adopted targeting either providers or the individuals in need of services and the recommendations of the Statewide Health Coordinating Council (SHCC).

As a final note, it is important to reiterate that SHCC believes this is a critical issue and medical indigency (especially during this time of government budget cutbacks along with the movement toward competition in the health care field) will continue to grow. Our legislators, policy makers, professionals in the health care system and society as a whole will need to move immediately on this issue in a proactive way. If we wait too long or believe Kansas is immune to this problem, the consequences would be unnecessary pain, suffering and perhaps even deaths.

HUMAN IMPACT
OF
PROPOSED SRS BUDGET CUTS
FY 1987

Proposed State General Fund Cut	Resulting Loss in Fed. Funds	HUMAN IMPACT
$ 451.837	$ 369,686	Dental MA Services: DENTAL CARE for public assistance recipients, which is currently severely restricted, would be ELIMINATED altogether for all adults and for over 50% of children on AFDC.
1,369,333	0	TGA-MA: 1,800 ADULTS currently on Transitional General Assistance would LOSE ALL MEDICAL SERVICES.
824,505	0	TGA: 1,800 ADULTS who currently can get $100 cash per month for 4 months of the year would GET ONLY $100 CASH FOR ONE MONTH OF THE YEAR.
803,000	863,210	Adult Care Homes: REDUCES cost centers that affect QUALITY OF CARE. Does not change eligiblity for services.
1,323,466	1,082,836	Medical Fees: DOCTORS AND PHARMACISTS, who currently participate voluntarily in the Medicaid program and are paid less than their normal fees, would have an additional cut of up to 10% in their fees. Some are LIKELY TO STOP ACCEPTING MEDICAID PATIENTS as a result.
228,000	66,000	Foster Care: Family foster care providers and group homes, both of which are currently paid less than the cost of caring for children, would have an additional cut of up to 3.8% in their reimbursement rate. The AVAILABILITY OF FOSTER CARE beds and the QUALITY OF CARE is LIKELY TO DIMINISH as a result.
17,000	0	Day Care: DAY CARE PROVIDERS, who currently are paid less than their normal fees, would have an ADDITIONAL CUT of 3.8%. The administrative cost to SRS of implementing this change could cost more than the saving projected.
1,191,236	876,518	GAU-ADC: 23,000 HOUSEHOLDS (including 45,000 children) on AFDC would LOSE $15 PER MONTH from February through June. Almost 5,000 people on General Assistance Unrestricted would also lose 3.8% of their monthly cash grant.

4-10

Proposed State General Fund Cut	Resulting Loss in Fed. Funds	HUMAN IMPACT
$1,596,933	0	GAU Medical Assistance: Almost 5,000 PEOPLE on General Assistance Unrestricted would LOSE CERTAIN MEDICAL CARE as follows: --Inpatient hospital payments limited to $225 per patient per fiscal year. In effect, SRS would pay for ONLY ONE HOSPITAL VISIT from 7/1/86 to 6/30/87 REGARDLESS OF HEALTH CONDITION of patient. --DOCTOR VISITS LIMITED TO 8 per patient per calendar year, regardless of health condition of patient. --ELIMINATES completely all OUTPATIENT HOSPITALIZATION, and outpatient LAB, AMBULANCE, optometric, audiology, podiatry and chiropractic services.
$7,805,310 SGF	$3,258,250 Federal	Subtotals
+ $5,410,683	+ $3,444,259	Other Cuts in SRS budget
$13,215,993 SGF	$6,702,509 Federal	TOTAL CUTS PROPOSED IN SRS BUDGET FOR FY 1987 = $19,918,502

1/5/87

4-11

Saint Vincent Clinic
P.O. Box 2426
422 Walnut Suite C
Leavenworth, Kansas 66048
(913) 651-8860

Introduction Sheet

Purpose

Saint Vincent Clinic provides health care for low income persons and families who are without health benefits.

Services

Saint Vincent Clinic provides primary health care services at the main clinic five days a week including evening hours on Tuesdays and Thursdays. The medical team at the clinic includes a family practice physician, a physician's assistant, and a registered nurse.

Through the cooperation of the two local hospitals, Saint John and Cushing Memorial, and three radiologists, x-ray, and laboratory services are provided for clinic patients.

Saint Vincent Clinic has a volunteer network of 26 doctors, 19 dentists, 4 optometrists, a podiatrist, and a certified hearing aid audiologist who have agreed to see our patient referrals.

The clinic helps with medications.

A Look at our Patients (Sample of 279 patients taken January 1987)

71% of our families show that someone in the household is employed.

57% of our families have incomes of less than minimum wage.

30% of our families have incomes of less than $3,600 a year.

38% of our patients are less than 18 years of age.

34% of our patients are young adults less than 30 years of age.

70% of employed families who gave a response as to why the patient did not have health insurance indicated the employer did not offer it.

Volunteers

Along with the volunteers from the medical community, Saint Vincent Clinic has a number of volunteers who work at the clinic as receptionists, clinic assistants, and nurses. Volunteers also serve on the Medical Policy Committee and Resource Council.

Support

Contributions by individuals and groups supplement our services.

Saint Vincen linic gratefully acknowledges cooperative efforts of:

Hospitals

Cushing Memorial Hospital
Saint John Hospital

Radiologists

William R. Allen, Sr.
William C. Strutz
William R. Allen, Jr.

Physicians

Robert Parker
Adnan Ashkar
M.A. Baghal
David Barry
Leslie Becker
Gary Boston
Sue Brown
Mark Cenac
Peter Cristiano
Derrick DeSouza
Gaston Diallo
Thomas Graham
John Hammeke
Debra Heidgen
Virgle Herrin
Kathleen McBratney
William McCollum
Merle Milburn
Vernon Mills
W. Lee Murray
Claudia McAllaster
Marsha Rogers
Benesto Tumanut
Carroll Voorhees
Gordon Voorhees
Charles Waltz

Optometrists

George Huck
William McKim
Mark Norris
Alan Snell

Dentists

Ralph Atchison
J. Page Barton
F. Robert Burns
Rick Biethman
John Fletcher
Keith Grigsby
Dale Hawley
Paul Hund
Kenneth Kindred
Robert Lederer
Kirk Collier
Robin Potter
Rodney Rivard
Michael Robinson
Thomas Schugel
Richard Radke
Roderick Thiele
Wayne Thompson
John Zillman

Podiatrist

Jerry Jackson

Certified Hearing Aid Audiologist

David Albee

Pharmacies

Corner Pharmacy
Gene's Pharmacy
Russell Pharmacies

Suppliers

Park Plaza Medical
Bill Gassen
Myron's Dental Lab

Ongoing Support

United Way of Leavenworth
Leavenworth Noon Lions Club
Donors
Sisters of Charity of Leavenworth
St. Patrick's Day Parade Committee

Saint Vincent Clinic

What is SVC?

Saint Vincent Clinic is a non-profit corporation providing outpatient health services. It is an affiliate of the Sisters of Charity of Leavenworth Health Services Corporation.

Our Purpose

We seek to provide health care for persons who have limited access to medical services because of financial barriers.

Our Philosophy

We believe all persons have the right of access to quality health care — care that reflects the dignity and respect due each individual.

Clinic Services

Primary Health Care . . .

Patients are seen by a Family Practice Physician or a Physician's Assistant.

Referrals . . .

Patients can be referred to physicians, dentists, and optometrists who have agreed to see patients on a free or reduced cost basis.

Laboratory and X-Ray services . . .

A limited number of tests are provided through cooperation with radiologists and the two local hospitals, Cushing Memorial and St. John.

Pharmaceuticals . . .

Full or partial coverage of the first prescription. Other pharmaceuticals as available.

Other health resources as available.

Cost . . .

A minimum amount must be paid for each clinic visit.

Volunteers

Both medical and non-medical volunteers are key to helping the clinic provide its services.

Volunteers are needed in the following areas:

- Physicians
- Dentists
- Ophthalmologists
- Optometrists
- Nurses
- Medical technologists
- Clinic assistants
- Office assistants
- Resource Council (members offer expertise and advice, recruit volunteers, and seek funding sources).

Contributions

Both small and large contributions are needed for continued operation. Contributions are tax deductible.

Mail contributions to:

Saint Vincent Clinic, Inc.
422 Walnut - Suite C
Leavenworth, Kansas 66048

Note:

Saint Vincent Clinic provides outpatient services. Hospitalization or medical costs incurred outside the clinic's resources are the responsibility of the patient. The clinic's services are directed toward those persons with limited financial means and without public or private health insurance coverage.

Clinic Hours

9:00 am - 4:00 p.m.
Monday, Wednesday, Friday

9:00 a.m. - 8:00 p.m.
Tuesday and Thursday

For an appointment phone:
651-8860

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4-13

Saint Vincent Clinic
422 Walnut - Suite C
Leavenworth, Kansas 66048

Saint Vincent Clinic

422 Walnut Suite C
Leavenworth, Kansas 66048
651-8860

A clinic providing health services to persons and families with limited financial means.

4-13

Saint Vincent Clinic

PROGRESS NOTES

Vol. 2 No. 2 Spring 1987

Saint Vincent Clinic Honors Volunteers and Major Donors

Saint Vincent Clinic will hold its first annual Charity Ball to honor the volunteers and donors who have made our health care services possible. John Tibbetts, author and media expert of KCTV 5, will be the guest speaker. Dance music will be donated by Leather and Lace, a local band. The Ball will be held March 7 in the St. Joseph Dining Hall at Saint Mary College in Leavenworth. The event will begin with a buffet, followed by a recognition program and dancing. Volunteers include doctors, dentists, optometrists, radiologists, and other health care providers as well as nurses, clinic assistants, office help, and a resource council.

The Charity Ball will also kick off the First Annual Medicine Chest Fund Raising Drive. Medicine Chest is a fund used to purchase medications, dental supplies, hearing aids, lenses, and frames for Saint Vincent Clinic patients.

If you are interested in invitations to the Charity Ball, please contact Narda McClendon at (913) 651-8860 between 8:30 a.m. and 4:00 p.m. weekdays. A donation of $25.00 is requested.

Saint Patrick's Day Parade on Schedule

The St. Patrick's Day Parade Committee is making final preparations for the annual St. Patrick's Day Parade March 17. Saint Vincent Clinic will be the recipient of any funds above the costs incurred by the Parade Committee. Twenty entries are scheduled and the parade will begin at 12 noon. Ed Larkin will be the Grand Marshall. The Immaculata High School Marching Band will perform and it is hoped the Fort Riley Marching Band will be a part of the parade.

Other activities of the day include the St. Patrick's Day Mass at Immaculate Conception-St. Joseph Church at 9:00 a.m.. Senator Edward F. Reilly, Jr. is the featured soloist and three priests native to Ireland, Fathers Tim Bourke, Daniel O'Shea, and Michael Moore will conduct the service. A drawing will be held after the parade. Prizes include a trip for two to Las Vegas, a $100 Savings Bond, and a $50 gift certificate for Waymire's IGA. For more information contact Tim Scanlon at 1428 Olive, Leav. KS. 66048 (913) 682-2566. Thanks to the parade committee for their support!

Patients Appreciate Help

We recieved these letters from patients and we would like to share them with our readers:

Happy Holidays:

I praise the good Lord we have St. Vincent Clinic for all us people who really need you. That is one more blessing we have recieved this year.

and

Dear Ms. Johnson:

I would like to thank you for getting me an appointment to have my eyes examined. I will be getting my glasses in two weeks. I really appreciate what you have done for me.

(A 17 year old student)

Every Little Bit Helps

The First Annual Medicine Chest Fund Raising Drive, initiated by the Charity Ball, will be underway throughout March. We are asking Leavenworth churches to consider Saint Vincent Clinic for a place in their annual budgets or to allow Medicine Chest envelopes to be distributed to their congregations during Lent.

For Medicine Chest, every little bit helps. Funds from this drive are used for medications, laboratory supplies, glasses and lenses, dentures and dental supplies, hearing aids, and x-ray procedures. Saint Vincent Clinic estimates over $25,000 of its budget will go for these costs per year. If any group or individual would like to distribute envelopes, please call Narda McClendon at (913) 651-8860.

-- --

Name of Donor ______________________ Phone ______

Address ______________________________

City ________________ State ________ Zip ______

Amount of Contribution ____________

Please make checks payable to: **Saint Vincent Clinic**
422 Walnut - Suite C
Leavenworth, Kansas 66048

(Contributions are tax deductible)

MEDICINE CHEST

MEDICINE CHEST is a special fund used to purchase medications, dental supplies, hearing aids, lenses and frames for persons with limited financial means. Saint Vincent Clinic provides health care for the medically poor - those families on limited incomes and without insurance benefits.

Your contribution is greatly appreciated.

Sincerely,
Sister Anna Totta
Clinic Director
Saint Vincent Clinic

Area Legislators Meet with Clinic Staff

Representatives Martha Jenkins and Clyde Graeber, and Senator Edward F. Reilly, Jr. met with the Saint Vincent Clinic staff to talk about health care for the poor December 16. Discussion focused on the 3.8% budget cuts, at that time proposed, focusing on reductions of health care for poor adults. These cuts will add to the thousands of Kansans who are medically indigent. Saint Vincent Clinic patients also spoke at the meeting about the circumstances which left them without resources to pay for health care needs.

The legistlators encouraged the clinic staff to participate in education of the state legislators. Many of the state's law makers are not aware there are over 500,000 persons in Kansas without access to health care.

The staff also attended an open meeting with Senator Bob Dole's field representative at the county courthouse on December 18.

Donors Praise Saint Vincent Clinic

Two donors sent us these two letters with contributions:

Dear Anna,

Since I don't have a car anymore I have loose money. This is the amount I usually spend for gasoline. Bus fare is only $.50 round trip. Keep the faith.

and

Dear Friends,

The quote on your card from James Russell Lowell has been a favorite of mine since I was a freshman back in 1936. I never forgot it. I have quoted it throughout the years and as I recall the last was, "Who gives himself with his alms, feeds three, himself, his hungering neighbor, and me." I have taken a close-up of the quote and all seven of our children will find a copy in the albums I am making them.

I'm glad my husband can contribute a little to the needy. It's so little. May God bless each of you so you can continue to do His work.

A Friendly Letter

Father John Stitz's Christmas letter to his friends every year suggests that their gift to him be a donation to a needy charity. This year Saint Vincent Clinic was the honored recipient. Father John sent the clinic a check for $2,050. What a Christmas gift!

We at Saint Vincent Clinic suggest that for the "person who has everything" a Christmas or birthday letter such as this may bring great returns not only to them, but to others as well.

Leavenworth Dentists Reaffirm Their Support

The Leavenworth Dental Society participating dentists reaffirmed their support of the Saint Vincent Clinic dental care at the February 4th meeting. They agreed to continue to see patients referred by the clinic on a rotation basis.

Health Club Fund Raising a Success

Forty-eight individuals, businesses, and organizations joined the Saint Vincent Clinic Health Club membership. Over $11,000 was raised for the operational costs of the clinic. We would like to thank club members for their support and contributions.

Saint Vincent Clinic
P.O. Box 2426
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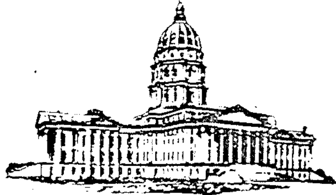

TOPEKA

COMMITTEE ASSIGNMENTS
RANKING MINORITY MEMBER: PUBLIC HEALTH AND WELFARE.
MEMBER: EDUCATION
TAXATION

HOUSE OF
REPRESENTATIVES

March 18, 1987

MEMORANDUM

TO: The Honorable Roy Ehrlich, Chairman
and Members
Senate Committee on Public Health and Welfare

FROM: Representative Jessie Branson Jessie

RE: Support of HB 2014

Thank you very much, Senator Ehrlich and Committee Members, for allowing me to make some comments in support of HB 2014.

After hearing considerable testimony on proposals concerning medical indigence and homelessness during the 1986 interim, the Special Committee on Public Health and Welfare did not question that these are severe and fast-growing problems in Kansas. But, rather, the committee felt at a loss in how to determine, in the short time available to us, what solutions to recommend or what might work best in our state.

Also, being aware of limited resources, the committee felt that little could be accomplished with any recommendations in the '87 Session. But at the same time, could we turn our backs, allowing some of our fine hospitals such as Bethany in Kansas City, Kansas, and others in the state to suffer or even go under? Should we continue to allow more and more children and working poor people to be without health care? Should we ignore the fast-growing number of farmers and others who have no health insurance coverage? Again, in view of limited funding possibilities, should certain populations, such as children be targeted? Should we focus on preventive measures or only provide for some acute or catastrophic care?

SPH&W
attachment 5
3-18-87

After grappling with these difficult questions, the Special Committee finally decided to recommend the establishment of a commission, as a number of other states have done, in order to determine how to address the medical indigency crisis. Expertise could be recruited to assist in determining what has been successful in other states and what might work for Kansas.

* * * * * * * * *

I would like to emphasize the following points:

--I would urge that the membership of the commission as provided in HB 2014 be retained. The proposed commission is designed after the SRS Review Commission which functioned during the years 1979 thru 1981. The presence of legislative members has proved to be effective, providing more legislative input and knowledge for any recommendations that come back to the Legislature. Also, keeping the membership at nine members would afford a more workable group.

--The Senate Subcommittee on Ways and Means, in their recent report on the FY'88 SRS budget, cited the problem of medical indigence and the fact that the state has no program to address this void.

--I believe that the fiscal note which accompanies this bill is excessive. As mentioned above, the commission proposed by HB 2014 is designed after the SRS Review Commission. <u>Actual total costs</u> of the SRS Review Commission <u>for a three year period</u> were only $36,000, rather than $30,000 for a single year as suggested by the fiscal note for HB 2014.

Thank you for your courtesy, Mr. Chairman and Committee Members. I urge you to pass HB 2014 favorably.

THE LAWRENCE DAILY
JOURNAL-WORLD

Friday
March 13, 1987
Lawrence, Kansas
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Hospital budgets feel the sting of caring for needy

By SANDY JOHNSON
Associated Press Writer

WASHINGTON (AP) — Big-city public hospitals and isolated rural hospitals say they bear a disproportionate share of caring for the poor, a financial burden that has grown to an estimated $7.4 billion a year.

Hospital officials urged Congress on Thursday to help underwrite the costs of caring for the 35 million Americans who are uninsured or underinsured and don't qualify for Medicare and Medicare.

"Unless new sources and methods of financing care for the indigent can be found, many public hospitals will be forced to close," said Ann Brown, administrator of the 30-bed Jefferson County Hospital in Fayette, Miss. Her hospital saw its uncollectible debts and charity cases soar 200 percent between 1981 and 1986.

AT THE PUBLIC Truman Medical Center in Kansas City, Mo., admissions have increased 28 percent over five years while other area hospitals lost patients.

"We're a fine hospital, but that's not what's causing this flood of patients," executive director James Mongan said. "It's the increased number of people without adequate coverage, and it's put a staggering burden on our facility."

(At Lawrence Memorial Hospital, officials have report a continuing rise in charity cases, along with less reimbursement for services provided to Medicare and Medicaid patients.

For example, LMH wrote off $466,000 last year on Medicare patients. The sum represented the difference between the hospital's charges and Medicare reimbursement. Another $288,000 was written off for Medicaid patients.

Bad debts cost LMH another $450,000. And the hospital provided $374,000 in charity care. Overall, however, the non-profit hospital reported it came out ahead on its finances for the year.)

THE AMERICAN Hospital Assn. said bad debts and charity costs have doubled from $3.5 billion in 1980 to $7.4 billion in 1985. In theory, bad debts are those which a patient could have paid but did not, while charity care is that provided by a hospital which decides the patient cannot afford to pay.

AHA spokesman Jack Owen said the distinction blurs because both categories involve people with very limited resources.

The association said Medicaid coverage of the poor has shrunk from 65 percent of costs to 38 percent in the last decade while at the same time the number of people below poverty has increased, creating a double whammy for hospitals.

"Large cutbacks in Medicaid under the Reagan administration have forced many states to reduce the number of poor covered, thus further exacerbating the problem of uncompensated care," said Rep. Fortney "Pete" Stark, D-Calif., chairman of the House Ways and Means subcommittee on health.

Witnesses also warned against a developing two-tier system.

'Access charge' on telephone bills may rise to $3.50

By MARTIN TOLCHIN
N.Y. Times News Service

WASHINGTON — In a careful compromise, a Federal Communications Commission board Thursday recommended a $1.50 in-

chairman, said in an interview after the meeting. "Additional increases beyond these will not be necessary."

Essentially the government is shifting costs to local telephone customers on the theory that long-

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

TESTIMONY ON H.B. 2014

PRESENTED TO SENATE PUBLIC HEALTH AND WELFARE COMMITTEE ON MARCH 18, 1987

This is the official position taken by the Kansas Department of Health and Environment on H.B. 2014.

BACKGROUND INFORMATION:

In July 1986, the Statewide Health Coordinating Council (SHCC) completed a study, entitled "The Medical Indigency Crisis in Kansas," which estimates that approximately 581,000 individuals in Kansas are unable to pay for health care. The medically indigent are not the very poor who are eligible for Medicaid or Medikan. Most of the medically indigent are employed, in full or part-time jobs that offer no health insurance coverage. Others are unemployed and therefore uninsured, or have chronic health conditions that prevent them from acquiring health insurance. SHCC and the Department of Health and Environment (KDHE) identified the homeless as one group at particularly high risk of being medically indigent. Other groups include low income women and children, displaced farmers, black Kansans, and migrant workers.

The SHCC study, as well as the indigency studies by the Kansas Hospital Association and the Special Interim Committee on Public Health and Welfare all concluded that the growing magnitude of medical indigency in Kansas calls for a well documented, well researched response by the State of Kansas. The consequences of not addressing this issue will be severe, not only in terms of human suffering, but in terms of dollars spent in hospital emergency rooms, for example, for services which could be more efficiently provided in other settings, or for neonatal intensive care to treat conditions which could be prevented with adequate primary care. In the long-term, a savings will be recognized through the availability of well-organized preventive services. But the provision of these and other services necessary to care for the indigent and homeless will obviously require a financial commitment.

STRENGTHS:

The greatest benefit of the Commission that would be established by this bill, especially during a time of fiscal constraint, is its potential to research and design the most efficient, cost-effective method of addressing the medical indigency crisis in Kansas. Kansas has the advantage of being able to learn from the successes and failures of other states that have already implemented medical indigency programs, and to utilize those approaches that are the best for all Kansans.

DEPARTMENT'S POSITION:

In conclusion, the Kansas Department of Health and Environment supports the provisions of House Bill 2014.

Presented for: Jack D. Walker, M.D., Secretary
Kansas Department of Health and Environment

HP/X13

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3-18-87
attachment 6

Donald A. Wilson
President

HOUSE BILL 2014

I. KHA supports H.B. 2014

II. Kansas hospitals provided $75 million in uncompensated care during 1984, an amount equal to the payments received through the Medicaid program. This represents an increase of 30 percent in two years. During this same timeframe, the average Kansas hospital's revenues have actually decreased.

III. While medical indigence is more difficult to measure, several studies document estimates:

--the SHCC has estimated that 580,000 Kansans from a wide variety of population groups are at risk;

--the American Hospital Association estimates that 37 million people nationally are without health insurance. If Kansas represents approximately 1 percent of the nation's population, we could say that approximately 370,000 Kansans are uninsured; and

--a recent KHA-sponsored Public Opinion Poll in Kansas indicated that 14 percent of households were uninsured, or approximately 333,000 Kansans. Another 16 percent of the households were only partially insured, a minimum of 147,000 additional people...totaling around 480,000.

No one is exactly sure of the number of Kansans at risk of being medically indigent, but an educated guess tells us that between 15 and 20 percent of our population could be included.

IV. One-half of the uninsured are working adults or dependents of working adults and one-third live in households earning in excess of 200 percent of the poverty level. On the other hand, only 211,000 of the approximately 500,000 Kansans living in households earning less than $10,000 a year are eligible for Medicaid.

V. Within the broad issue of indigent/uncompensated care, we feel there are two areas which need study: public program coverage of health care for the poor, and private insurance coverage for the large number of currently uninsured working adults.

VI. According to the Public Opinion Poll mentioned before, Kansans believe that people should be responsible for their own health care when they can afford it. If they cannot afford it, government has a responsibility to finance their care. The bottom line, however, is that no one should be denied access to health care.

SPH&W
3-18-87
attachment 7

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VII. Technical Advisory Group. Since this is such a complex issue, which will require a great deal of technical expertise, we would like to suggest that the Commission be encouraged to appoint a Technical Advisory Group to work with them as they seek solutions to fit Kansans' needs.

VIII. This is a complex issue which cannot be solved overnight. While we are disappointed that the interim study did not result in more substantive recommendations, we recognize that the complexity requires a concentrated effort. Therefore, we wholeheartedly support the creation of a commission.

TESTIMONY ON HB 2014
TO
SENATE PUBLIC HEALTH AND WELFARE
BY
KANSAS DEPARTMENT ON AGING
MARCH 18, 1987

Bill Summary:

Act would create a commission on access to services for the medically indigent and the homeless.

Bill Brief:

1) Commission would consist of nine members -- three from the general public and six legislators.

2) Commission would study and review access to services for the medically indigent and the homeless.

3) Commission would submit an annual report of findings and recommendations to the Governor and Legislature by December 15 of each year.

4) Commission would be staffed by Revisor of Statutes, Legislative Research, Legislative Administrative Services and Legislative Division of Post Audit personnel as required.

5) Commission's powers and duties would expire December 31, 1989.

Bill Testimony:

In August 1986, the Kansas Department on Aging testified before the Special Committee on Public Health and Welfare during the hearings held on Proposal No. 24 -- Access to Health Care for the Medically Indigent. Individuals representing 25 other agencies/organizations also testified on the Proposal. There was unanimous agreement that medical indigency was a problem the State needed to address.

Kansas is not alone in addressing this issue. In a survey conducted in September 1986, program officials, legislators and their staffs in 43 of the 49 states responding placed indigent care highest on their list of priorities. As you are aware, this issue is also receiving national attention. Last September, the Department submitted testimony to the U.S. House Select Committee on Aging for the hearing "The Catastrophe of Uninsured and Underinsured Americans."

The problem is indeed real. Since 1979, there has been a 20 percent increase in the number of Americans under age 65 who lack health insurance. In 1983, there were 3 million people age 55 to 64 without health insurance. Persons aged 55 to 64 are at the greatest risk of any age group of having inadequate coverage. This subgroup is 2 to 4 times more likely to have a chronic illness and they are 4 times as likely to be hospitalized.

SPH&W
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attachment 8

In 1983, nearly 400,000 Americans over the age of 65 were without insurance of any kind. The common perception that the elderly are taken care of by Medicare and Medicaid is not founded.

Older persons are uninsured for a variety of reasons -- they may be unemployed (and once unemployed they remain out of work longer than younger workers, increasing the risk of no health coverage); they may have retired early and are not eligible for health insurance; they may be working but do not receive insurance as a benefit of their employment (either because their jobs are low paying, part-time, with small firms, or in service industries or agriculture, so insurance is not offered); they may be widowed or divorced and no longer covered under their spouse's insurance; they may have one of the high-risk conditions that insurance companies do not cover; or they may be poor.

To personalize the issue of medical indigence, I cite examples from the files of the State Long Term Care Ombudsman.

Case No. 51 & 52 A woman who was a resident in a nursing home received medications which were not covered by Medicaid. As she was very ill at the time, she was not aware of this. Having now returned home, she must make payments to the pharmacy from an income that is very limited. There is concern that her emotional state combined with her physical condition may cause her to be re-admitted.

Case No. 644 An adult care home resident has no spend-down because he has no Social Security or other pension benefits. He is totally dependent on Medicaid. He requires special medications which are not covered by Medicaid's pharmacy program. It is not known at this time how his needs will be met. The nursing home staff is required to administer the medications ordered by his physician, yet there is no way to pay for them.

Kansas has many people who are in situations similar to the cases cited here. The Kansas Department on Aging is especially concerned for the welfare of Older Kansans who are medically indigent. Their needs must be addressed.

Recommended Action:

The Kansas Department on Aging supports HB 2014 and encourages this Committee's favorable passage of it. The State must examine the issues surrounding the medically indigent and the homeless. The Department stands ready to provide the Commission on Access to Services with any information necessary to address its tasks.

SW:mj
3/17/87

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Testimony in Support of H.B. 2014

I am appearing today in support of the proposed legislation contained within House Bill No. 2014.

The bill establishes a commission to study and review the issue of access to services for the medically indigent and the homeless. The commission is to report its findings and recommendations over the next two years for helping resolve that issue.

The Department strongly endorses this initiative as a means to begin addressing the problems of the medically indigent and homeless in this State. We believe there is a problem of growing magnitude in meeting the needs of these two groups and reported on the extent of the problem last summer and fall to the Special Committee on Public Health and Welfare.

To briefly highlight our findings concerning the medically indigent, we have defined the term "medically indigent" to include those individuals who do not qualify for the State's medical assistance (MA) programs because of either financial or nonfinancial reasons and individuals who qualify for medial assistance but have medical needs which are not fully covered based on the scope of services offered in the MA programs as well as co-payment requirements. We have noted that the Department provides medical coverage to most of the groups which can be covered in accordance with federal Medicaid law. This includes families with dependent children and persons who are aged, blind, or disabled. For those who do not qualify under the Medicaid categories (primarily, single adults and childless couples), the State has provided MediKan coverage. However, only individuals who are eligible for a cash benefit under the General Assistance Unrestricted (GAU) or General Assistance Reintegration (GAR) programs can receive this coverage. If the person has too much income or resources, he or she will be ineligible for cash and, therefore, medical benefits.

We have also noted a number of significant changes on both the federal and state level which have eliminated access to medical services from either an eligibility or service-related perspective. These included:

1. Elimination of the State funded GA medically needy program in July 1981. This program provided medical coverage based on the spenddown concept utilized in the federal Medicaid programs to persons who did not qualify for a GA cash benefit because of excess income. At the time of the program's termination over 2,000 persons were involved in the program.

2. Implementation of restrictive changes in the ADC program resulting from the federal Omnibus Budget Reconciliation Act (OBRA) of 1981. These changes eliminated cash and medical eligibility for over 10,000 recipients.

3. Creation of the GAU and TGA cash programs in April 1983. This resulted in a loss of eligibility for approximately 2,000 persons due to the lower TGA standards.

SPH&W
3-18-87
attachment 9

4. Cutback in covered medical services for the adult population in all programs over the past several years including elimination of elective surgery, limits in drug coverage, and limits in vision services.

In addition to the above changes, the Department has recently had to make further cuts due to the State's budget crisis including total elimination of medical assistance for TGA recipients, limiting the TGA program to 1 month of cash assistance in a fiscal year, further reducing MediKan coverage for adults in the GAU and GAR programs to allow for only $225 per person of inpatient hospital services in a fiscal year and 8 physician office visits in a calendar year, and elimination of dental coverage for adults in all programs.

All of these changes have exacerbated the growing problem of persons who are unable to afford basic as well as catastrophic medical care.

The growing homeless population has also generated widespread concern and attention. Because of the diversity between definitions of homelessness, there are no firm statistics to illustrate the extent of the problem. Although single males are traditionally thought of when the word homeless is mentioned, women and children are being found more frequently in emergency shelters and soup lines. It is anticipated that recent elimination of monthly TGA benefits (which averaged $100) will create an increase in the Kansas homeless population.

The Department of Housing and Urban Development has provided funds allowing SRS to administer a limited housing assistance program for homeless in Greater Kansas City. The pilot project is the only Section 8 program in the nation specifically designed for homeless. Under the program, the household is responsible for 30% of their adjusted income as rent payment, and the Homeless Program pays the landlord for the difference. Monthly housing assistance fluctuates according to changes in the household income. Since the experimental program began one year ago, HUD has increased the allocation three times, allowing for a total of 134 homeless households to be housed and to receive ongoing monthly rental assistance. According to HUD, the homeless need in Kansas City alone far exceeds their ability to fund this type of assistance.

Other SRS assistance programs are available to homeless according to the same eligibility requirements applied to persons with homes. Furthermore, the Department has recently established special procedures to assure that homelessness does not prevent access to assistance.

In summary, the Department supports H.B. 2014 as a means toward resolving the problems of the medically indigent and homeless in Kansas.

Carla Nakata, Director
Income Maintenance for
Robert C. Harder
Secretary
Social and Rehabilitation Services
913-296-3271

March 18, 1987

1986-1987
KANSAS STATE LEGISLATIVE COMMITTEE

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H.B. 2014

ACCESS TO HEALTH CARE FOR THE MEDICALLY INDIGENT AND THE UNINSURED

TESTIMONY BEFORE THE SENATE COMMITTEE ON PUBLIC HEALTH & WELFARE

Mr. Chairman; members of the Committee:

You are to be commended on your decision to study all avenues on how to provide medical care for the medically indigent and the uninsured. The State Legislative Committee of the American Association of Retired Persons in Kansas is in total agreement.

The Association, at both the Federal and State levels, is concerned about the ill, frightened, medically indigent, and the effects of uncompensated care on the health care system.

Physicians, hospitals, and other providers do turn away those who cannot pay, even during emergencies. Many states have hospitals that routinely dump emergency patients on public facilities without first stabilizing them. People have died, or been seriously injured because of such practices.

Kansas has specific high risk populations that are either medically indigent or at risk of impoverishment:

1. Older Adults between the ages of 60 to 64 who are not employed, cannot afford to purchase adequate coverage and are ineligible for Medicare;

2. The Homeless in which an increasing number appear to be women and children, young people, and mentally ill persons;

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3. Mid-Life Women between the ages of 45 to 65 in which many are either not in the work force, are in low paying jobs, or have had a change in marital status, find cost to be the main deterrent in purchasing adequate health insurance;

4. Minorities, Migrant and Seasonal Farm Workers that do not have the financial resources to pay for adequate health care, and suffer from a number of health problems far exceeding the general population;

and

5. Displaced Farmers who have experienced farm losses due to declining farm economy, and cannot afford to maintain medical insurance, and do not qualify for public assistance.

Health care providers who deliver much of the free care to persons without adequate financing, are at a great disadvantage in an increasingly competitive health-care marketplace.

The medically indigent, and the uninsured are in a giant lottery, gambling they'll stay well. What's unfair, is that most do not have a real choice about playing; moreover, the stakes if they lose are precariously high, because many will be pushed into official poverty if accident or ill ness of any magnitude occurs.

These problems point out that the health care system is not functioning for vulnerable portions of our population. Access to care and the support of public hospitals are the major issues that the State and Federal governments must deal with.

AARP has always supported governmental efforts to deal with the health care financing problems of vulnerable groups.

We were and are active in advocating for Medicare, Medicaid, and State programs to provide what support there is for the aged and the poor.

Unfortunately, these programs, which were never adequate, have eroded over time. Medicare now pays only 45% of the elderly's health care bill, and Medicaid serves less than half of the poor population. The question is, "What can the states do to deal with these problems, particularly those of the indigent, and the uninsured poor?"

If a program for the medically indigent is to be established in KANSAS, public policymakers must consider the types of taxes that would be used to support additional expenditures.

KANSAS should study innovative financing programs. Ten states have adopted legislation requiring health insurance companies to form a pool, through which high risk persons can obtain health insurance. In addition, the STATE should investigate the best method of encouraging small employers to band together, and purchase insurance at low group rates, or provide tax credits for small employers who often do not offer coverage because of high premiums.

Doctors and other practitioners ever more readily, though still reluctantly, acknowledge there is a two-class system of health care delivery. Unfortunately, the longer the bloc of the medically indigent is permitted to grow, the more final is the fact that duality is here to stay.

AARP believes that consideration of H.B. 2014 is one way to address a very serious problem in Kansas. The medically indigent and the uninsured problem is growing at a alarming rate in Kansas.

KANSAS and the NATION must ensure that persons of all ages have access to good quality care.

The Kansas State Legislative Committee of the American Association of Retired Persons in Kansas thanks the committee for this opportunity to testify.

Jim Behan, Chairman
Kansas AARP SLC

KANSAS' OLDER CITIZENS

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Many older people are eager to participate in all facets of political life. Quite often, older persons are involved in registering voters, assisting voters in traveling to the polls, and actually conducting poll operations on election day. They believe in the Eisenhower adage, "Politics should be the part-time profession of every citizen."

With increased longevity for the elderly of our nation, the older population of Kansas is expected to continue to grow steadily. During the years 1980-1984, the population aged 60+ realized a 5.8 percent increase. The latest census data indicate that this same age group (60+) constitutes 17.9 percent of our state's total population.

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OF OUR KANSAS MEMBERSHIP FOR 1987

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- Enact "Division of Assets" legislation.
- Expand and coordinate community in-home services offering quality alternatives. Control and expand health care services for low income Kansans.
- Equalizing adult care home rates charged to private pay and public assistance residents.
- Exempt Social Security benefits from state income tax and protect the purchasing power of retirement income.
- Legislation establishing legal representatives for consumers in the utility rate hearing process.

SUPPORT ITEMS

- Legislation or regulations to enhance the quality of nursing home care.
- Support improved retirement benefits for retired teachers and state employees.
- Support efforts to meet health care needs for the uninsured and underinsured.
- Establish regulations and statutes governing and promoting the sale of long-term care insurance.
- Legislative and regulatory actions to restrain health care costs and enhance the quality of health care.

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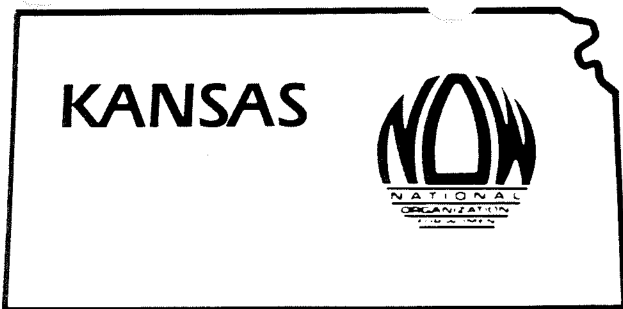
KANSAS FACTS FOR YOU TO REMEMBER

1987

KANSAS STATE LEGISLATIVE COMMITTEE
AMERICAN ASSOCIATION OF RETIRED PERSONS



Wednesday March 18, 1987
Testimony on HB2014

Mr. Chairman, members of the Committee, thank you for the opportunity to appear before you today. I am Gail Hamilton, Kansas National Organization for Women. On behalf of the members of KNOW, I ask that you support HB 2014. This bill would create a commission on access to services for the medically indigent and the homeless.

As reported in the interim study an ever increasing number of people in Kansas lack access to health care services, to affordable housing, to jobs, to childcare and to other opportunities that might improve the situation in which they find themselves. The interim study identified that we do have a problem of medically indigent and homeless in our state. The Committee also gained information about what state agencies and private organizations are currently doing to help alleviate these problems. They became aware of programs that are currently in place, as well as, identified key individuals as resources for helping to fulfill the responsibilities of the commission as outlined in the bill. Let's not waste the progress that has been made. The information generated from this study needs to be utilized now to solve the problems identified. This is the first reason we urge you to support HB2014.

I recognize that many subpopulations were identified in both the study of homeless and medically indigent; however there are four groups identified throughout both reports that are of particular concern to KNOW. Those subpopulations include women between the ages of 45 and 65 who are not in the workforce, are in low-paying employment, are widowed or divorced, do not qualify for Medicare and who for all those reasons find cost a major deterrent to the purchase of adequate health insurance.

Pregnant teenagers and other poor pregnant women are two more groups at a high-risk. Infant mortality and the risk of low birth-weight doubles where care is lacking. Comprehensive prenatal and infant care is much less costly than the neonatal care for a low birth weight baby. Our state's participation in two new Federal Medicaid options to increase access and eligibility for pregnant women and children could be supported

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by this commission as an immediate priority.

Statistics from both Johnson and Wyandotte Counties found the homeless served to be 50percent two-parent families with minor children and 30 percent single-parent (usually female) families with minor children. Further quoting the study, "For some two-parent families and certainly for most single-parent families among the homeless, the cost of child care can and does extend the period of homelessness because the parent is prevented from even seeking employment. In thse cases where employment is found, jobs acquired by the homeless tend to pay at the minimum wage level and, thus, provide insufficient income to afford most available day care services." In five years, publicly funded daycare slots in Kansas have declined 45%. The availability of affordable day care must also be a priority for this group of people.

In closing, I once again ask that you pass HB2014 favorably. Policy makers, the public and providers do not want to deal with the results of failing to cope with these problems now. Thank you.

POSITION PAPER

THE UNINSURED AND THE UNDERINSURED

American Association
of Retired Persons

by:
Oscar M. Haugh
Secretary
Kansas State
Legislative Committee

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THE UNINSURED AND THE UNDERINSURED

I. EXPLANATION AND PRESENT STATUS

The concept for health care of "equality of access for all" is a relatively recent concept. The following illustrates this point:

1. The Hospital Survey and Construction Act, known as the Hill-Burton program, was started in 1946. It requires hospitals who have received funds for construction or renovation through this program, to provide certain types of charity care.

2. H.A.R. 28-34-1(7)(h) states in its definition of a hospital as a requirement for state licensing, that emergency room services are a basic function of a hospital and must be provided.

3. In 1965, Medicare was introduced to provide health care for those over 65 and Medicaid to provide health care for the indigent. Both programs are subject to specific limitations so they are not total care programs.

The Kansas Department of Health and Environment has estimated that, according to the 1985 census, the total number of uninsured and underinsured in Kansas is 581,000. (July 1986 report, Medical Indigency, Statewide Health and Coordinating Council and the Office of Health and Environmental Planning of the Kansas Department of Health and Environment, page 1.) This report divides this 581,000 total into three sub-groups as follows:

1. The Short Term Unemployed. It was estimated that in 1983, 72,000 Kansans lost employment-based health insurance coverage. Many of these could not carry individual health insurance policies as substitutes for the group benefits lost through unemployment.

2. The Medically Uninsurable. It is estimated that in 1983 there were 11,000 individuals who were unable to obtain private health insurance coverage because of poor health, previous medical history, or employment in a hazardous occupation.

3. The Premium Indigent. This group of 500,000 individuals includes many who are self-employed, part-time employees in firms without health insurance, and families who have no active member in the labor force.

II. POPULATION AFFECTED

The July 1986 report, Medical Indigency, (page 4) lists six specific high risk groups as follows:

1. Older Adults. A study, commissioned by the Kansas Department of Aging in 1979-80, reported that 4% (16,491 persons) of all Kansans who are 60 or older are not covered by Medicare, Medicaid, or private health insurance. The greatest group is the 11,663 persons in the 60-64 age group who have no health insurance.

2. Mid-Life Women. These are women between the ages of 45 and 65, who are not in the work force, work part-time in jobs offering no health benefits, widows who may not have known of their conversion rights, and divorcees who may not have received medical insurance as part of the their divorce settlement.

3. Blacks. Blacks represent only 5% of the Kansas population but they constitute nearly 25% of those eligible for medical assistance. The National Medical Care Expenditures Survey (NMCES) in 1977 reported that Blacks are less likely to be insured than Whites, and both Blacks and Hispanics are more likely to be insured only part of the years than Whites.

4. Migrants and Seasonal Farmworkers. The Kansas Advisory Committee on Mexican Affairs in a 1986 report, estimated that there are between 5,000 and 8,000 migrants in Kansas who are in need of health care and the majority are not covered by Medicaid or private health insurance.

5. The Homeless Population. While no one knows how many homeless people there are in Kansas, if one extrapolates the number reported in nationwide estimates of the Department of Housing and Urban Development, the totals would range from a low 2,600 to 3,700.

6. The Farming Community. The deterioration of the financial status of farmers over the past four years has forced many farmers to forego such necessities as medical insurance for their families, according to the FACTS program of the Kansas State Board of Agriculture in Manhattan (1986 report).

Medicare and Medicaid are the principal programs providing support for the aged and the poor, but they pay less than half of the costs. Hospitals, who deliver much of the free care in Kansas for those without adequate finances, must raise their prices for paying patients to cover the cost of charity cases, and, then these hospitals lose out when group purchasers seek hospitals with the lowest costs. It is clear that our present health care system is not functioning as it should.

III. INTENDED EFFECTS OF REMEDIAL LEGISLATION

In Uncompensated Health Care - Rights and Responsibilities (1986), two experts in the area of medical care for the poor, Wilenski (pp. 149-166) and Meyer (pp. 167-184) have outlined a number of suggestions to address the above problems. Included are the following:

1. All-Payer Rate Setting. Here an allowance is included for charity and bad debt patients in each payment made to hospitals. States that have regulations for a plan of this type are Massachusetts, Maryland, New York, and New Jersey.

2. A Common Pool of Revenues. In Florida, a pool is financed by hospitals, counties, and the state. Hospitals are taxed a percentage of their net patient revenue, counties pay on a per capita rate based on their ability to pay, and the state matches county contributions at a specific rate.

3. A Catastrophic Illness Program. In this program, individuals are protected from financial ruin due to large medical expenses. Co-insurance would be paid by individuals based on their ability to pay, and the state would be a payer of last resort. Such a program exists in Alaska, Maine, and Rhode Island.

4. Risk Sharing Pools. Insurance companies are required to provide insurance to high-risk individuals on a sharing basis. Such plans exist in Connecticut, Minnesota, Wisconsin, Indiana, North Dakota, and Florida.

5. Insurance for Some or All of the Indigent. This would be an extension of the Medicaid program. State dollars would be used to leverage additional federal dollars for the state. Florida has provided such a program for the medically needy.

6. A Voucher System. The indigent would have the opportunity to purchase a health care plan among several offered, using a specific amount of funds provided by the government or by employers.

IV. ESTIMATED COSTS AND SUGGESTIONS FOR MEETING THEM

No estimate could be placed upon the costs of remedial legislation to protect the uninsured and the underinsured until a plan of action has been formulated. Costs would depend upon which of the plans outlined above, or some others, would be chosen to best meet the needs of the people of the state.

Various financial methods might be used to raise the money that would be required. Among those that might be considered are the following:

1. Direct Appropriation of State Funds. Colorado uses this method with a line-item appropriation method of funding for the state program for medical indigents.

2. Earmarking State Lottery Funds. Pennsylvania earmarks funds for senior citizens, and Michigan, New Hampshire, and Ohio do likewise, for education.

3. Increasing State Taxes on Items Such as Alcohol and Tobacco. Since 1939, Ohio has earmarked highway user taxes to finance care of the medically indigent.

4. The Income Tax Form Check-off Box. Here, individuals would be able to contribute to an uncompensated care fund by checking a box on the state income tax return. A bill in the Massachusetts legislature has been introduced which would use the tax check-off box as a method for paying for the care of the uninsured and the victims of catastrophic illness.

5. A Hospital Revenue Pool. A tax is levied on the revenues of some or all hospitals to develop the revenue pool. Florida and New York have a plan of this type.

6. <u>Tax on Health Insurance Premiums.</u> New Jersey is currently considering a surcharge on health insurance premiums to be used to finance care for children with catastrophic illnesses.

7. <u>Tax Deductible Trust Fund.</u> Such a fund would be provided for those of the public who wish to contribute with the contributions being tax deductible. Children's trust funds of this type have been set up in Alabama, California, and Illinois.

8. <u>Tax on All Health Services.</u> Here, all health care users would support the cost of care for those who cannot afford to pay. No state has yet adopted such a plan.

V. RECOMMENDATIONS

Obviously, a plan as complex as that of proper health care for all the people of Kansas can not be developed in a short period of time. An interim study would need to be formed, consisting of members of the Public Health and Welfare Committees of both the House and the Senate, as well as representatives from the Office of the State Commissioner of Insurance, the State Hospital Association, and those state agencies whose work relates to the uninsured and the underinsured. This Committee should begin by listing all of the specific items that need to be addressed, in order to cover all phases of the health program to care for all Kansans. These will next need to be placed in an order of three-tier priority as follows:

1. <u>Immediate Legislation.</u> These are the urgent items that need to be addressed at once and which can be accomplished by legislation in the present session of the legislature.

2. <u>Short-term Legislation.</u> These are the items which will require some additional study and analysis to develop suitable remedial legislation. These items should be ready for introduction in the next legislative session.

3. <u>Long-term Legislation.</u> These are items which, because of their complexity, will take more time for study and the formulation of appropriate remedial legislation. These items should be ready for introduction within the next two-year period. Some of the items addressed in Immediate and Short-term Legislation may need to be reviewed and amendments may be needed to improve them.

This Committee will obviously have to be a "Blue Ribbon" Committee, consisting of members who are interested, dedicated, and willing to serve for a considerable period of time. Extensive service will be one of the Committee's strengths because with each passing year, members will gain additional expertise and knowledge of this difficult problem of proper health care and coverage for all Kansans.

KANSAS' OLDER CITIZENS

In Kansas, 436,000 persons are over age 60. They constitute 24.4 percent of the voting-age population in our state. Because persons 60 and over register and vote in much higher proportions than any other group, older people comprise as much as 40-50 percent of the actual voters in many elections.

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KANSAS FACTS FOR YOU TO REMEMBER

1987

KANSAS STATE LEGISLATIVE COMMITTEE AMERICAN ASSOCIATION OF RETIRED PERSONS

For Re-Submittion to the Senate Public Health & Welfare Committee

Chairperson: Senator Roy Ehrlich & Members

TESTIMONY ON HB NO. 2014
by
Sister Ann Marita Loosen, SCL
President, St. Francis Hospital and Medical Center
Topeka, Kansas
Representing Catholic Health Association of Kansas
February 4, 1987

My name is Sister Ann Marita Loosen and I am President of the St. Francis Hospital and Medical Center here in Topeka. I am appearing before you today, representing the Catholic Health Association of Kansas. Our members include 18 Catholic hospitals in Kansas and 7 nursing homes, as well as Sister sponsor organizations.

We support House Bill No. 2014 to create a commission on access to services for the medically indigent and homeless. The proposed commission's responsibilities are major, and are very timely now, because there are thousands of people in Kansas who are denied access to health care today more than ever before. They include the unemployed, the uninsured, and those no longer eligible for Medicaid or Medi-Kan. The list is growing daily. We are concerned about these people. Our hospitals do not wish to deny them admission for lack of funds or insurance, but we are concerned that we may not be able to provide this care adequately in the future, unless we find support from local and state government. Because of the

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changing financial regulations we are no longer able to shift the cost for those unable to pay. In 1986 at St. Francis Hospital and Medical Center our care for the poor doubled. So far in this fiscal year we see that same pattern continuing.

Hospitals are probably the only entities where people can receive service without paying in advance. If you go to a grocery store, you need to be able to pay for groceries before leaving the store -- the same holds for clothing stores and furniture stores, yet in hospitals we have given service and are expected to give that care whether or not patients have the money or insurance to cover such care.

We understand that this is a complex subject, one which was partially studied by the special committee on Public Health and Welfare this last summer. This committee came to the same conclusion as we have, and I quote from their interim report:

> "...there is a problem which is rapidly approaching major proportions in securing access to health care for those Kansas citizens who lack private or governmental third party coverage and who also lack the personal resources to pay for all or a part of their health care..."

We agree with the committee's further conclusion that, again quote,

> "...an additional commitment must be made to the indigent...and the homeless and the medically indigent."

We support HB 2014. We believe this to be appropriate for the following reasons, and urge your favorable consideration:

1. The commission will be able to spend the required time to study this issue and report findings of use to the governor and the legislature.

2. The commission, made up of legislative as well as several public members, will provide for legislative inter-action and consultation, to help in eventual, hopeful, positive, legislative action.

Thank you for your courtesy and interest.

END

MIKE HAYDEN
Governor
JACK D. WALKER, M.D.
Secretary

STATE OF KANSAS

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DEPARTMENT OF HEALTH AND ENVIRONMENT

March 17, 1987

M E M O R A N D U M

TO Senate Public Health and Welfare Committee

FROM James R. Power, Acting Director of Environment

SUBJECT Safe Drinking Water Act Amendments of 1986

This is in response to the Committee's request for a readable copy of Section 1428.

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99TH CONGRESS
2d Session

HOUSE OF REPRESENTATIVES

REPORT
99–575

SAFE DRINKING WATER ACT AMENDMENTS OF 1986

MAY 5, 1986.—Ordered to be printed

Mr. WAXMAN, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany S. 124]

The committee of conference on the disagreeing votes of the two Houses on the amendments of the House to the bill (S. 124) entitled the "Safe Drinking Water Amendments of 1985", having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its disagreement to the amendment of the House to the text of the bill and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the House amendment insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Safe Drinking Water Act Amendments of 1986".

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Sec. 1. Short title.

TITLE I—PUBLIC WATER SYSTEMS

Sec. 101. National primary drinking water regulations.
Sec. 102. Enforcement of regulations.
Sec. 103. Public notification.
Sec. 104. Variances.
Sec. 105. Exemptions.
Sec. 106. Monitoring for unregulated contaminants.
Sec. 107. Technical assistance for small systems.
Sec. 108. Tampering with public water systems.
Sec. 109. Lead free drinking water.

TITLE II—PROTECTION OF UNDERGROUND SOURCES OF DRINKING WATER

Sec. 201. Restrictions on underground injection of hazardous waste and regulation of State programs.

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Sec. 202. Enforcement.
Sec. 203. Sole source aquifer demonstration program.
Sec. 204. Emergency powers.
Sec. 205. State programs to establish wellhead protection areas.

TITLE III—GENERAL PROVISIONS

Sec. 301. Authorization of appropriations.
Sec. 302. Indian tribes.
Sec. 303. Judicial review.
Sec. 304. Miscellaneous provisions.

TITLE I—PUBLIC WATER SYSTEMS

SEC. 101. NATIONAL PRIMARY DRINKING WATER REGULATIONS.

(a) SIMPLIFICATION OF STATUTORY SYSTEM.—Section 1412(a) of the Safe Drinking Water Act (title XIV of the Public Health Service Act; 42 U.S.C. 300f and following) is amended to read as follows:

"(a)(1) Effective on the enactment of the Safe Drinking Water Act Amendments of 1986, each national interim or revised primary drinking water regulation promulgated under this section before such enactment shall be deemed to be a national primary drinking water regulation under subsection (b). No such regulation shall be required to comply with the standards set forth in subsection (b)(4) unless such regulation is amended to establish a different maximum contaminant level after the enactment of such amendments.

"(2) After the enactment of the Safe Drinking Water Act Amendments of 1986 each recommended maximum contaminant level published before the enactment of such amendments shall be treated as a maximum contaminant level goal.

"(3) Whenever a national primary drinking water regulation is proposed under paragraph (1), (2), or (3) of subsection (b) for any contaminant, the maximum contaminant level goal for such contaminant shall be proposed simultaneously. Whenever a national primary drinking water regulation is promulgated under paragraph (1), (2), or (3) of subsection (b) for any contaminant, the maximum contaminant level goal for such contaminant shall be published simultaneously.

"(4) Paragraph (3) shall not apply to any recommended maximum contaminant level published before the enactment of the Safe Drinking Water Act Amendments of 1986.".

(b) STANDARD SETTING SCHEDULES AND DEADLINES.—Section 1412(b) of the Safe Drinking Water Act is amended by striking paragraphs (1), (2), and (3), and inserting in lieu thereof the following:

"(1) In the case of those contaminants listed in the Advance Notice of Proposed Rulemaking published in volume 47, Federal Register, page 9352, and in volume 48, Federal Register, page 45502, the Administrator shall publish maximum contaminant level goals and promulgate national primary drinking water regulations—

"(A) not later than 12 months after the enactment of the Safe Drinking Water Act Amendments of 1986 for not less than 9 of those listed contaminants;

"(B) not later than 24 months after such enactment for not less than 40 of those listed contaminants; and

"(C) not later than 36 months after such enactment for the remainder of such listed contaminants.

(1) In the first sentence of subsection (a) add the words "or an underground source of drinking water" after the words "to enter a public water system".

(2) In the last sentence of subsection (a) add "including orders requiring the provision of alternative water supplies by persons who caused or contributed to the endangerment," after the words "including travelers),".

(3) In subsection (b):

(A) Strike "willfully".

(B) Strike "fined not more than" and insert in lieu thereof "subject to a civil penalty of not to exceed".

SEC. 205. STATE PROGRAMS TO ESTABLISH WELLHEAD PROTECTION AREAS.

The Safe Drinking Water Act is amended by adding the following new section after section 1427, as added by section 203 of this Act:

"SEC. 1428. STATE PROGRAMS TO ESTABLISH WELLHEAD PROTECTION AREAS.

"(a) STATE PROGRAMS.—The Governor or Governor's designee of each State shall, within 3 years of the date of enactment of the Safe Drinking Water Act Amendments of 1986, adopt and submit to the Administrator a State program to protect wellhead areas within their jurisdiction from contaminants which may have any adverse affect on the health of persons. Each State program under this section shall, at a minimum—

"(1) specify the duties of State agencies, local governmental entities, and public water supply systems with respect to the development and implementation of programs required by this section;

"(2) for each wellhead, determine the wellhead protection area as defined in subsection (e) based on all reasonably available hydrogeologic information on ground water flow, recharge and discharge and other information the State deems necessary to adequately determine the wellhead protection area;

"(3) identify within each wellhead protection area all potential anthropogenic sources of contaminants which may have any adverse effect on the health of persons;

"(4) describe a program that contains, as appropriate, technical assistance, financial assistance, implementation of control measures, education, training, and demonstration projects to protect the water supply within wellhead protection areas from such contaminants;

"(5) include contingency plans for the location and provision of alternate drinking water supplies for each public water system in the event of well or wellfield contamination by such contaminants; and

"(6) include a requirement that consideration be given to all potential sources of such contaminants within the expected wellhead area of a new water well which serves a public water supply system.

"(b) PUBLIC PARTICIPATION.—To the maximum extent possible, each State shall establish procedures, including but not limited to the establishment of technical and citizens' advisory committees, to encourage the public to participate in developing the protection pro-

gram for wellhead areas. Such procedures shall include notice and opportunity for public hearing on the State program before it is submitted to the Administrator.

"(c) DISAPPROVAL.—

"(1) IN GENERAL.—If, in the judgment of the Administrator, a State program (or portion thereof, including the definition of a wellhead protection area), is not adequate to protect public water systems as required by this section, the Administrator shall disapprove such program (or portion thereof). A State program developed pursuant to subsection (a) shall be deemed to be adequate unless the Administrator determines, within 9 months of the receipt of a State program, that such program (or portion thereof) is inadequate for the purpose of protecting public water systems as required by this section from contaminants that may have any adverse effect on the health of persons. If the Administrator determines that a proposed State program (or any portion thereof) is inadequate, the Administrator shall submit a written statement of the reasons for such determination to the Governor of the State.

"(2) MODIFICATION AND RESUBMISSION.—Within 6 months after receipt of the Administrator's written notice under paragraph (1) that any proposed State program (or portion thereof) is inadequate, the Governor or Governor's designee, shall modify the program based upon the recommendations of the Administrator and resubmit the modified program to the Administrator.

"(d) FEDERAL ASSISTANCE.—After the date 3 years after the enactment of this section, no State shall receive funds authorized to be appropriated under this section except for the purpose of implementing the program and requirements of paragraphs (4) and (6) of subsection (a).

"(e) DEFINITION OF WELLHEAD PROTECTION AREA.—As used in this section, the term 'wellhead protection area' means the surface and subsurface area surrounding a water well or wellfield, supplying a public water system, through which contaminants are reasonably likely to move toward and reach such water well or wellfield. The extent of a wellhead protection area, within a State, necessary to provide protection from contaminants which may have any adverse effect on the health of persons is to be determined by the State in the program submitted under subsection (a). Not later than one year after the enactment of the Safe Drinking Water Act Amendments of 1986, the Administrator shall issue technical guidance which States may use in making such determinations. Such guidance may reflect such factors as the radius of influence around a well or wellfield, the depth of drawdown of the water table by such well or wellfield at any given point, the time or rate of travel of various contaminants in various hydrologic conditions, distance from the well or wellfield, or other factors affecting the likelihood of contaminants reaching the well or wellfield, taking into account available engineering pump tests or comparable data, field reconnaissance, topographic information, and the geology of the formation in which the well or wellfield is located.

"(f) PROHIBITIONS.—

"(1) Activities under other laws.—No funds authorized to be appropriated under this section may be used to support activities authorized by the Federal Water Pollution Control Act, the Solid Waste Disposal Act, the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, or other sections of this Act.

"(2) Individual sources.—No funds authorized to be appropriated under this section may be used to bring individual sources of contamination into compliance.

"(g) Implementation.—Each State shall make every reasonable effort to implement the State wellhead area protection program under this section within 2 years of submitting the program to the Administrator. Each State shall submit to the Administrator a biennial status report describing the State's progress in implementing the program. Such report shall include amendments to the State program for water wells sited during the biennial period.

"(h) Federal Agencies.—Each department, agency, and instrumentality of the executive, legislative, and judicial branches of the Federal Government having jurisdiction over any potential source of contaminants identified by a State program pursuant to the provisions of subsection (a)(3) shall be subject to and comply with all requirements of the State program developed according to subsection (a)(4) applicable to such potential source of contaminants, both substantive and procedural, in the same manner, and to the same extent, as any other person is subject to such requirements, including payment of reasonable charges and fees. The President may exempt any potential source under the jurisdiction of any department, agency, or instrumentality in the executive branch if the President determines it to be in the paramount interest of the United States to do so. No such exemption shall be granted due to the lack of an appropriation unless the President shall have specifically requested such appropriation as part of the budgetary process and the Congress shall have failed to make available such requested appropriations.

"(i) Additional Requirement.—

"(1) In general.—In addition to the provisions of subsection (a) of this section, States in which there are more than 2,500 active wells at which annular injection is used as of January 1, 1986, shall include in their State program a certification that a State program exists and is being adequately enforced that provides protection from contaminants which may have any adverse effect on the health of persons and which are associated with the annular injection or surface disposal of brines associated with oil and gas production.

"(2) Definition.—For purposes of this subsection, the term 'annular injection' means the reinjection of brines associated with the production of oil or gas between the production and surface casings of a conventional oil or gas producing well.

"(3) Review.—The Administrator shall conduct a review of each program certified under this subsection.

"(4) Disapproval.—If a State fails to include the certification required by this subsection or if in the judgment of the Administrator the State program certified under this subsection is not being adequately enforced, the Administrator shall disap-

prove the State program submitted under subsection (a) of this section.

"(j) COORDINATION WITH OTHER LAWS.—Nothing in this section shall authorize or require any department, agency, or other instrumentality of the Federal Government or State or local government to apportion, allocate or otherwise regulate the withdrawal or beneficial use of ground or surface waters, so as to abrogate or modify any existing rights to water established pursuant to State or Federal law, including interstate compacts.".

TITLE III—GENERAL PROVISIONS

SEC. 301. AUTHORIZATION OF APPROPRIATIONS.

(a) TECHNICAL ASSISTANCE AND EMERGENCY GRANTS.—Section 1442(f) of the Safe Drinking Water Act is amended by inserting the following at the end thereof: "There are authorized to be appropriated to carry out subsection (a)(2)(B) not more than the following amounts:

"Fiscal year:	Amount
1987	$7,650,000
1988	7,650,000
1989	8,050,000
1990	8,050,000
1991	8,050,000

There are authorized to be appropriated to carry out the provisions of this section (other than subsection (g), subsection (a)(2)(B), and provisions relating to research), not more than the following amounts:

"Fiscal year:	Amount
1987	$35,600,000
1988	35,600,000
1989	38,020,000
1990	38,020,000
1991	38,020,000".

(b) STATE SUPERVISION PROGRAMS.—Section 1443(a)(7) of the Safe Drinking Water Act is amended by adding at the end thereof: "For the purposes of making grants under paragraph (1) there are authorized to be appropriated not more than the following amounts:

"Fiscal year:	Amount
1987	$37,200,000
1988	37,200,000
1989	40,150,000
1990	40,150,000
1991	40,150,000".

(c) UNDERGROUND WATER SOURCE PROTECTION PROGRAM.—Section 1443(b)(5) of the Safe Drinking Water Act is amended by adding the following at the end thereof: "For the purpose of making grants under paragraph (1) there are authorized to be appropriated not more than the following amounts:

"Fiscal year:	Amount
1987	$19,700,000
1988	19,700,000
1989	20,850,000
1990	20,850,000
1991	20,850,000".

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