Approved 3-5-90
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

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

1:30 /~~a.m.~~/p.m. on February 27, 1990 in room 423-S of the Capitol.

All members were present except:

Rep. Foster, excused

Committee staff present:

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

Conferees appearing before the committee:

Representative Kerry Patrick
Terri Roberts, Executive Director, Kansas Nurses Association
Kay Hale, Director of Education Services, Kansas Hospital Association
Elizabeth Taylor, Federation of Licensed Pracatical Nurses
Steve Weir, Attorney representing First Rule Properties
Representative Anthony Hensley, (Printed information only)
David Traster, Legal Counsel, Department of Health/Environment
Theresa Nuckolls, Assistant Attorney General
Marilyn Bradt, Kansans for Improvement of Nursing Homes
Representative Nancy Brown
Kenneth Clark, Chairperson of Kansas Commission for Deaf/Hearing Impaired
Jim Wise, Audiologist with Associated Audiologists, Olathe, Ks.
Marnie Campbell, KU, Chair of early I.D./Interventing Council and Parent of a hearing impaired child.
Tina Owsley, Kansas Educators of Hearing Impaired
Tom Bell, Kansas Hospital Association
Lorraine Michel, Coordinator, Speech-Language-Hearing/Vision Bureau of family health/Department of Health/Environment
Valerie Mcanay, Kansas Division of Early Childhood/Council for Exceptional Children.
Jackque Jones, Outreach Department of Kansas School for Deaf.
David Rosenthal, Executive Director, Kansas Commission for Deaf/Hearing Impaired, Dept. of SRS. (printed testimony only)
Chip Wheelen, Kansas Medical Society
Keith Landis, Christian Science Committee on Publication for Kansas
Representative Carol Sader
Mary Ann Gabel, Executive Director/Behavioral Sciences Regulatory Board
Debra Courtney, Practicing Clinical Social Worker
Mike Moreno, Concerned parent, Kansas City, Ks.
Bob Fry, Kansas Trial Lawyers Association
Terry Hostin, President of Kansas Association of the Deaf, (Printed testimony only).

Chair drew attention to bill deadline for activity on legislation. The deadline to hear and work legislation is this Friday, March 2, 1990, so any bill not having hearings scheduled by then will not be heard.

Chair recognized Representative Patrick.

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S Statehouse, at 1:30 a.m./p.m. on February 27, 19 90

HEARINGS BEGAN ON HB 2824.

Representative Patrick, (Attachment No. 1) introduced HB 2824, and he explained rationale, i.e., payments made to "health care providers" to nursing homes, etc., are not subject to any systematic audit or review to see if those charges are reasonabale/within the law; billing codes from Hospital charges are very difficult to comprehend. He noted honest health care providers have nothing to fear from this kind of audit. He drew attention to an amendment, see Line 23, Page 4, "may" should be changed to "shall". He stated this type of program will more than pay for its costs. He noted hand-out contained article from Wall Street Journal 12/29/89. He answered questions.

HEARINGS CLOSED ON HB 2824.

Chair admonished conferees and members in regard to time restrictions, they would need to be very brief. He thanked conferees who had returned today after not giving testimony yesterday on HB 3022 as time did not allow more testimony.

HEARINGS CONTINUED ON HB 3022. (Second day.)

Terri Roberts, Kansas STate Nurses' Association, (Attachment No. 2) drew attention to several concerns, i.e., requirements for nurses coming in from other states in regard to temporary permits; request for excessive caps in fees; un-scheduled survey visits at educational sites. She noted the present workload of the Board of Nursing, then questioned the wisdom of adding more work that is not directly related to the protection of the public. She drew attention to a position statement that has been endorsed by other statewide nursing organizations, requesting the implementation of Continuing Education requirements be consistent for programs presented both in Kansas and outside the state.

Kay Hale, Kansas Hospital Association, (Attachment No.3) spoke to sections of HB 3022 that concern their Association. We project, the increasing of fees at a tripled rate will cause a decline in the availability of continuing education, and asked the fees not be raised, if anything they might be decreased; they feel it would seem best if the Board would focus on disciplining licensees, rather than to conduct unnecessary/unwarranted site visits; regarding annual report, she recommended that information be confined to statistical data. She drew attention to a telephone survey done last week that indicates the only licensing Board that reported making site visits to providers of continuing education was the Bureau of Emergency Medical Services. She recommended Section 4 (e) (2) be deleted from HB 3022. She stressed their Association does support quality continuing education for nurses, but has problems with requests in this bill.

Elizabeth Taylor, Federation of Licensed Practical Nurses, spoke in support the position of the State Board of Nursing in regard to Temporary Permits. This is the only provision in the bill that would affect her Federation.

HEARINGS CLOSED ON HB 3022.

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S Statehouse, at 1:30 ~~a.m.~~/p.m. on February 27, 1990

HEARINGS BEGAN ON 2802.

Steve Weir, First Rule Properties, (Attachment No. 4) noted the handout contained legal research Memorandum addressing the issues created by the apparent "chargeback" language ambiguity. He noted further he had provided the Chair with copies of the Attorney General's Opinion and the most recent receivership accounting. The memo supports the rulings of both the Attorney General and District Court that the legislature intended to include into term, "owner or licensee". He requested committee approve the proposed amendment in HB 2802 that would clarify language in statutes to include "only those persons with whom the legislation was originally concerned". He explained his connection with a client who is owner of land that is leased to the operator of Pioneer Village that has declared bankruptcy. bankruptcy and the connection of his client, the owner of the land and leases it to the operator of that facility. He drew attention to the need for changes in regard to defining "owner or licensee" in the statutes. He noted a client of his is embroiled in the receivership primarily because of interpretations by Department of Health/Environment of current statutes. He answered questions, i.e., if this bill were passed the owner of the licensee, or the Corporation that filed bankruptcy, or the Officers/Directors of that facility filing bankruptcy/or Mortgage Bank Holder. We are asking in this legislation is what was originally intended, that the person causing the problem is the one who pays for receivership costs.

David Traster, General Counsel for Department of Health/Environment, (Attachment No. 5) answered question asked of Mr. Weir, noting the one paying these receivership costs (if HB 2802 is passed) will be the taxpayers. Further, the taxpayers will have to pay for receiverships in the future if this bill does not pass, because those going into receivership are not solvent. The lessor voluntarily agrees to become involved in the nursing home industry, gains benefit from that operation (as he accepts the rent money), but wishes to be relieved of all responsibility when the operation of the adult care home sours. The Legislature determined in 1984 it was appropriate for lessors to be accountable in this type of operation. We believe current legislation is clear, (not as Mr. Weir believes). He stressed that many problems that occur in nursing homes have less to do with operations and more to do with physical plant type issues, so it is difficult to find a situation where a "mere owner" or "mere lessor" has no involvement in the day to day operation of the facility, therefore they should be held accountable as should the others involved. He answered questions. i.e., yes, receivership of a nursing home is very different from any other business because someone has to take care of the residents; yes we do take over and try to take care of these people; yes, we do pay rent for the facility; yes, Health/Environment is required to honor existing leases/mortgages.

Theresa Nuckolls, Assistant Attorney General, (Attachment No. 6) offered Attorney General's Opinion No. 89-96. Their office supports HB 2802, noting the bill clarifies who is responsible for adult care home facilities. It was concluded the mere lessor does not have the same responsibility as the operators of an adult care home business. HB 2802 clearly defines what the Attorney General believes current law to be.

Marilyn Bradt, Kansans for Improvement of Nursing Homes, (Attachment No. 7) indicated they agree with Department of Health/Environment. A concern they have with HB 2802 in that when the State takes over a facility after receivership they must then make improvements to make the facility inhabitable for residents, the lessor is in no way responsible for these costs. Then when (if) receivership was terminated the owner could get the improved facility back without having to pay for any of those improvements. As a tax payer, she questioned the use of tax dollars in this manner. All parties should be held responsible. She answered questions.

HEARINGS CLOSED ON HB 2802.

HEARINGS BEGAN ON HB 2915.

Representative Nancy Brown offered hand-out (Attachment No. 8), letters from various persons in support of HB 2915. She noted they have worked for over a year with the Kansas Medical Society and Kansas Hospital Association, Kansas Department of Health/Environment formulating language that would address early identification of hearing loss for high-risk infants. She thanked other conferees who would appear for their interest and concern.

Kenneth Clark, Chairperson of Kansas Commission for Deaf/Hearing Impaired, (Attachment No. 9). He supports legislation in HB 2802. He sees this Early Identification bill as the ticket to sparing future new-borns with hearing loss, parents experience agony/complications that result from public ignorance, lack of preparedness on deafness/hearing loss. The passage of this bill will help those with hearing loss from birth to have a more purposeful/meaningful life, have a greater sense of direction to help them become better self-supporting/independent citizens. He asked for support.

Jim Wise, Associated Audiologists, (Attachment No. 10-A) has had the opportunity to evaluate infants/children in varying degrees of hearing impairments/developmental disabilities. He can see the need for early detection. Approximately one child in 1,000 will be born with profound deafness, two in 1,000 will acquire deafness during early childhood. Hearing loss can be devastating, particularly if accompanied by other developmental disabilities or if hearing loss diagnosis is delayed. Currently there is no systematic approach to early hearing assessment within the child healthcare system. Plans have been developed in recent years, and HB 2915 could provide a step towards establishing a statewide high risk registry to identify infants at risk; provide for educational program planning. He indicated hand-out included Guidelines on Audiologic Screening of newborn infants at risk for hearing impairment, (Attachment No. 10-B) and asked for support of HB 2915. He answered questions.

Marnie Campbell, Chair of Ks. Commission for the Deaf/Hearing Impaired, also a parent of a deaf child. She cited specific concerns in regard to availability of hearing testing for infants/newborns. Early years of misdiagnosis are very difficult for families, extremely difficult to know your child has a problem, but you are unable to find out what it is. She noted they have worked collaboratively with many agencies and have presented data; it is well known now that early testing is a valuable tool. She asked for support of HB 2915. (Attachment No. 11.)

Tina Owsley, President of Kansas Educators of Hearing Impaired, (Attachment No. 12-A, 12-B) noted the earlier intervention is received, the better children with hearing impairments will perform on language, academic/social variables. Early Identification is essential for any hope of normalcy. Early Intervention cannot be achieved without early Identificationn. She asked for support.

Tom Bell, Kansas Hospital Association, (Attachment No.13) stated their Association is willing to cooperate in a program to provide such screening, but all must keep in mind at a time when medical assistance budgets are being cut, this must be done in the most efficient manner possible. He suggested amendments to HB 2915, i.e., adding the word "newborn before "infant" in lines 3,12,13,on Page 2, and to add language after the word "thereto" on Page 2, line 28, "the following information: (1) a description of the factors or conditions of hearing loss and the effect of such a loss on an infant or child's language development; and (2) a listing of medical care facilities, clinics or other facilities in this state that provide follow-up hearing evaluation." Further, Page 3, lines 18 and 22 after "such person" to insert, "or entity". He then answered questions.

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S, Statehouse, at 1:30 ~~a.m.~~/p.m. on February 27, 1990

HEARINGS CONTINUED ON HB 2915.

Lorraine Michel, Department of Health/Environment (Attachment No.14) detailed advantages for children and their families when early detection is done for hearing impairment. No dollar value could be placed on the outcome, however all persons cound gain from early identification/ intervention, i.e., children themselves, families, taxpayers. We need no longer wait until the disorder becomes obvious because of delay in language development. Early detection can be a long-term benefit to many. She noted no funds for the initiation of this program are included in the Governor's Budget for the Department of H&E, and their agency cannot support its funding for FY 1991. She noted former Surgeon General C. Everett Koop's position paper on Early Identification of Hearing Problems is part of her hand-out. She answered questions, i.e., she could not answer whether or not funding could be supported in FY 1992.

Valerie McNay, V. President Kansas Division for Early Childhood, (Attachment No. 15) would forgo her prepared statement to answer some questions that had been asked. She noted testing being done indicates it is unbelievable what newborns can absorb in the first few weeks of life. Language intervention at the earliest possible time is critical. There has been a reluctance on the part of physicians to refer very young children since they felt there were no programs availabale. She detailed testing.

Jacqui Jones, Kansas State School for the Deaf, (Attachment No. 16), stated it is her responsibility to provide technical assistance, resources, information to families and teachers working with deaf/hearing impaired children. Often families must drive great distances for services. She feels Statewide public awareness programs for early education/identification/referral need to be established. She noted a great challange would be to comply with Federal mandate that states programs must be family focused. She challanged committee in helping to bring Kansas to the forefront of early identification/intervention programs.

David Rosenthal, Executive Director for Ks. Commission for Deaf/Hearing Impaired, Department of SRS, left for distribution to committee, (printed comments and SRS Recommendation) (Attachment No. 17). The recommendation from SRS urges for favorable consideration of HB 2915.

Chip Wheelen, Kansas Medical Society, (Attachment No. 18) voiced their support of HB 2915, noting screening newborn infants can assist physicians/other specialists to provide for early treatment necessary to correct or minimize hearing impairment. He noted many hospitals already do some testing. He noted such testing does not directly affect the practice of medicine, but does impose many requirements on the Department of Health/Environment and the Kansas Hospitals.

Keith Landis, Christian Science Committee , (Attachment No. 19) suggested an amendment on HB 2915, Page 2 after line 6, add: "No risk screening shall be provided to an infant whose parent/guardian objects on the grounds that such screening is contrary to the religious beliefs of such parent or guardian." With this amendment in place, they believe it would not significantly alter the impact of the bill, but would still allow those with religious objections to avoid the initial screening. He asked this amendment be considered when the bill is discussed.

Representative Brown noted fiscal concerns, but stressed the need for this type of program in our state.

HEARINGS CLOSED ON HB 2915.

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S, Statehouse, at 1:30 ~~a.m.~~/p.m. on February 27, 1990

HEARINGS BEGAN ON HB 2878.

Representative Carol Sader, who had introduced this legislation, noted she did so in order to prevent social workers from refusing to accept court appointments to provide family assessments for fear of being sued or subjected to disciplinary proceedings. She stressed there is no fiscal impact. (See Attachment No. 20).

Mary Ann Gabel, Executive Director of Behavioral Sciences Regulatory Board, (Attachment No. 21) voiced the Boards opposition to HB 2878. She noted their concern is reflected also in a copy of an Attorney General's opinion attached to her testimony. She requested this committee consider one of three options she recommended, i.e., amend to remove "or subject to any administrative disciplinary proceedings," in lines 15-16; refer the bill for interim study; or to not pass the bill.

Debra Courtney, licensed practicing clinical social worker in Kansas, (Attachment No. 22). He area of specialty is with children involved in custody cases. Presently she chooses not wanting to work with the cases due to potential liability. It is also a financial burden as it is difficult to collect fees from these cases. Her concerns are; social workers may be setting themselves up as a target for professional complaint. These cases are emotional, and parties involved may choose to file unjustified complaints either from mis-information, or as an intimidation tactic. If this happens, the innocent social workers becomes a victim and the child suffers in these situations.

Mike Moreno, concerned citizen, (Attachment No. 23) provided a letter from Senator Kanan to SRS, and a reply. He noted concerns in regard to children being separated from parents unnecessarily. He is opposed to HB 2878. People must be held responsible for their actions, including social workers. He answered questions, i.e., yes, he is a victim of a bad situation with the Department of SRS. His children were taken from him 4 years ago because he struck his daughter on the behind, which he does not deny. Their situation has gone from bad to worse, and they have still kept their children away from them. He said he would continue to do whatever he can to get his children home. No one is immune to the SRS. If they come into your home, they disrupt, they do not try to work with families, (that is the experience he has had with them). A little guy does not have a chance standing up against a big system. Allegations against me are false, but he has been unable to correct the mess. He stated his daughter had become impregnated while in the care of SRS, his son has been incarcerated while under the care of SRS. There are real problems that need to be corrected. He offered to answer questions anyone had, and would be happy to come to their offices later since he knew time did not permit further discussion in committee today.

Bob Fry, Kansas Trial Lawyers Association, (Attachment No. 24) stated opposition to HB 2878. We believe there are good reasons why persons should be held accountable for negligent acts when performing professional duties, which could cause personal injury. It is possible that a poorly done family assessment could result in the loss of custody of children in custody case, or severance of parental rights of a child in need of care case. There are many social workers willing and able to conduct necessary investigations in a responsible manner. There does not appear to be any insurance availability or affordability crisis, not a noticeable increase in suits which have been filed against social workers who do this kind of work. If licenses social workers are granted immunity from liability, they will have less incentive to do a good job, therefore more likely to cause reports to be written which could cause damage to innocent people.

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S Statehouse, at 1:30 ~~a.m.~~/p.m. on February 27, 19 90

HEARINGS CONTINUED ON HB 2878.

Bob Fry continued:---He urged the bill not be passed. He answered questions, i.e., no they would not object to adding language, "providing social worker acting in good faith, without malice/without negligence", however, he felt it is only another way of saying what is already in the law; no, he did not know fees charged by social workers; yes, other than civil action taken against social workers, they could lose licenses also if they have acted inappropriately.

HEARINGS CLOSED ON HB 2878.

Recorded this date, (Attachment No. 25) information sheet provided by Representative Hensley.

(Attachment No. 26) printed testimony only from Terry D. Hostin, President of Kansas Association of the Deaf.

Meeting adjourned 3:16 p.m.

VISITOR REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE Tuesday 2-27-90

NAME	ORGANIZATION	ADDRESS
Marilyn Bradt	KINH	Lawrence
Lorraine I. Michel	K.D.H.E.	Topeka
Judy A. Moler	KCCC-CCECDS	Topeka
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS	"
Virginia Anderson	AARP	Overland Park
Robert Anderson	AARP	Overland Park
WALT COLE	AARP	overland park
Gigi Zeliff	K-NASW	Topeka
Barbara Wilson		Topeka
Nancy McRay	Jo. Co. Area Agency on Aging	Olathe
Katie J. Boyer	Jo. Co. Area Agency on Aging	Olathe KS
Rochell White	Jo Co Area Agency on Aging	Olathe Ks
Darla Jenkins	Jo Co Area Agency on Aging	K.C. Ks.
Aletha Adams	Catholic Women's NCCW "Respite Program"	Prairie Village, Ks.
Cecil Waage	AARP	Westwood, Ks
Hazel Waage	AARP	Westwood, Ks.
John McGee		Topeka
Fred Jenkins	Area Agency on Aging	K C Ks.
Mary Ann Isabel	BSRB	Topeka
ELIZABETH E. TAYLOR	FED OF LICENSED PRACTICAL Nurses	"
Terri Roberts	KSNA	Topeka
Theresa Marcel Nuckols	AG	2d Fl Jud. Bldg
Jean Braxil	KCAA	Topeka, Ks

GUEST REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

Date _____

Name	Organization	Address
Barb Higgins	NCFHAAA	Stray City
Chris Dayton	NC-FH AAA	Manhattan KS
Mary Douglas	NCFHAAA	Manhattan, KS
Hannah Wae Rachkra		Great Bend KS.
Deb Hummel	Ks Health Care Assn	Topeka
Jean Marshall	KSDE	Topeka
R Frey	KTLA	TOPEKA.
Shirley Spradlin	NC FHAAA PSA #8	Manhattan Ks

To: House Public Health & Welfare Committee

Date: February 23, 1990

From: Kerry Patrick

Re: House Bill 2824 - Requiring the audit of all claims submitted to SRS for payment out of state funds for the medical care of needy persons

I. **Rationale**:

No business, particularly a business with over $250 million in costs, can survive without those costs being subject to scrutiny or an audit. Yet that is taking place today in the Department of Social and Rehabilitative services.

a. **Payments made to "health care providers", to nursing homes, etc. are not subject to any systematic audit or review to see if those charges are reasonable and within the law**.

1. Cheating could be taking place and we not even know it because of the archaic bookeeping and payment system that we use in Kansas. It is an open invitation for overcharging, fraud and abuse.

2. With costs for MediKan and nursing homes running in the tens of millions of dollars over projected costs, an outside audit of those charges and how the state is reimbursing them is clearly, now more than ever, in order.

b. **A review of a December 29, 1989 article in the *Wall Street Journal* shows the need for such an audit program and the benefits that it would bring to the people of the state of Kansas. Let's look at some excerpts from that story.**

1. Since 1985, Medicare payments for physician services in the U.S. have increased by 77% while the number of beneficiaries have risen only 8%.

2. Article refers to "upcoding" by certain Health care providers in an attempt to charge more for a patient visit than the

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rules allow. Some physicians or their business managers have even attended schools on how to "upcode" and thus generate more fee income.

My mother recently died of colon cancer and I consider myself a fairly intelligent person but I have been unable to decipher the billing code of the Hospital and the attending physicians in an attempt to figure out what is a proper charge to pay and what isn't. If I can't figure it out how can we expect some overworked and underpaid bookeeper in SRS to do so?

3. The Health Care Financing Administration (HCFA) decided to have the new administrator for Medicare payments contract with an outside watchdog company to scrutinize suspect claims in the State of Georgia. Medicare is now doing something which private insurers have done for years, that is, they hire outside claims examiners to review claims.

C. Honest health care providers have nothing to fear from this bill only the unscrupulous ones who take advantage of the system and charge more than the rules require. Further the honest ones are helped by reducing costs and we are placed in a better position to pay valid bills on time.

Shouldn't we be doing that very same thing in Kansas?

1. Shouldn't we proceed in a more business like manner so that the taxpayers get their monies worth?

2. By avoiding overpayment, might we be able to prevent a situation that just occurred when many social welfare recipients faced cuts or elimination of some or all of their benefits?

II. Amendment

Line 23 of page 4 should be changed from "may" to "shall" for I believe that this type of program will more than pay for its costs. Talks that I have had with several insurance companies in the KC area have indicated that some outside claims examiners are willing to work on a contingent fee basis so the cost to the state is zero unless they find overcharging.

MEDICINE

Georgia Doctors Are Undergoing A Medicare Test

By JAMES R. SCHIFFMAN
Staff Reporter of THE WALL STREET JOURNAL

ATLANTA — Doctors in Georgia are guinea pigs of sorts these days, and they don't like it one bit.

The Health Care Financing Administration, which oversees Medicare, is using the state to try out a system of intensified scrutiny of doctors' charges, all in an effort to rein in costs. The result: Medicare claims are being denied, delayed and "downcoded," or reimbursed at lower rates than doctors expect. In some cases, doctors have had to refund money to patients.

"It's been a nightmare really," says Charles Harrison, an Atlanta internist who, like many compatriots, complains of extra paper work and the dread of having every move put under a microscope.

Nightmare or not, it could be a glimpse of the future for Medicare, the federal health-care insurance program for the elderly that pays about a quarter of the nation's doctor bills. The HCFA says the Georgia experiment is a pilot that may be extended, perhaps even nationwide.

Altering Behavior

Other states face cost-control tactics, too. The Medicare administrator in North Dakota is looking for ways to identify suspicious combinations of procedures and diagnoses. In New York and Massachusetts, Medicare administrators write letters to doctors who perform more of certain procedures than is typical in those areas. "The intent is to change physician behaviors," says Barbara Gagel, director of the HCFA's bureau of program operations.

Basic numbers underscore the desire: Since 1985, Medicare payments for physician services in the U.S. have increased 77%, while the number of beneficiaries has risen only 8%.

The endeavor in Georgia is the most controversial so far. The experiment came about at the beginning of 1989 when the HCFA switched its Medicare administrator in the state. When the agency made the change, it decided to have the new administrator, Aetna Life Insurance Co., contract with an outside watchdog company to scrutinize suspect claims. Medicare is taking a tip from private insurers, which have used outside claims examiners for years.

Aetna chose HealthCare Compare Corp., a claims-scrutinizer based in Downers Grove, Ill. HealthCare Compare, which came on the scene in January,

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Continued From Page B1

quickly began hitting Georgia physicians in their pocketbooks by taking a jaundiced look at claims for "comprehensive" consultations.

Such visits should be rare because they involve an intensive look at a patient, including the taking of a full medical history, says Robert J. Becker, a physician who is chairman of HealthCare Compare. Yet the HCFA's own statistics show that in 1987, Georgia doctors billed for comprehensive visits 23% more than the U.S. average.

The suspicion was that some doctors were "upcoding," or charging Medicare for comprehensive visits—at more than $100 a shot—when they should have been billing in the $30 range for simpler consultations.

In one case, Dr. Becker recounts, a doctor treating a 92-year-old patient for dementia billed for 72 comprehensive visits in two months. In another, a physician filed for 17 comprehensive visits in as many days for treatment of a single patient. Yet another doctor billed Medicare for seven emergency-room visits on the day his patient had a heart attack. "If they had been reimbursed, it would have been an outrageous expenditure of Medicare funds," Dr. Becker says.

Doctors concede there may be a few among them who make inappropriate claims, but they say the scrutiny is uncalled for. Moreover, they say, dealing with Aetna has been a bureaucratic disaster. And HealthCare Compare, they charge, is arbitrarily withholding payments to impress the HCFA in hopes of landing contracts if the review program expands. HealthCare Compare rejects the accusation.

Paul Shanor, executive director of the Medical Association of Georgia, also takes issue with statistics showing that doctors bill for too many comprehensive visits. And he questions the general fairness of the new procedure. One physician in Newnan, Ga., spent more than two hours in the middle of the night with a heart-attack victim, he says, only to be reimbursed $23 by Medicare. "That doesn't seem like a very fair amount to me," Mr. Shanor says.

Moreover, physicians say they have been made to feel like criminals and have been subjected to long delays in receiving legitimate payments. Take the case of Mary Sper, a 68-year-old who was hospitalized for six weeks late last year for gallbladder surgery. Because she had a history of heart trouble, her cardiologist, Wm. Michael Brown, visited her daily in the hospital. But it wasn't until August, after several appeals of payment denials and the submission of reams of documentation, that the cardiologist collected the $1,000 he sought from Medicare. "It was a headache on that one," says Mabel K. Kim, Dr. Brown's office manager.

Aetna does accept some blame. As a new Medicare administrator, the carrier faced a huge backlog of claims and admits mistakes in processing at the start. Aetna says the problems have largely been overcome, but only a few weeks ago a computer glitch resulted in erroneous underpayments for laboratory tests. The medical association calls the incident an example of Aetna's "bad faith."

The changes have shocked physicians, who had grown accustomed to certain givens in billing. Linton H. Bishop Jr., a cardiologist here, says he charged his "usual consulting fee of $117" to see a 73-year-old patient who was hospitalized for prostate surgery. The patient paid, but Medicare later said a comprehensive visit wasn't necessary and authorized payment of only $30. In this case, Dr. Bishop had to reimburse the patient the difference between the higher and lower fee.

Some doctors now protect themselves by forcing patients to sign waivers, making them responsible if Medicare denies payment. Exactly that happened to Grady Rutherford, a 75-year-old retired carpenter who had to fork over $85 for a "downcoded" visit to his internist. "I just feel like my Medicare insurance isn't doing justice one way or the other," a distressed Mr. Rutherford says.

Intensified Examinations

Dr. Becker of HealthCare Compare dismisses the criticisms, saying his company is only ensuring that physicians aren't paid for unnecessary services. "Some of the people who have made some of the most noise are people who in fact are overutilizing and upcoding," he says.

Dr. Becker adds that it's going to get tougher for physicians before it gets easier. Starting in January, he says, scrutiny will be intensified for Georgia doctors who do tests and surgical procedures.

Meanwhile, the issue is spilling into politics. Responding to the medical lobby, Georgia congressmen persuaded Rep. Henry Waxman to examine the state's Medicare situation before his health and environment subcommittee. The inspector general of the Health and Human Services Department, the agency housing the HCFA, also is conducting a probe, as is the General Accounting Office.

But don't expect too much sympathy for Georgia's generally well-heeled physicians. Says Michael Cadger, managing consultant in Atlanta for A. Foster Higgins & Co., a benefits consultant: "Doctors are finally getting caught and they don't like it."

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KSNA
the voice of Nursing in Kansas

FOR MORE INFORMATION CONTACT:
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H.B. 3022 Amendments to the Nurse Practice Act.

Chairman Littlejohn and members of the Public Health and Welfare Committee, my name is Terri Roberts and I am the Executive Director of Kansas State Nurses' Association. Thank you for the opportunity to testify on House Bill 3022.

As you know this bill amends the Kansas Nurse Practice Act in several ways. The Kansas State Nurses' Association would like to go on record supporting amendments to the Practice Act that will enable nurses from other states who hold valid licenses to be able to endorse into the state of Kansas. The first change being proposed on line 21 through 24 on page 2 deals with issuance of temporary permits. If it is the intent of this legislation to require a refresher course for a nurse coming from another state into the state of Kansas with an active license but without having been engaged in nursing for five years preceding application, then we cannot support it. It is unclear from the changes whether or not the Board of Nursing will continue to require a nurse who has not been engaged in nursing practice in five years but holds a valid license in another state to take a refresher course. **This is the current practice under K.A.R. 60-3-106.** This provision is suppose to increase the temporary permit opportunities for refresher course. The second change in section 3, the caps for Board of Nursing fees are being raised. The Board of Nursing has not indicated their immediate intent regarding raising fees. We would however, like to bring to your attention that the Board of Nursing fee balance has been increasing dramatically over past two years due to a 60% increase in license renewal fees for the more than 37,000 licensees of the Board. The fees caps being requested in two areas are particularly high, that being the annual fee for continuing education providers from $100 every two years to $150 every year and the approval of single continuing education offerings is being raised 400% from $25 to $100. We believe these fees to be exessive at this time. When a non-Board of Nursing approved continuing education provider wishes to provide a continuing education program that will be acceptable to the Board of Nursing for use by licensees in accumulating their 30 hours of continuing education such as an individual who wishes to offer a course then he or she must submit at this time a very complex set of forms and documentation and if the fee is raised to $100 it seems prohibitive for an individual or small group wishing to offer a single continuing education offering to Board of Nursing licensees.

As one of the oldest C.E. providers in the state we have for over 25 years provided quality C.E. programs to nurses.

On page 5 of bill, the Board of Nursing will change its current policy to require an annual report versus a bieannual report.

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The fee caps have tripled for this privilege also. We support any reduction in paperwork to be submitted to the Kansas State Board of Nursing, we hope that this is the intent.

On page 6 of the bill is a new section providing for surveys of C.E. providers. The Boards purpose is protection of the public and mandatory C.E. is one vehicle that has been implemented by this legislature to meet this goal. The process of "approving C.E. providers and programs" has been going on for over 10 years. There appears no data to support that the C.E. providers approved by the Kansas State Board of Nursing warrant survey visits for compliance with the Boards standards.

We believe that the Kansas Nursing C.E. providers are doing an exceptional job of providing quality and accessible C.E.

Considering the workload of the Board of Nursing, accrediting all the schools preparing R.N.'s, L.P.N.'s and L.M.H.T.'s as well as licensing and disciplining the more than 37,000 licensees, we question the wisdom in this new layer of oversight on something that is not directly related to the protection of the public.

Lastly, we'd like to bring to your attention a matter of concern relative to the Board of Nursings approval process for C.E.

Attached is a position statement that has been endorsed by several other statewide nursing organizations. It specifically requests that the implementation of C.E. requirements be consistent for programs presented both in Kansas and outside the state.

Thank you.

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89-2.

RECOGNITION OF ANA APPROVED PROGRAMS IN KANSAS

POSITION

The Kansas State Nurses' Association recommends that:

The Kansas State Board of Nursing adopt a policy recognizing ANA and other nationally accredited Nursing Continuing Education programs presented in Kansas.

These programs be acceptable Continuing Education for relicensure **without** the requirement for KSBN provider approval.

SUPPORTING DOCUMENTATION

Background:

Mandatory Continuing Education for relicensure currently exists in twelve (12) states. Only three other states require approval through the State Board of Nursing for ANA and nationally accredited programs. These are Iowa, Kentucky and California. The remaining eight mandatory states accept ANA approved programs. On July 1, 1978, Kansas was the third state to institute this type of competency demonstration for relicensure by RN's and LPN's. The Legislature passed the mandatory language in 1976 with a 1978 implementation date. Guidelines were implemented by September 1976.

Historical:

Continuing Education has been provided by KSNA since 1973. In 1974 KSNA administered a federal grant to implement a continuing education program for RN's in Kansas.

In 1976 the Kansas State Board of Nursing began to set up a system for providing and approving continuing education. From February to July, 1977 workshops were held throughout the state for potential providers. The Task Force on Continuing Education operational bylaws were adopted on April 18, 1978. The Continuing Education Task Force has been instrumental in dissemination of KSBN CE Provider information since their inception in 1978. This committee then existed to provide information to the Kansas State Board of Nursing regarding Continuing Education. In FY 1986, there were 96 longterm continuing education providers approved by the Kansas State Board of Nursing.

KSA 65-1117 (1985)

KAR 60-9-101 (1984) provides that nurses attending CE outside Kansas be approved by accrediting acencies recognized by the Kansas State Board of Nursing.

There are currently organizations recognized by KSBN to provide Continuing Education that is acceptable when nurses seek Continuing Education outside Kansas. The organizations are:

The state's Board of Nursing
The National League for Nursing
The CEARP of a state's professional nurse association
The National Federation of Licensed Practical Nurses
The National Association for Practical Nurse Education & Service
National "speciality" nurse associations
Agencies accredited/approved by the American Nurses Association

KSNA believes the current KSBN policy should be revised based on the following:

1) There exists no documentation that the quality of Continuing Education accredited by the ANA is less than that of KSBN providers.
2) ANA accredited Continuing Education obtained outside Kansas is currently acceptable for relicensure.
3) There are six (6) other Health Related Disciplines in Kansas requiring Continuing Education. All of them recognize nationally accredited Continuing Education in the particular discipline, both inside/outside Kansas for relicensure.
4) The current KSBN policy discourages programs that have been accredited by ANA and other nationally accredited organizations from entering Kansas to present programs. Instead these programs are presented across state lines for Kansas nurses to attend.

The Kansas State Board of Nursing has developed criteria to accredit Providers of Continuing Education in Kansas. At this time we believe it is essential that KSBN evaluate their commitment to access for quality Continuing Education in Kansas by licensees.

KSBN functions are to:

1. Adopt Rules and Regulations in the Nurse Practice Act defining what constitutes CE for licensees.
   The purpose is to identify for licensees what is expected of them for relicensure. These requirements are broadly defined to cover in-state and out-of-state licensees. (K.A.R. 60-9-101 & 60-9-102)
2. Adopt Rules and Regulations in the Nurse Practice Act for CE Providers that are accredited by the Kansas State Board of Nursing.
   The purpose is to ensure an adequate number of Continuing Education providers with board-recognized quality in the Continuing Education they provide. (K.A.R. 60-9-103 & 60-9-104)
3. Accredit and ongoing monitoring of Kansas State Board of Nursing Continuing Education Providers. (K.A.R. 60-9-104 (B))
4. Monitor satisfactory proof that the licensee has met the minimum continuing education requirements as established in K.A.R. 60-9-102.

The purpose of KSBN accrediting Continuing Education providers has been to assure quality of programing and access for Kansas nurses to approved programs. The Kansas State Nurses' Association recommends that the Board of Nursing revise regulations to accept ANA and other nationally accredited nursing Continuing Education programs. This progressive step is parallel to gaining access to quality programs for Kansas nurses.

Adopted by the KSNA Board of Directors
May 29, 1987
Adopted by the KSNA Convention Body
October 8, 1987
Endorsed by the Kansas Association of Nursing Continuing Education Providers.
October 19, 1987
Endorsed by the Kansas Association of Nurse Anesthetists

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Attn # 2.
39.3

KA HOSPITAL ASSOCIATION

Memorandum

Kay Hale
Director of Education Services

Donald A. Wilson
President

February 26, 1990

TO: House Public Health and Welfare Committee

FROM: Kansas Hospital Association

SUBJECT: House Bill 3022

Thank you for the opportunity to comment regarding the provisions of House Bill 3022. This Bill includes several technical amendments to the Kansas Nurse Practice Act. We would like to comment on the three sections of the Bill.

Section 1 (d)

Section 1 (d) concerns the granting of temporary permits by the Board of Nursing to registered nurses who are enrolled in a refresher course. The existing statute authorizes the Board to issue a 180 day temporary permit to a registered nurse who was previously licensed in this state. House Bill 3022 would authorize the Board to issue a 180 day temporary permit to a nurse from another state who is seeking Kansas licensure by endorsement if they have not been engaged in the practice of nursing for the preceding five years. We support the amendment.

However, in view of the current nursing shortage, we would like to make you aware of an underlying issue concerning the administrative regulations for licensure by endorsement. KAR 60-3-106 states:

A. Individuals applying for licensure in Kansas by endorsement will be granted a license, if in the opinion of the Board, their work record indicates current practice during the five years preceding application provided that they meet all of the other requirements in effect at the time of application.

B. Individuals applying for licensure in Kansas by endorsement who have not been engaged in current nursing practice during the five years preceding application will be required to complete an approved refresher course in addition to meeting all of the other requirements in effect at the time of the application.

This requirement presents a barrier to licensure for nurses moving into the state. This is especially true when a refresher course

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approved by the Board is not available in the community where the nurse resides. Currently there are nine approved providers of refresher courses in the state of Kansas. We raise this issue because the Kansas Nurse Practice Act gives the Board of Nursing extremely broad authority to establish rules and regulations. We want the legislature to be aware that regulations such as this may impact adversely on the supply of nurses available to meet the health care needs of Kansans.

Section 3

Section 3 is amended to increase the limits on fees which may be collected by the Board of Nursing. In each case the amounts have been increased significantly. For instance the fee for approval of a single continuing education offering has been increased from $25 to $100, a three hundred percent increase. The fee for accreditation as a school of nursing is doubled from $700 to $1500. The fee for continuing education providers increased by three hundred percent.

In view of the fact that the Board of Nursing has more than $275,000 in its fee fund, we find it difficult to understand the need for increasing fee limits as much as this. We believe that a $400 fee to make application as a continuing education provider would discourage certain agencies who might otherwise apply. Likewise, colleges would be discouraged from seeking application to offer an accredited nursing program. We project that the long-term impact of escalating fees would cause a decline in the availability of basic nursing education programs and continuing education providers. We ask the committee to consider maintaining fees as they are now, or at the very least, a smaller increase.

Section 4 (e) (1) and (2)

This section of the Bill deals with the qualifications of continuing education providers. The proposed amendments would greatly expand the authority of the Board of Nursing to promulgate regulations pertaining to the qualifications of continuing education providers. Section 4 (e) (1) proposes to establish a five year renewal cycle with annual reports from approved continuing education providers. Currently there is a two year renewal cycle with no annual report required.

Section 4 (e) (2) authorizes the Board to survey continuing education providers, and to determine if they are meeting the standards required by rules and regulations prescribed by the Board. A provider that fails to correct deficiencies to the satisfaction of the Board would be removed from the list of approved providers. <u>The Kansas Hospital Association and the Kansas Organization of Nurse Executives do not support this section of the Bill.</u>

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pg. 2.

We believe that the five year reapplication and the annual reports called for in Section 4 (e) (1) are more than ample evidence to show that the standards for continuing education are being met. Therefore, we believe that it is more important for the Board to monitor the practice of individual licensees than to conduct surveys of continuing education providers. Currently a total of 71 disciplinary cases are waiting to be processed. We believe that it is more important for the Board to respond to disciplinary reports which include instances of professional incompetency than to survey continuing education providers.

Attached to our testimony is a copy of the results of a telephone survey we conducted last week. It shows that 28 categories of health personnel are credentialed by the state and three-fourths of them have mandatory continuing education. The only licensing board that reported making site visits to its providers of continuing education was the Bureau of Emergency Medical Services.

We would like for the Committee to consider the considerable costs associated with site visits and whether they are justified. We believe that it is more important for the resources of the Board of Nursing to be directed to the area of regulating individual providers under its purview. Therefore we would like to recommend that Section 4 (e) (2) be deleted from the Bill.

Kansas hospitals do support quality continuing education for nurses. According to the 1989 KHA Nursing Survey almost seventy percent of the responding hospitals paid the registration fees for their nurse employees to enroll in continuing education courses. One-half of the long-term providerships are hospital-based.

Thank you for your consideration of our comments.

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Title of Health Care Personnel and the State Regulatory Body of the Health Care Personnel Credentialed in Kansas - 1988

Title of Health Care Personnel	State Regulatory Body	Mandatory CE	Site Visit
Medical doctors	Board of Healing Arts	Yes	Not by law
Osteopathic doctors	Board of Healing Arts	Yes	No
Chiropractors	Board of Healing Arts	Yes	No
Podiatrists	Board of Healing Arts	Yes	
Physical therapists	Board of Healing Arts	Yes	No
Physical therapist assistants	Board of Healing Arts	No	No
Physicians' assistants	Board of Healing Arts	Yes	
Occupational therapists*	Board of Healing Arts	Yes	No
Occupational therapist assistants*	Board of Healing Arts	Yes	No
Respiratory therapists	Board of Healing Arts	Yes	
Registered nurses	Board of Nursing	Yes	
Licensed practical nurses	Board of Nursing	Yes	
Mental health technicians	Board of Nursing	Yes	
Dentists	Dental Board	Yes	No
Dental hygienists	Dental Board	Yes	No
Optometrists	Board of Examiners in Optometry	Yes	No
Pharmacists	Board of Pharmacy	Yes	No
Adult care home administrators	Board of Adult Care Home Administrators	Yes	No
Nurse aides (nursing homes)	Dept. of Health & Environment	Yes/No	No
Home health aides	Dept. of Health & Environment	No	No
Dietitians*	Dept. of Health & Environment	Yes	No

*These professions went through the credentialing review program.

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Title of Health Care Personnel	State Regulatory Body	Mandatory CE	Site Visit
Hearing aid dispensers & fitters	Board of Hearing Aid Examiners		
Psychologists (PhD)	Behavioral Sciences Regulatory Board	Yes	No
Master's level psychologists*	Behavioral Sciences Regulatory Board	Yes	No
Professional counselors*	Behavioral Sciences Regulatory Board	Yes	No
Social workers	Behavioral Sciences Regulatory Board	Yes	No
Emergency medical technicians	Bureau of Emergency Medical Services	Yes	Yes
Medication aides	Dept. of Education Dept. of Health & Environment	Yes	No

*These professions went through the credentialing review program.

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TESTIMONY TO THE

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

by Stephen P. Weir

ON

Tuesday, February 27, 1990

House Bill 2802

Mr. Chairman and members of the Committee:

My name is Steve Weir and I appear before you today on behalf of First Rule Properties, a general partnership located in Topeka, Shawnee County, Kansas. I appreciate the opportunity to speak to you today regarding House Bill 2802.

I am representing my client as a landlord caught in the middle of a pending receivership of an adult care home facility. My client has no connection with the adult care home other than the fact that it owns the land and leases it to the corporation which operated the facility.

The problem arises out of the Kansas Department of Health and Environment requiring my client, as landowner, to sign the "disclosure of information" portion of the actual operators license. KDHE then placed my client's name on the license along with the actual operator's for disclosure purposes. The actual operator of the adult care home, a non-profit corporation, declared bankruptcy due primarily to the fact SRS refused to pay more than $60.00 to $70.00 per patient per day for patient care.

A receiver was appointed under the terms of the current statute and for the first ten (10) months of the receivership SRS paid the receiver from $83.88 per patient, per day to $196.15 per patient, per day, a huge increase from the amount paid to the original operator.

My client is embroiled in this receivership primarily because of the ambiguities in the present statutes as interpreted by KDHE. The statutory language in question allows the receiver of the adult care home to charge the excess, which SRS pays the receiver to operate or close down the facility, back against the "owner or licensee".

The terms "owner or licensee" are not defined in the statutes. Based upon the "chargeback" language previously noted, the fact that the Kansas Department of Health and Environment required my client's signature on the operator's license application and independently put my client's name on the license

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with the operator's for disclosure purposes, and the fact that my client "owns" the land where the facility is located, the receiver has advised my client that it is an "owner or licensee" under the statutes. The receiver has also advised my client it will not pay all the payments required by the lease and will attempt to collect all of the cost of the receivership from my client, which as of last September, was in excess of One Million Five Hundred Thousand Dollars.

Attorney General Robert Stephan has issued an Attorney General's Opinion regarding the definition of owner or licensee. His opinion states that the legislature intended to require those who controlled the operations of the facility and caused the need for the appointment of the receivership, to be included in the term "owner or licensee" and not mere landlords who are required by Kansas Department of Health and Environment to be placed on the license for disclosure purposes.

In the pending receivership action, Shawnee County District Court Case No. 89-CV-318, Judge Jackson in his Memorandum Decision and Order of February 6, 1990 ruled that "The Court is in agreement with the rationale expressed in the Attorney General's Opinion No. 89-96."

Despite these judicial decisions, the receiver has continued to assert that its interpretation of the term "owner or licensee" as including mere landlords is what the legislature intended. Because of this continued insistence that my client be financially responsible for the independent acts of another, I appear before you today requesting your support of this legislation. In support of my request for your support, I have researched the law and legislative intent with regard to the issues created by the current ambiguity in the statutes.

I have prepared a legal research Memorandum addressing the issues created by the apparent "chargeback" language ambiguity. I have provided copies of that Memorandum to this Committee. I have also provided copies of the Attorney General's Opinion and the most recent receivership accounting to staff and the Chairman only as I did not believe each of you would want all of this voluminous information. However, I would be happy to present copies of those documents to individual committee members if requested. My Memorandum merely supports, through extensive research, the rulings of both the Attorney General and the District Court that the legislature intended to include into the term "owner or licensee" only those persons who actually controlled the operation of the facility.

I would therefore respectfully request that this Committee approve of the proposed amendment in House Bill 2802 which clarifies the language of the statute to include only those persons with whom the legislation was originally concerned.

Thank you.

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092.

MEMORANDUM REGARDING THE LEGISLATIVE INTENT OF THE USE OF THE TERM "OWNER OR LICENSEE" IN THE ADULT CARE RECEIVERSHIP STATUTES IN SUPPORT OF HOUSE BILL #2802

K.S.A. 39-926 requires:

> "It shall be unlawful for any person or persons acting jointly or severally to operate an adult care home within this state except upon license first had and obtained for that purpose from the secretary of health and environment as the licensing agency upon application made therefor as provided in this act, and compliance with the requirements, standards, rules and regulations, promulgated under its provisions."

The New American Webster Dictionary defines operate as "to direct the working of".

It seems obvious that a lessor of property who has no control of the day to day affairs of a lessee adult care home business would not be an "operator" of the adult care home.

However, K.S.A. 39-923(a)(13) seems to create an ambiguity which KDHE uses to corral all known persons however related to the actual operator. That statute states:

> "(13) 'Operate an adult care home' means to own, lease, establish, maintain, conduct the affairs of or manage an adult care home, except that for the purposes of this definition the word, 'own' and the word 'lease' shall not include hospital districts, cities and counties which hold title to an adult care home purchased or constructed through the sale of bonds."

Neither "own" nor "lease" is defined in the statutes. However, lending to the problem is the section on denial, suspension or revocation of licenses which states:

> "39-931a. Denial, suspension or revocation of license; grounds; 'person' defined. (a) As used in this section the term 'person' means any person who is an applicant for a license to operate an adult care home or who is the licensee of an adult care home and who has any direct or indirect ownership interest of twenty-five percent (25%) or more in an adult care home or who is the owner, in whole or in part, of

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any mortgage, deed of trust, note or other obligation secured in whole or in part by such facility or any of the property or assets of such facility, or who, if the facility is organized as a corporation, is an officer or director of the corporation, or who, if the facility is organized as a partnership, is a partner."

Blindly following the exact wording in these statutes, KDHE provides forms to prospective applicants which not only contain a regular license application form it also contains a separate "Disclosure Form" (PRS Form 102) (A copy of said form and its instructions are attached.)

Besides requiring the applicant to list the names of mortgage holders and the names of all officers and directors of corporations, the form requires the applicant to "Item G -- Enter name and address of owner(s) of the land and building where the adult care home is located." If the owner of the land is different than the applicant the State of Kansas KDHE personnel require that the owner of the land prepare and execute Part II of the application. "Part II" of the application states: "Each Disclosing Entity Must Complete A Part II Of The Application For Adult Care Home License" and then states, "The undersigned hereby applies to the Kansas Department of Health and Environment for a license to operate an adult care home subject to the provisions of K.S.A. 39-923 through 963 and in accordance with the appropriate Kansas Administrative Regulations."

However, at the end of "Part II", the signature line states, "The following is the legal signature and title of the individual authorized to represent the governing body, corporation, partnership, joint venture, individual, or organization in the operation of the facility by the disclosing entity."

The United States Department of Health and Human Services also requires an "Ownership and Control Interest Statement (HCFA-1513)" (see attached) but that statement has "Detailed Instructions" with definitions stating, "Controlling interest is defined as the operational direction or management of a disclosing entity...."

The difference being that the actual applicant (nursing home operator) prepares and files HCFA's form while KDHE and its forms absolutely require that all other entities including mortgage holders, corporate officers, directors and landlords, prepare and file the KDHE forms and thereby become "co-licensees".
Based upon our statutory and regulatory background, can KDHE require, that the owner of the land and building, who has no interest or control of the nursing home business, be a co-licensee with the operator.

The answer to this question appears to be based upon what the legislator meant when it said that to "own" and to "lease" ... "an adult care home" is equivalent to "operating" the adult care home.

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pg. 4.

"The requirement of a license, or the imposition of a license tax, by a state is in pursuance of the police power and for purposes of revenue,...and when required or imposed under the police power, the regulation or imposition will constitute an infringement of the constitutional guaranties of person or property, if it is not based on any reasonable consideration of the public health, morals, or safety." 16A C.J.S. Constitutional Law §454, p. 471-72

"Admitting that the subject to which the statute relates is within the scope of legislative power, the test of validity within the police power is whether or not the ends sought to be attained are appropriate and the regulations prescribed are reasonable. The measure of reasonableness of a police regulation is what is fairly appropriate to its purpose under all circumstances, and not necessarily what is best.

The test of reasonableness is whether attempted regulation makes efficient constitutional guaranties and conserves rights, or is destructive of inherent rights. If the regulations prescribed are reasonable, they are valid, but, if they are unreasonable, they are void as a taking of private property without compensation and without due process of law." 16A C.J.S. Constitutional Law §442, p. 448-50.

Therefore, we must look to the "purpose" behind these statutes to see who the legislature intended to reach.

On December 1, 1977 the Governor's Special Advisory Committee on Nursing Homes IN THE STATE OF KANSAS issued its "Report and Recommendations".

The report concluded that the State needed legislation for "nursing homes which consistently flaunt basic regulations" ... "to seek the appointment of a receiver for nursing homes which are totally unable to care for their residents" and to require "full financial disclosure of the operation of nursing homes so that the reasonable cost of that operation can be effectively and truthfully ascertained and utilized in the development of the state's financial support program".

The report speaks only of the "nursing home owner" who does not comply with health and safety regulations; the need for disclosure of "actual ownership" "to determine whether excessive rates are being charged through repeated sales of a nursing home or through nursing home dealings with persons or organizations related to the owner or licensee of the nursing home ... (to make) an effective comparative analysis of the ownership and financial backers"; and the need to appoint receivers to "continue the operation" of the owner or licensee".

PHHC 2-27-90 attm. #4, pg. 5.

None of these purposes appear to support a requirement that a disclosed landlord be licensed. In fact this report clearly differentiates between those who operate (owners & Licensees) and all other related persons. The licenses, fines and penalties all appear to be aimed at the "operator"/owner/licensee.

In his address to the Legislature dated January 10, 1978 (attached hereto) Governor Bennett also read his Committee's report to be aimed at the "operators" and disclosure of "related" parties was requested only for financial considerations and not for licensure.

The Address states:

> "Because of these numerous complaints and apparent public confusion and because public funds finance more than 50 per cent of the nursing home beds in Kansas, I believe the public has the right to ask nursing homes to make full financial disclosure of their profits, losses, and ownership. In this way, nursing homes can show their efforts to give quality care at a reasonable cost while satisfying demands for accountability.
>
> . . . .
>
> To achieve this end, I have moved to effect administrative changes which will require such financial disclosure and make this information available to the public in line with the recommendations of the Special Advisory Committee.
>
> . . . .
>
> In the rare instances when nursing homes appear to be disinterested in the welfare of their residents, the state needs more authority to cite and subsequently force them into needed compliance. I believe that in many instances a penalty in the form of a fine is the only way to effectively reform homes which do not provide adequate care and which consistently flout basic regulations. This kind of legislation has been considered in the past, and I am recommending that you delay no longer in passing such a measure.
>
> I recommend the enactment of laws which will provide for a system which combines public citation with fines for those homes which make no move to remedy deficiencies affecting the health, safety, nutrition, or sanitation of their residents after they have been directed to do so by the Department of Health and Environment.
>
> So that enforcement is fair, such a citation must follow repeated infractions by the nursing home, unless the deficiencies are life-threatening or endangering and require an immediate reprimand and correction. Also, the nursing home management should be provided with the right to a hearing on an appeal from any fine. It is not a desire of the state to interfere with the delivery of conscientious care, but only to assure that such care is guaranteed to those who need it.
>
> In extreme cases, where disinterest and mismanagement by nursing home administrators results in an environment where the health and safety of residents is severely threatened, the state needs the authority to seek the appointment of a

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receiver for the home. This authorization would allow for the facility to stay in operation under proper management while improvements were being made in order that residents would not have to be dislocated. At present, there is no way to assure that nursing home residents receive adequate care during this interim period.

. . . .

I am recommending the passage of legislation which will authorize court appointment of a receiver for a nursing home in appropriate circumstances--when life-threatening conditions exist in the home, when it is insolvent, or when its license has been revoked. Again, care must be taken to be fair to management in this process while protecting the welfare of those who cannot protect themselves."

The statutes were subsequently passed by the legislature. (Copies of the Legislative Minutes for 1978 with regard to this Bill are attached.)

Thus, from the very beginnings of these statutes the intent was to license, cite or fine the people who ran the business or caused the problems, and no one else is mentioned.

In 1982 the definition of "operate an adult care home" was added to the adult care home act which is separate from the receivership act in a last minute two (2) day scramble. (See Chapter 189 of 1982 session laws attached hereto.)

On April 28, 1982 SB902 was introduced by the Senate Ways and Means Committee. The bill was referred to the committee of the whole, emergencied to final action and passed by the Senate. Following passage in the Senate, SB902 was read in on the House floor on April 28, 1982, referred to the committee of the whole and emergencied to final action. The House passed SB902 122-1. The bill was presented to Governor Carlin on April 30, 1982. There are no known committee meeting reports or minutes.

K.S.A. 39-943 was amended as follows:

"Sec. 4. K.S.A. 39-943 is hereby amended to read as follows: 39-943. Any person operating an adult care home in this state without a license under this law shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than $100, or by imprisonment in the county jail for a period of not more than six months, or by both such fine and imprisonment. Any person who shall violate any other provision of this act or the requirements of any rules and regulations promulgated hereunder shall be guilty of a misdemeanor and shall upon conviction thereof be punished by a fine of not more than $100, or by imprisonment in the county jail for a period of not more than six months, or by both such fine and imprisonment."

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Attm #4
39.7.

Then K.S.A. 39-923 was amended to add:

> "(13) 'Operate an adult care home' means to own, lease, establish, maintain, conduct the affairs of or manage an adult care home, except that for the purposes of this definition the word 'own' and the word 'lease' shall not include hospital districts, cities and counties which hold title to an adult care home purchased or constructed through the sale of bonds."

The only "legislative history" available in the legislative records is a copy of a April 29, 1982 press clipping. (A copy of which is attached.)

That press clearly indicates that the penalty and fine provisions were being amended to allow the State to penalize and fine actual "owers" of the business who control the business to avoid having a person set up a shell corporation to manage the business and be licensed, then skim the profits from the shell corporation while being shielded from the liabilities and duties of the license.

The press clipping states:

> "'I THOUGHT there was a real urgency in this regard,' she said. 'As I understand it, there's such a tangle of ownerships that you can't ever get the person who is responsible (for nursing home problems).
>
> . . . .
>
> The bill would require that all those involved in the ownership and operation of nursing homes have their names on the home's license, which is granted by the state. That way, the state could take action against all those involved in cases of violations of state nursing home standards.
>
> . . . .
>
> Harkins had said his department was having 'severe' problems with out-of-state nursing home owners -- usually corporations -- that hire other parties to operate the homes.
>
> Without the bill, the department can do little to prevent an owner from hiring a management group to run the nursing home, then violating the same standards the previous operators had violated under the owner's supervision.
>
> Harkins said the license of a nursing home operator in Winfield was revoked, but the actual owners of the building and property could not be touched, even though they were suspected of paying a role in the management of the home. (emphasis added)

PH&W 2-27-90 attm. #4 pg. 8.

Nothing can be made more clear than that the legislation was aimed at those involved in the control and operation of the business, so that the State could reach beyond "shell" or "straw man" corporations force those persons in control to comply with nursing home standards.

The separate receivership law was not amended at this time and still had no provisions regarding charging the costs of receiverships to any persons or entities.

Then in 1984, the legislature changed the receivership law (K.S.A. 39-960) to require the "owner or licensee" to repay the costs of any appointed receiver. See Chapter 158, Senate Bill No. 656 attached.)

The problem, again, was that nowhere in the receivership act does the legislature define "owner or licensee". However, K.S.A. 39-954(a) modifies the term "owner" with "owner of an adult care home" stating:

> "(a) The secretary of health and environment, the owner of an adult care home, or the person licensed to operate an adult care home may file an application with the district court for an order appointing the secretary of health and environment or the designee of the secretary as receiver to operate an adult care home whenever: (1) Conditions exist in the adult care home that are life threatening or endangering to the residents of the adult care home; (2) the adult care home is insolvent; or (3) the secretary of health and environment has issued an order revoking the license of the adult care home."

Would a mere landlord be entitled to request a receiver or even be in a position to correct the operational and management defects that a receiver is appointed to correct? Obviously not. Then why would he be required to pay for a receiver?

The minutes of the Committees which recommended the change in the law are also attached hereto.

It is obvious from a review of those minutes that the law is aimed at "owners and operators" ... "to bear enough of the consequences of actions that brought about the receivership".

A true landlord plays no role in the business or operation of the adult care home business.

In Borders v. Roseberry, 216 Kan. 486, 488, 533 P.2d 1366 (1975) the Court stated:

> "When land is leased to a tenant, the law of property regards the lease as equivalent to a sale of the premises for the term. The lessee acquires an estate in the land, and becomes for the time being the owner and occupier, subject to all of the responsibilities of one in possession, both to those who enter onto the land and to those outside of its boundaries. Professor William L. Prosser in his Law of Torts, 4th Ed. §63, points out that in the absence of agreement to the contrary, the lessor surrenders both possession and control of the land to the lessee, retaining only a reversionary interest; and he has no right even to enter without the permission of the lessee."

PHCW 2-27-90 Attm't #4. 89.9.

Furthermore, the testimony also refers to the statutory requirement of meeting all contract obligations of the owner. If the operator/business owner were the "owner", this provision would make sense. But if you claim a landlord is the "owner", then the State has a statutory duty to meet all the landlords other contractual obligations that have nothing to do with the property. The statute does not make sense in this regard.

Returning to the legal requirement that the exercise of police power be based upon reasonableness and that there be a clear connection between the action and the ends sought to be achieved, the statutes only appear to be reasonable if they are applied to actual operators and owners who have control of the business.

There is no logical or rational nexus between the goals sought to be achieved [1) licensure of persons who control the business, 2) penalties for persons who control the business and cause it to be put into receivership, and 3) disclosure of ownership and related parties for financial purposes] with the application of the statutes by the KDHE (Requiring persons who have no control, possession or ownership interest to be a co-licensee and pay for the errors and omissions caused by the wholly unrelated business operator).

The only common sense method of interpreting these statutes to comply with constitutional requirements would be that they require licensure of all persons who would actually have control in operating the business and all other persons, including landlords, should merely be required to be reported to the public for financial purposes.

Therefore, any action by the KDHE in co-licensing mere landlords is an unconstitutional application of the statutes and may be a violation of those persons constitutional rights.

From the foregoing it obviously appears that if KDHE required a landlord or even led a landlord to believe that the landlord had to apply for a license, (i.e. sign "Part II") that the action by the State was unconstitutional as applied and must be void or voidable.

Not being a proper "owner" or "licensee" as intended by the legislature, the landlord would not be liable for the costs of the receivership pursuant to K.S.A. 39-960. To find otherwise would deprive the landlord of his property without any casual relationship, justification or basis to support the reason for the statute - i.e. to make those who caused the problems, pay for them.

Stephen P. Weir

PHW
2-27-90
Attn. #4.
Pg. 10.

PIONEER VILLAGE
STATEMENT OF EXPENSE-BUDGET v. ACTUAL
PERIOD FROM FEBRUARY 27, 1989 TO
SEPTEMBER 30, 1989

	CURRENT PERIOD				YEAR TO DATE			
	ACTUAL	BUDGET	VAR	% VAR	ACTUAL	BUDGET	VAR	% VAR
HEALTH CARE COSTS:								
PROG COORD	0	7,400	7,400	100.00%	0	44,400	44,400	100.00%
CONSULTANTS	0	6,800	6,800	100.00%	1,610	40,800	39,190	96.05%
HEALTH SERV COORD	4,518	4,600	82	1.79%	15,379	27,600	12,221	44.28%
DIETARY SUP	5,370	1,400	(3,970)	-283.57%	46,163	8,400	(37,763)	-449.56%
CMA'S	9,514	3,500	(6,014)	-171.84%	41,449	21,000	(20,449)	-97.38%
SOCIAL WORKER	15,283	1,840	(13,443)	-730.58%	92,047	11,040	(81,007)	-733.76%
D.C. PROG COOR	0	5,500	5,500	100.00%	0	33,000	33,000	100.00%
VACATION BENS	0	3,200	3,200	100.00%	0	19,200	19,200	100.00%
TEACHING STAFF	98,313	87,400	(10,913)	-12.49%	513,727	524,400	10,673	2.04%
NSG SUPPLIES	1,857	375	(1,482)	-395.10%	20,811	2,250	(18,561)	-824.95%
UNCOVERED MED/DENT	0	400	400	100.00%	0	2,400	2,400	100.00%
TRAINING SUPPLIES	5,589	600	(4,989)	-831.48%	11,546	3,600	(7,946)	-220.71%
RES ACTIVITIES	0	210	210	100.00%	0	1,260	1,260	100.00%
HEALTH CONSULTANTS	8,759	2,100	(6,659)	-317.07%	32,938	12,600	(20,338)	-161.41%
CONSULTANTS EXP	0	50	50	100.00%	1,403	300	(1,103)	-367.50%
PERSONNEL POOL	4,048	0	(4,048)	0.00%	86,763	0	(86,763)	0.00%
TOTAL HC EXP	153,250	125,375	(27,875)	-22.23%	863,836	752,250	(111,586)	-14.83%
TOTAL FACILITY EXP	282,653	216,135	(66,518)	-30.78%	1,539,517	1,296,810	(242,707)	-18.72%

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Attn: #4
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PIONEER VILLAGE
STATEMENT OF EXPENSE-BUDGET v. ACTUAL
PERIOD FROM FEBRUARY 27, 1989 TO
SEPTEMBER 30, 1989

	CURRENT PERIOD				YEAR TO DATE			
	ACTUAL	BUDGET	VAR	% VAR	ACTUAL	BUDGET	VAR	% VAR
ADMIN COSTS:								
SUPPLIES	3,313	1,000	(2,313)	-231.27%	17,254	6,000	(11,254)	-187.56%
PRINTING	1,854	350	(1,504)	-429.77%	4,941	2,100	(2,841)	-135.28%
POSTAGE & DELIVERY	123	275	152	55.36%	937	1,650	713	43.24%
TELEPHONE	1,174	400	(774)	-193.40%	6,450	2,400	(4,050)	-168.77%
SALARIES	8,877	13,750	4,873	35.44%	58,836	82,500	23,664	28.68%
EMPLOYEE BENEFITS	9,548	4,200	(5,348)	-127.33%	40,018	25,200	(14,818)	-58.80%
PAYROLL TAXES	10,704	13,500	2,796	20.71%	62,924	81,000	18,076	22.32%
TRAVEL	967	500	(467)	-93.34%	10,095	3,000	(7,095)	-236.48%
ADVERTISING	890	1,000	110	11.03%	2,447	6,000	3,553	59.22%
CONFERENCES	288	450	162	35.94%	2,925	2,700	(225)	-8.34%
MGMT CONSULTANTS	14,917	14,000	(917)	-6.55%	116,162	84,000	(32,162)	-38.29%
LICENSES,DUES,SUBS	214	500	286	57.27%	389	3,000	2,611	87.02%
INSURANCE	6,231	3,000	(3,231)	-107.69%	21,134	18,000	(3,134)	-17.41%
OTHER	19,798	75	(19,723)	-26297.31%	35,364	450	(34,914)	-7758.64%
TOTAL ADMIN COSTS	78,896	53,000	(25,896)	-48.86%	379,875	318,000	(61,875)	-19.46%
PROPERTY COSTS:								
TELEPHONE	0	400	400	100.00%	0	2,400	2,400	100.00%
MAINT & REPAIR	9,903	4,150	(5,753)	-138.63%	65,000	24,900	(40,100)	-161.04%
MAINT STAFF	3,503	1,200	(2,303)	-191.94%	15,717	7,200	(8,517)	-118.29%
UTILITIES	5,812	3,500	(2,312)	-66.05%	24,366	21,000	(3,366)	-16.03%
HOUSE ACCESSORIES	0	200	200	100.00%	0	1,200	1,200	100.00%
VAN DEP/LEASE	268	2,200	1,932	87.83%	2,708	13,200	10,492	79.48%
VAN MAINT	1,956	250	(1,706)	-682.56%	5,393	1,500	(3,893)	-259.54%
RENT	11,711	14,000	2,289	16.35%	102,804	84,000	(18,804)	-22.39%
CLEANING SERV	0	1,000	1,000	100.00%	7,285	6,000	(1,285)	-21.42%
TOTAL PROP EXP	33,153	26,900	(6,253)	-23.24%	223,273	161,400	(61,873)	-38.34%
RM & BD EXPENSES:								
FOOD	11,663	8,900	(2,763)	-31.04%	59,245	53,400	(5,845)	-10.95%
KITCH SUPP & EQUIP	0	425	425	100.00%	0	2,550	2,550	100.00%
LINEN & BEDDING	0	110	110	100.00%	0	660	660	100.00%
LAUNDRY SUPPLIES	0	400	400	100.00%	0	2,400	2,400	100.00%
HSKPG SUPPLIES	5,692	1,025	(4,667)	-455.30%	13,289	6,150	(7,139)	-116.07%
TOTAL RM & BD	17,354	10,860	(6,494)	-59.80%	72,533	65,160	(7,373)	-11.32%

P Nelli
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attm # 4.
09.12.

PIONEER VILLAGE IN-PATIENT COST PER DAY ANALYSIS:	FEB 27 THRU MARCH 31	APRIL 1 THRU APRIL 30	MAY 1 THRU MAY 31	JUNE 1 THRU JUNE 30	JULY 1 THRU JULY 31	AUGUST 1 THRU AUGUST 31	SEPT 1 THRU SEPT 30	FEB 27 THR SEPT 30
RESIDENT DAYS:								
PRIVATE PAY	33.0	30.0	31.0	30.0	31.0	31.0	30.0	216.
MEDICAID DAYS	1,698.0	1,476.0	1,501.0	1,433.0	1,464.0	1,398.0	1,394.0	10,364.
HOME DAYS	47.0	27.0	49.0	37.0	24.0	19.0	17.0	220.
TOTAL DAYS	1,778.0	1,533.0	1,581.0	1,500.0	1,519.0	1,448.0	1,441.0	10,800.
AVERAGE PER DAY	53.9	51.1	51.0	50.0	49.0	46.7	48.0	50.
OPERATING COSTS	COST PER RES. DAY	COST PER RES. DAY	COST PER RES. DAY	COST PER RES. DAY	COST PER RES. DAY	COST PER RES. DAY	COST PER RES. DAY	COST PER RES. DAY
NURSING CARE	$5.74	$3.28	$25.03	$8.97	$13.10	$30.00	$22.20	$15.1
DIRECT CARE	$29.58	$33.41	$36.93	$36.94	$36.10	$36.85	$36.78	$35.0
SOCIAL SERVICES	$6.57	$5.58	$6.80	$10.72	$13.16	$15.09	$11.74	$9.8
RECREATION	$0.61	$0.22	$0.17	$0.02	$0.18	$0.16	$0.27	$0.2
DIETARY	$9.89	$9.64	$10.45	$10.04	$11.15	$9.93	$12.30	$10.4
HOUSEKEEPING	$4.28	$3.61	$0.54	$0.76	$0.24	$0.01	$4.38	$2.0
TRAINING	$5.94	$8.15	$17.40	$17.51	$22.57	$36.29	$42.29	$20.8
MAINTENANCE	$4.62	$5.32	$9.20	$12.16	$7.26	$10.38	$11.53	$8.5
UTILITIES	$1.02	$1.03	$3.08	$2.27	$0.59	$2.53	$3.43	$1.9
ADMINISTRATION	$11.40	$12.41	$15.54	$15.05	$22.29	$24.69	$32.96	$18.6
MANAGEMENT FEE	$11.24	$9.69	$8.08	$8.85	$13.24	$10.29	$9.27	$9.6
BUILDING INS. & TAXES	$0.56	$0.65	$0.63	$0.67	$0.66	$0.69	$0.69	$0.6
PROPERTY	$0.00	$0.00	$0.00	$0.00	$0.00	$8.25	$8.31	$9.6
OPERATING COST PER DAY	$91.47	$92.97	$133.87	$123.96	$140.56	$185.15	$196.15	$142.5
LESS:								
REVENUE FROM RESIDENT	$7.59	$6.64	$7.64	$6.85	$7.11	$7.63	$7.60	$6.3
NET OPER. COST PER DAY	$83.88	$86.33	$126.23	$117.10	$133.45	$177.51	$188.55	$136.2
ADDITIONAL CASH DISBURSEMENTS:								
CAPITAL EQUIPMENT PURCHASED		$18,027.00	$1,393.00	$39.00	$1,535.00	$0.00	$0.00	$1.9
INVENTORY PURCHASED		$4,253.78	$0.00	$0.00	$0.00	$0.00	$0.00	$0.3
PREPAID INSURANCE		$4,304.00	$0.00	$8,342.00	$0.00	$0.00	$25,262.00	$3.5
TOTAL NET COST PER RESIDENT DAY								$142.1

P. H & W
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Attm's #4.
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STATE OF KANSAS

OFFICE OF THE ATTORNEY GENERAL

2ND FLOOR, KANSAS JUDICIAL CENTER, TOPEKA 66612-1597

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July 31, 1989

ATTORNEY GENERAL OPINION NO. 89- 96

The Honorable William W. Bunten
State Representative, 54th District
1701 W. 30th
Topeka, Kansas 66611

Re: Mentally Ill, Incapacitated and Dependent Persons; Social Welfare -- Adult Care Homes -- Licensure and Receivership

Synopsis: Where an owner of a building which is leased by an adult care home business does not have an express or implied interest in the business of operating the adult care home, it is our opinion that the legislature did not intend to impose a duty upon the owner to assume such an interest. Rent moneys owed to such an owner should be paid to the owner by a receiver unless such moneys are otherwise subject to valid legal claims. However, where a landlord has an interest in the operation of the adult care home and merely seeks to escape licensure requirements or financial responsibility for operation of an adult care home business, that landlord should be on the license and will be subject to cost recovery procedures set forth at K.S.A. 39-960 and 39-961. Cited herein: K.S.A. 39-923; 39-926; 39-954; 39-959; 39-960; 39-961; 39-962; 39-963.

* * *

P Hrd
2-27-90
Attn. #4,
Cg. 14.

Dear Representative Bunten:

You request our opinion concerning interpretation of K.S.A. 39-954 et seq. as it relates to the authority of a receiver to retain lease payments claimed by a co-licensee who is not involved in the management of the affairs or operation of an adult care home but is rather a mere landlord. You specifically ask that we address these questions:

"(a) May a lessor, who is not involved in the management of the affairs or the operation of the adult care nursing home, be held liable for program deficiencies in a receivership pursuant to K.S.A. 39-360?

"(b) Whether a lessor who is not involved in the management of the affairs or the operation of the adult care home, may be required by the Secretary of Health and Environment to be a co-licensee under the provisions of 39-954, et seq., so as to make that lessor liable for program deficiencies in a receivership pursuant to K.S.A. 39-960?

"(c) May the Secretary of Health and Environment withhold lease payments to a lessor who is not involved in the management of the affairs or the operation of the adult care home, in a receivership pursuant to K.S.A. 39-960?"

We note that these issues have been the subject of litigation which we understand has been dismissed without prejudice. We also understand that the district court continues to exercise jurisdiction over this matter pursuant to K.S.A. 39-954 et seq. and the resulting receivership. Many of the issues discussed herein cannot be resolved without examination of specific facts. We cannot act as a fact finder and therefore defer such fact questions to the proper state agency or the district court.

You ask whether a lessor may be required to be a co-licensee pursuant to K.S.A. 39-954 et seq. K.S.A. 39-926 makes it unlawful to operate an adult care home without a license. K.S.A. 39-927 sets forth who must sign the application for a license:

> "An application for a license to operate an adult care home shall be made in writing to the licensing agency upon forms provided by it and shall be in such form

PHHW
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Attm. #4
Pg. 5.

> and shall contain such information as the licensing agency shall require, which may include affirmative evidence of the applicant's ability to comply with such reasonable standards and rules and regulations as are adopted under the provisions of this act. The application shall be signed by the person or persons seeking to operate an adult care home, as specified by the licensing agency, or by a duly authorized agent of any person so specified. . . ." (Emphasis added).

Thus, anyone seeking to operate an adult care home must sign the application for licensure. K.S.A. 39-923(a)(13) defines the term "operate an adult care home":

> "(13) "Operate an adult care home" means to own, lease, establish, maintain, conduct the affairs of or manage an adult care home, except that for the purposes of this definition the word "own" and the word "lease" shall not include hospital districts, cities and counties which hold title to an adult care home purchased or constructed through the sale of bonds." (Emphasis added).

A problem arises because, while K.S.A. 39-923(a)(13) defines operation of an adult care home to mean "to own . . . an adult care home," it is not clear from the language of the statute whether "to own an adult care home" means to own an interest in the building or facility itself or to own an interest in the business of the adult care home.

The words chosen by the legislature are the most persuasive evidence of the purpose of the statute. However, if the plain meaning of the statute is not clear or leads to futile or unreasonable results, courts may look beyond the words to the purposes of the act. Atchison, Topeka and Santa Fe Ry. Co. v. U.S., 628 F.Supp. 1431, mod. on reconsideration 660 F.Supp. 29 (Kan. 1986); State v. Adee, 241 Kan. 825 (1987); Ludwick v. Johnson County, 233 Kan. 79 (1983). When a statute is susceptible to more than one construction, it must be given the construction which gives expression to the intent and purpose of the legislature, even though such construction is not within the strict literal interpretation of the statute. Reeves v. Board of County Commissioners of

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Johnson County, 226 Kan. 397 (1979). In determining legislative intent, the court may not look to statements made years after the enactment, but may properly look to historical background, circumstances pending passage, purposes to be accomplished, and the effect the statute will have under the various suggested constructions. Board of Education of Unified School District 512 v. Vic Regnier Builder's, Inc., 231 Kan. 731 (1982); State v. Freeman, 236 Kan. 274 (1984); State v. Phifer, 241 Kan. 233 (1987). When a statute is ambiguous, the courts consider and give great weight to the interpretation of the appropriate administrative agency. Matzke v. Block, 564 F.Supp. 1157, affd. in part, rev. in part, 732 F.2d 799 (Kan. 1983); Dennison v. Topeka Chambers Indus. Dev. Corp., 527 F.Supp. 611, affd. 724 F.2d 869 (10th Cir. 1981); Board of County Commissioners of Johnson County v. Greenshaw, 241 Kan. 119 (1987). However, where an agency interpretation is clearly erroneous, in contravention of the law, or not consistent, a court may depart from agency interpretation. DSG Corp. v. Shelor, 239 Kan. 312 (1986); Appeal of Sterling Drill Company, 9 Kan.App.2d 367 (1981).

The Kansas Department of Health and Environment (KDHE) provides forms to applicants seeking to operate an adult care home. These forms include a disclosure statement which requires information concerning the owner of the land and building. If the applicant and the owner of the land are different entities, KDHE requires the owner of the property or building to join in the application for a license. Thus, KDHE requires such owners to become co-licensees. The issue thus becomes whether the legislature intended to mandate that owners of property obtain a license to operate an adult care home where such owners do not otherwise seek or possess authority to control, operate or own an interest in the separate legal entity providing the adult care.

Attorney General Opinion No. 84-66 discussed whether a foreign corporation licensed to operate and manage an adult care home in the state of Kansas should register pursuant to K.S.A. 17-7301 et seq. We opined that such corporate registration was required because of the active part the company in question took in the operations of the adult care home and considered the fact that this out-of-state corporation had entered into a management contract for the purpose or providing for the day-to-day affairs of the adult care home. This opinion did not discuss a situation involving a company that merely owned the building and which did not otherwise have or seek to exert any control or interest in the

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operation of the adult care home. Similarly, in response to a March 17, 1982 letter from KDHE, this office addressed the authority to hold principals accountable as licensees. The principals discussed in this letter were indirectly involved in the operation of an adult care home through a contract for the performance of the day-to-day functions by a management group. We advised that in such a fact situation it seemed reasonable to require a real estate investment corporation to be licensed to operate an adult care home. Our advice was predicated upon the operation of an adult care home by the agent of the principal, and thus both entities were, to some degree, engaged in and legally responsible for the operation of the adult care home. Thus, we believed both entities should be required to obtain a license to operate that adult care home because both had a legal interest in the the adult care home.

Following our 1982 letter, L. 1982, ch. 189, § 1 amended K.S.A. 39-923(a) to include section (13) as it currently reads and to define "operate an adult care home" to include "to own . . . an adult care home". Unfortunately, legislative history in the form of committee meeting reports or minutes is virtually nonexistent because this amendment was introduced on April 28, 1982 and final action was taken on the same day. However, in determining legislative intent, statutory construction rules permit consideration of the circumstances and history surrounding the enactment. See State v. Phifer, 241 Kan. 233 (1987).

It is our understanding that in enacting the 1982 emergency amendment to K.S.A. 39-923, legislators apparently believed the amended language countered the problem of the adult care home property owner who violated standards but was not on the license. This was regarded as necessary legislation because some owners of property were suspected of playing a role in and having an interest in the management and operation of the home. The amendment required all parties involved in the ownership and operation of an adult care home business to be on the license. The question of whether mere ownership of the building was enough to trigger licensure requirements was not clearly addressed. KDHE proffers the legal principle inclusio unius est exclusio alterious as support for the proposition that if the legislature had not intended for mere property owners to be liable in receivership, it would have written into the receivership law the type of exception it included in K.S.A. 39-923(a)(13) for hospital districts, cities and counties. We note, however, that other entities peripherally involved in an adult care home are also not

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included in the exception but are nevertheless excluded from licensure requirements: e.g., health care professionals providing services; equipment lessors or suppliers who own property located in the building; employees, residents and staff at the adult care home. These entities are involved in the ownership of adult care home property or the daily operation of the facility, but are not required to be on the license to operate, perhaps because of their relative lack of interest or control over business operations.

Licensure by the government is an exercise of police power:

> "The right to engage in a legitimate employment or business receives recognition as a portion of the individual freedoms secured by the due process provisions of the federal and state constitutions. However, this fact does not close the door to all legislative control over the exercise of the right. A state's police power with regard to the protection of health, morals, and welfare of the public includes the right to regulate, by requiring a license as a prerequisite to the carrying on of certain activities, commonly designated as businesses, occupations, vocations, trades, or callings.
>
> The right of personal liberty and the right to earn a livelihood in any lawful calling and to pursue any lawful trade or vocation is subject to the governmental right to require a license where justified under the police power." 51 Am.Jur.2d License and Permits, § 14 (1970); See also 16A C.J.S. Constitutional Law, § 454 (1984).

License means permission or authority, and a license to do any particular thing is permission or authority to do that thing. Federal Land Bank of Wichita v. Board of County Commissioners of Kiowa County, State of Kansas, 368 U.S. 146, 82 S.Ct. 282, 7 L.Ed.2d 199 (1961). The legislature may require a license in order to engage in certain occupations or businesses. However, statutes restraining the exercise of a trade, operation or business must not be deemed to extinguish or restrain private rights unless that is clearly the

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legislatively intent. State v. Gillen, 126 Kan. 368 (1928). We must therefore determine whether there is a clear legislative intent to license the private right to own a building which is used as an adult care home.

KDHE believes that a license is required in order to own and lease a building to a non-profit corporation that operates an adult care home. The state obviously has a legitimate interest in the care given and the maintenance of adult care homes. The 1982 amendments to K.S.A. 39-923 et seq. sought to assure the state, and those residing in adult care homes, that those entities involved in providing such a service and maintenance could be held to certain standards. Prior to 1982, owners of adult care homes were occasionally using "straw men" as fronts, thus escaping responsibility for operation and maintenance. It is clear that the legislature intended to provide a mechanism whereby all the proper entities were required on a license.

It is not as clear whether a landlord of an adult care home is such an entity. Determining the future extent and nature of involvement in operations or maintenance by a facility owner could be difficult, especially before operations and maintenance actually commence or if an owner seeks to avoid such responsibility or hide such a relationship. Thus, application for license and disclosure forms require information concerning each person who has a direct or indirect ownership in an adult care home.

Given the deference afforded to agency interpretation and the compelling state interest in insuring that all adult care home operators and owners are held to certain standards, it is our opinion that K.S.A. 39-923 et seq. may be read to include a requirement of licensure for the owner of the building in which an adult care home is operated. However, such a requirement is not without limitation. The legislature clearly intended to require licensure of an owner who uses another entity to operate his or her business. A landlord will not necessarily have, seek or be able to exert any control over a separate legal entity which is completely independent in its operation of an adult care home occupying the property.

Requiring a landlord to be on the license could be characterized as allowing the landlord to permit the tenants to make this particular specialized use of the property. If the financial disclosure forms, application for license and the license itself assure the state that persons connected

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with ownership and operation of the adult care home can be adequately monitored and enables enforcement of compliance with all applicable standards by those entities possessing such authority or responsibility, the state may require the owner of a building to obtain a license. A license for these purposes is within the scope of state police power. However, if requiring a landlord to be on a license mandates that the landlord assume some sort of additional control over or responsibility for operations, where none was heretofore intended, sought, or even available, it is our opinion that this goes beyond the intent of the legislature. Thus, whether a particular entity has or should have some responsibility concerning the operation of an adult care home becomes a fact question dependent upon the extent of legal interest, involvement or responsibility of each entity. Such fact questions fall within the province of authority delegated to KDHE. Therefore, that agency may require an owner of an adult care home to be on the adult care home license when there is factual evidence that the owner is using another entity to operate an adult care home business for which the owner of the building is or should be responsible.

The second issue is whether the receiver and KDHE must pay rent to a landlord, or whether such payments may be suspended or denied because of costs incurred by the state due to the receivership status of the adult care home.

If an adult care home is unable to continue for one or more of the reasons enumerated under K.S.A. 39-954 et seq., a court may appoint a receiver, who essentially runs the adult care home until the fulfillment of one of the circumstances listed under K.S.A. 39-963. A receiver is "a ministerial officer, agent, creature, hand or arm of, and temporary occupant and caretaker of the court and he represents the court appointing him and he is the medium through which the court acts." Blacks Law Dictionary 1140 (5th ed. 1979); see also Cates v. Musgrove, 190 Kan. 609 (1962); W-V Enterprises, Inc. v. Federal Savings and Loan Insurance Corporation, 234 Kan. 354 (1983). The receiver remains subject to the supervision of the district court under K.S.A. 39-962, and we note that the court appointing this receiver has continuing jurisdiction and authority to advise, supervise and authorize a receiver to either retain or pay over rent moneys claimed by an owner of the adult care home property. This review by the court provides due process notice and hearing opportunity.

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In addition to those authorized or imposed by the district court, K.S.A. 39-959 sets forth the powers and duties of a receiver:

> "A receiver appointed in accordance with the provisions of this act shall have the following powers and duties:
>
> (a) Conduct the day to day business operations of the adult care home;
>
> (b) reimburse the owner or licensee, as appropriate, a fair monthly rental for the adult care home, taking into account all relevant factors, including the condition of such adult care home and set-offs arising from improvements made by the receiver;
>
> (c) give fair compensation to the owner or licensee, as appropriate, for all property taken or used during the course of the receivership if such person has not previously received compensation for the property being taken or used;
>
> . . .
>
> (g) honor all existing leases, mortgage, chattel mortgage and security interests." (Emphasis added).

Thus, when appropriate and taking into account all relevant factors, the receiver is clearly authorized to pay the owner or licensee a fair monthly rental. The receiver also has the power and duty to honor all existing leases. We note the two separate provisions discussing these reimbursements. This may indicate that some persons having a mortgage or lease arrangement with an adult care home may differ from the owner or licensee; e.g. the building or equipment lessor; the bank holding a mortgage, etc.

Subsection (g) of K.S.A. 39-954 requires the receiver to honor all existing leases, and thus a receiver may step into the preexisting contractual relationship as a party. Subsection (b) permits reimbursement to an owner or licensee to be affected by certain factors. Thus, one issue becomes whether the entity claiming a payment from a receiver is an owner or

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licensee. The factual determinations discussed under the first issue impact upon this question. If an owner is required to be on an license, K.S.A. 39-959(b) permits consideration of all relevant factors and rent payments may be withheld "when appropriate". "Appropriate" is not defined by statute and what is appropriate must therefore be determined in light of all relevant factors. If an owner is not or should not be on a license, K.S.A. 39-954~~(g)~~ allows the receiver to make rent payments, subject to any restrictions imposed by the district court or by restrictions on funds available to the receiver. However, K.S.A. 39-954 discusses the power and authority of the receiver, not KDHE. While the statutes permit the state to fund the costs of receivership, KDHE is a separate entity. Thus, the obligation of the state to pay rent moneys to a landlord must be established pursuant to other authority.

The third issue concerns liability for costs and necessarily involves elements discussed under the first two issues. In addition to retention of reimbursement as authorized by K.S.A. 39-959(b), K.S.A. 39-960 and 39-961 discuss costs incurred as a result of an adult care home going into receivership. Both the secretary of KDHE and the secretary of the Social and Rehabilitation Services (SRS) are statutorily authorized to recover costs resulting from expenditures by the state due to the receiver's operation of the adult care home. These amounts "shall be owed by the owner or licensee . . . and until repaid shall constitute a lien against all nonexempt personal and real property of the owner or licensee." Thus, a lien arises by operation of law and creates a right or claim which the state, as creditor, has in order to secure the payment of a debt or obligation. See Blacks Law Dictionary 832 (5th ed. 1979). K.S.A. 39-963 authorizes the court to make additional orders to recover costs and expenses incurred pursuant to receivership. These statutes evidence a clear legislative intent to allow and facilitate recovery of costs incurred by the state. However, determining from whom such costs may be recovered requires analysis of the statutory language and legislative intent.

While K.S.A. 39-959 remains unchanged from the original 1978 enactment, K.S.A. 39-960 and 39-961 were added to the act pursuant to L. 1984, ch. 158 (1984 Senate Bill No. 656). Testimony received on Senate Bill No. 656 from KDHE and SRS indicates that these agencies saw this amendment as a means by which the state could recover costs of a receivership when costs paid by the state exceeded the revenue generated by the adult care home. These agencies believed that the

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amendment allowed payments made by the state to be recovered from the owner or licensee. Testimony does not evidence a discussion of whether "the owner" included a "mere landlord" or rather, was directed at an owner who sought to escape responsibility by using another entity to operate the business. Testimony before the committee does exhibit a strong desire to recover costs expended by the state due to an adult care home going into receivership. The state was obviously seeking a method by which to impose and recover a debt. When the adult care home goes into receivership because of insolvency, recovery of debt from the bankrupt business becomes problematic if not impossible.

Liability for or the obligation to pay a debt may be created in many ways: by contract (implied or express); through a judgment; or through enforcement of a statutory obligation. See 26 C.J.S. Debt § 2 (1956). There has not been a judicial order concerning the payment of this obligation. Therefore, the possible theories upon which this debt may be based are contractual or statutory.

The landlord in question has a lease agreement with the tenant, but the contract does not express contractual agreement by the owner to assume responsibility for debts. Therefore, it becomes necessary to imply such contractual liability. Financial responsibility for a debt may be implied or arise because of special relationships; i.e. parents may be held liable for the actions of their children, masters or principals for the actions of their servants or agents and partners for their co-partners. These relationships are either based on consensual agreement, joint action or ability to control. These types of relationships will not necessarily exist between a landlord and tenant unless there is joint action, the landlord expressly or impliedly agrees to be financially responsible for the debts of a tenant or the landlord exercises some control over the business of the tenant.

The agreement in question does not expressly seek to assume or exert any control or interest in the day-to-day operation, or other business aspects of the adult care home. However, joint action or ability to control may be implied from facts outside the scope of the agreement. Such a fact determination must be made by the appropriate authority. If joint action or ability to control is not evidenced, individual liability must be present. Individual liability may exist if there is some indication that the landlord agreed to assume liability for debts owed to the state.

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A surety contract represents a type of agreement whereby one entity agrees to assume liability for a debt. Surety is defined as "one who undertakes to pay money or to do any other act in the event that his principle failed therein." Blacks Law Dictionary 1293 (5th ed. 1979). See also U.S. v. Gonzales, 541 F.Supp. 783 (Kan. 1982). A bond is a contract, and a surety is bound to the extent it has agreed to be bound. Fink v. Allen, 11 Kan.App.2d 27 (1985). Introduced in the same year as Senate Bill No. 656, 1984 House Bill No. 2368 did not pass. This bill sought to require a surety bond in order to protect against financial failure of an adult care home. If this bill had been enacted, the costs incurred by the receiver could be in part recovered from the surety. The failure of this bill could mean that such financial surety was not intended or required by the legislature or that the legislators believed that other enactments provided for such assurances.

If a landlord agrees to pay the debts of a tenant, creditors of that tenant may look to the landlord for payment. Requiring a landlord to be on a license could arguably imply a consensual agreement on the part of a landlord to act as surety for that tenant. Where a surety contract does not exist and cannot be implied, recovery for costs must be predicated upon other authority. From the facts available to us, there does not appear to be an express or implied contract between these parties whereby the landlord promised the tenant or creditors that he would assume responsibility for the debts owed to the state.

Thus, the issue becomes whether the statutes create an obligation on the part of the landlord. K.S.A. 39-960 and 39-961 establish a statutory obligation on the part of the owner or licensee of an adult care home. As previously discussed, the legislature clearly intended to impose some liability upon those owners of adult care homes who sought to escape responsibility through the use of another entity who conducted the day-to-day operations of the adult care home in which the facility owner had a legal interest. Legislative history indicates that K.S.A. 39-960 and 39-961 were enacted with the support of the state agencies as a counter to situations wherein a for-profit entity reaped the benefits of owning or operating an adult care home but escaped the responsibilities connected with this type of business. Personal and real property become subject to a lien pursuant to these statutes until amounts owed are paid by the owner or licensee. The statutes seek, in effect, to "pierce the corporate veil" and insure financial responsibility on the

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part of those who directly or indirectly have an interest in the adult care home. Thus, the statutes dictate that an owner of an adult care home may be individually or jointly liable for the costs incurred by the state as a result of the adult care home going into receivership.

While a landlord may own the building which houses an adult care home, not all such landlords own or operate any part of the business conducted on their property. Some property owners may neither seek nor possess responsibility for the activities conducted on their premises, nor will they always have the prerequisite capability to conduct such a business. Thus, there may be no joint undertaking. However, licensing procedures may notify a landlord that, if they choose to permit a tenant to make a certain use of their property, they are acquiescing to assumption of some responsibility for the actions of the tenant. Such statutory imposition of responsibility for the obligations and debts of a separate legal entity not connected with or controlled by the debtor resembles absolute liability principles.

The federal government has legislatively created absolute liability in certain situations involving environmental protection: 43 U.S.C.S. § 1814(d) requires the owner or operator of a vessel from which a pollutant discharges to pay all removal costs incurred by federal or state governments or agencies; 33 U.S.C.S. § 497 enacted the refuse act which is a criminal strict liability statute providing for attachment of the liability without regard to the question of mistake or innocence. However, a defendant may show that someone else is responsible for the discharge, and thus escape strict liability. See 61A Am.Jur.2d Pollution Control, § 214 (1981); 42 U.S.C.S. § 6973 and § 7003 amended the solid waste disposal act and, under the Comprehensive Environmental Response, Compensation and Liability Act (CERCLA), owners of landfill property purchased several years after all dumping of hazardous materials have ceased can be held liable for costs. United States v. Price, 523 F.Supp. 1055, 1073 (1981). This liability can be assessed unless the subsequent owners "could not reasonably be expected to have actual knowledge of the presence of hazardous waste at such facility or site and of its potential for release." Id. at 1074. Moreover, legislative history concerning enactment of CERCLA indicates that, in the interests of fairness, courts may apply common law joint and several liability on a case by case basis. United States v. A & F Materials Co., Inc., 578 F.Supp. 1249, 1256 (1984). Thus, legislation can dictate liability without fault or negligence.

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However, absolute liability, while not requiring proof of negligence, is a judicial doctrine which imposes liability upon proof of statutory violation. See United States v. A & F Materials Co., Inc., 578 F.Supp. 1249 (Ill. 1984). When an adult care home goes into receivership for insolvency reasons, a statutory violation has not necessarily occurred. Additionally, absolute or strict liability is premised on some degree of involvement. Persons who have absolutely no connection with an adult care home would not be subject to the terms of the statute or absolute liability. The issue becomes whether the legislature intended to impose absolute liability upon a landlord who rents to a non-profit tenant when that for-profit landlord's only connection with the adult care home is ownership of the specially built building and collection of rent moneys.

It is our opinion that legislative history does not support the imposition of strict or absolute liability against owners of property in which adult care homes are operated. Rather, K.S.A. 39-954 et seq. gives the state a statutory cause of action allowing recovery of costs from owners, operators or licensees who have some express or implied duty concerning the adult care home. The extent to which a specific entity is actually responsible for the finances or operations of an adult care home requires a determination concerning the nature of the relationship between the entity owning the building and the entity operating the adult care home. Such fact questions are properly addressed by the appropriate state agency or a court of law.

Where an owner of a building which is leased by an adult care home business does not have an express or implied interest in the business of operating the adult care home, it is our opinion that the legislature did not intend to impose a duty upon the owner to assume such an interest. However, where a landlord merely seeks to escape licensure requirements or financial responsibility for operation of an adult care home business in which the landlord has an interest, that landlord is required to be on the license and will be subject to cost recovery procedures set forth at K.S.A. 39-960 and 39-961.

Very truly yours,

Robert T. Stephan

ROBERT T. STEPHAN
ATTORNEY GENERAL OF KANSAS

Theresa Marcel Nuckolls

Theresa Marcel Nuckolls
Assistant Attorney General

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INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR ADULT CARE HOME LICENSE (PRS Form 102)

Item A -- Enter name of adult care home. If doing business under a name other than legal name, enter that name and indicate as d/b/a (i.e., doing business as). Enter telephone number including area code.

Item B -- Enter address of adult care home to be licensed.

Item C -- Enter name and address of administrator. Include administrator's license number.

Item D -- Mark the box which indicates the reason for the application request. An **Initial** is when a facility is newly constructed; or when an existing building is to be converted for use as an adult care home; or when a structure is to be modified or expanded; or is requesting a change in bed capacity or requesting a change in license classification; or is anticipating change of ownership. A **change of ownership** is one in which there is a change of control over the capital assets of the facility and/or licensees. A **Renewal** is for a facility that has previously been licensed.

Item E -- Mark the box which indicates the classification of facility. If the home offers different levels of nursing care, the license must be issued for the highest level of care given.

Item F -- The facility may provide different levels of nursing care in defined nursing units each served by a nurse's station. If more than one level of care is offered, indicate the number of beds in each classification. Refer to KSA 39-923 for a definition of each level. If beds are licensed at different levels submit a list of all room numbers and beds per room showing which level of care is provided for each nursing unit. On **all single rooms** indicate with an asterisk (*) if they are equipped with bathing facilities.

Item G -- Enter name and address of owner(s) of the land and building where the adult care home is located. If a corporation owns the land and building enter the corporation name, **not the stockholders.**

Item H -- Enter the name(s) and address(es) of lessee or Contract Purchaser, if applicable. Complete a Part II.

Item I -- Enter name(s) and address(es) of sublessees, if applicable. Complete a Part II.

Item J -- Enter name and address of management firm who operates facility, if applicable. Complete a Part II.

Item K -- List all others involved in the operation of the facility who have not been previously mentioned.

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Item L.-- Indicate by a check mark by "yes" or "no" if the building was financed by revenue bonds. If yes, give the name and address of the governmental unit and the date of maturity of the bonds. The city or county will appear on Item G.

The licensing procedure is described in KAR 28-39-77.

An **initial licensure application** must be submitted with two (2) sets of preliminary construction plans and outline specification in compliance with KAR 28-39-108 to KAR 28-39-113, inclusive. The owner shall submit to the licensing agency any changes in the information in the initial application, plans or specification.

A **renewal application** shall be submitted not less than 120 days before the existing license expires.

The licensee shall notify the licensing agency of any anticipated **change of ownership** information sixty (60) days in advance of the proposed effective date of the change.

An initial application for changes in an existing facility must be filed and approved prior to the time the change occurs. A proposed change in the bed capacity of the facility, whether an increase or a decrease, shall be approved by the licensing agency before the change is made.

Each initial application for a license and each application for renewal of a license shall be accompanied by a license fee of $50.00 plus $7.00 for each bed.

No refund of a license fee shall be made if a license application is denied.

Payment shall be by check or money order made payable to the Kansas Department of Health & Environment. All applications and correspondence should be addressed to

KANSAS DEPARTMENT OF HEALTH & ENVIRONMENT
FIELD SERVICES
LANDON STATE OFFICE BUILDING
900 SW JACKSON STREET
TOPEKA KS 66612-1290

TELEPHONE NUMBER: (913) 296-1260

Part II-- **Each** licensee must complete a Part II of the application for Adult Care Home License. If another corporation owns the disclosing entity, a separate Part II is required for each subsidiary or parent company. The information completed for the resident agent should be the name and address of the person listed for the corporation as it is registered with the Secretary of State's office. The Secretary of State's phone number is 913-296-4564.

Part III--If application is being completed for an initial license, all items requested on Part III must be included.

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EACH DISCLOSING ENTITY MUST COMPLETE A PART II OF THE APPLICATION FOR ADULT CARE HOME LICENSE

The undersigned hereby applies to the Kansas Department of Health and Environment for a license to operate an adult care home subject to the provisions of KSA 39-923 through 963 and in accordance with the appropriate Kansas Administrative Regulations.

A. Facility Name _____
Street Address City

B. Disclosing Entity's Name _____

C. Resident Agent name and address as file/registered with the Secretary of State's office for the disclosing entity listed on Line B of this form.

_____
Resident Agent Name Address

_____
City State Zip

D. Type of Entity

- ☐ 1. Sole Proprietorship
- ☐ 2. Partnership
- ☐ 3. Joint Venture
- ☐ 4. Corporation - for profit
- ☐ 5. Corporation - not for profit (Enclose copy of tax exempt notice received from IRS)
- ☐ 6. Government - Type _____
- ☐ 7. Other (Explain) _____

1. List the name(s) and address(es) of each person who has any direct or indirect ownership of 5 percent or more in entity listed above.
2. List each person who is the owner (in whole or in part) of any mortgage, deed or trust, note or other obligation secured (in whole or in part) by such facility or any of the property or assets of such facility.
3. If the disclosing entity is organized as a corporation, attach a list showing the names and address of each officer and director.
4. If the disclosing entity is organized as a limited partnership, please indicate limited liability of each.
5. If the disclosing entity is a governmental unit, attach a list showing the names and addresses of each responsible official (i.e., county commissioner).

Indicate with "X"					INDIVIDUALS NAME	ADDRESS	CITY	STATE
1. Owner	2. Mortgagor	3. Director/Officer	4. Limited Partner (Describe limited liability)	5. Elected Officials				

The following is the legal signature and title of the individual authorized to represent the governing body, corporation, partnership, joint venture, individual, or organization in the operation of the facility by the disclosing entity.

Rec'd 2-27-90 attm #4 09.30

_____
Signature and Title

_____
Address

_____
Telephone Number Date

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

OMB No. 0938-0086

INSTRUCTIONS FOR COMPLETING DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT (HCFA-1513)

Completion and submission of this form is a condition of participation, certification, or recertification under any of the programs established by Titles V, XVIII, XIX, and XX, or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the secretary of appropriate state agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the Secretary or appropriate State agency to enter into an agreement or contract with any such institution or in termination of existing agreements.

SPECIAL INSTRUCTIONS FOR TITLE XX PROVIDERS

All title XX providers must complete Part II(a) and (b) of this form. Only those Title XX providers rendering medical, remedial, or health related homemaker services must complete Parts II and III. Title V providers must complete Parts II and III.

General Instructions

For definitions, procedures and requirements, refer to the appropriate Regulations:

Title V - 42CFR 51a.144
Title XVIII - 42CFR 420.200-206
Title XIX - 42CFR 455.100-106
Title XX - 45CFR 228.72-73

Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information under the Remarks Section on page 2, referencing the item number to be continued. If additional space is needed use an attached sheet.

Return the original and second and third copies to the State agency; retain the first copy for your files.

This form is to be completed annually. Any substantial delay in completing the form should be reported to the State survey agency.

DETAILED INSTRUCTIONS

These instructions are designed to clarify certain questions on the from. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

Item I (a) Under identifying information specify in what capacity the entity is doing business as (DBA), example, name of trade or corporation.

(b) **For Regional Office Use Only.** If the yes box is checked for Item VII the Regional Office will enter the 5-digit number assigned by HCFA to chain organizations.

Item II - Self-explanatory.

Item III - List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier, or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program, or health related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownerwhip interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be repor

Controlling interest is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Items IV-VII - Changes in Provider Status

Change in provider status is defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any change of ownership.

For Items IV-VII, if the yes box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

Item IV - (a & b) If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

Item V - If the answer is yes, list name of the management firm and employer identification number (EIN), or the name of the leasing organization. A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility.

Item VI - If the answer is yes, identify which has changed (Administrator, Medical Director, or Director of Nursing) and the date the change was made. Be sure to include name of the new Administrator, Director of Nursing or Medical Director, as appropriate.

Item VII - A chain affiliate is any free-standing health care facility that is either owned, controlled, or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, are not considered to be chain affiliates.

Item VIII - If yes, list the actual number of beds in the facility now and the previous number.

Rec'd 2-27-90 Attn #41 - Dy. 31.

D[illegible]ent of Health and Human Services
H[illegible]are Financing Administration

Form Approv
OMB No. 093

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

I. Identifying Information

(a). Name of Entity	D/B/A	Provider No.	Vendor No.	Telephone No.
Street Address		City, County, State		Zip Code

(b) *(To be completed by HCFA Regional Office)* Chain Affiliate No. ☐☐☐☐☐ LB1

II. Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations under Remarks on page 2. Identify each item number to be continued.

A. Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX?

☐ Yes ☐ No LB2

B. Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?

☐ Yes ☐ No LB3

C. Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVIII providers only)

☐ Yes ☐ No LB4

III (a) List names, addresses for individuals, or the EIN for organizations having direct or indirect ownership or a controlling interest in the entity. (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under "Remarks" on Page 2. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.

Name	Address	EIN
		LB5

(b) Type of Entity: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation LB6
☐ Unincorporated Associations ☐ Other (Specify)

(c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations under Remarks.

Check appropriate box for each of the following questions

(d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor, partnership or members of Board of Directors.) If yes, list names, addresses of individuals and provider numbers.

☐ Yes ☐ No LB7

Name	Address	Provider Number

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[D]ment of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938-0086

IV. (a) Has there been a change in ownership or control within the last year?
If yes, give date _____ ☐ Yes ☐ No LB8

(b) Do you anticipate any change of ownership or control within the year?
If yes, when? _____ ☐ Yes ☐ No LB9

(c) Do you anticipate filing for bankruptcy within the year?
If yes, when? _____ ☐ Yes ☐ No LB10

V. Is this facility operated by a management company, or leased in whole or part by another organization?
If yes, give date of change in operations _____ ☐ Yes ☐ No LB11

VI. Has there been a change in Administrator, Director of Nursing or Medical Director within the last year?
☐ Yes ☐ No LB12

VII. (a) Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN)
Name EIN # ☐ Yes ☐ No LB13

Address

LB14

VII. (b) If the answer to Question VII.a. is No, was the facility ever affiliated with a chain?
(If YES, list Name, Address of Corporation and EIN)
Name EIN # ☐ Yes ☐ No LB18

Address

LB19

VIII. Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last 2 years?
☐ Yes ☐ No LB15

If yes, give year of change _____
Current beds _____ LB16 Prior beds _____ LB17

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

Name of Authorized Representative (Typed)	Title

Signature	Date

Remarks

PHEW
2-27-90
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...n, yet it ranks 28th in its ratio of ... of our 105 counties have at least ...ons, and the actual shortage of such

...y travel distance of a larger city have ...ical practictioners are retiring and ...is dropping. The population is not ...s that tend to locate in urban areas. ...ause 45 per cent of the elderly, the ...are, live in these communities.

...ician shortage through the develop- ...programs at our universities have ...n's assistants. The impact of these ...problem may be positive. However, ...s financing of services provided and ...to financing, federal Medicaid and ...y a physician which limits efficient ...ician's practice.

...being limited by state law, specifi- ...ugh our universities are working to ...rses to practice independently once ...rent law. On the one hand, we are ...by enlarging training opportunities, ...giving them adequate legal support ...them to perform.

...has been discouraged by a lack of ...lth care delivery system. Their role ...ed so that they can be fully utilized. ...state participate financially in es- ...munication network on a pilot basis ...emergencies for whom immediate ...progressed to the point where 42 ...g in such a system early this year. ...lephone operators at the medical ...quipment for communication be- ...ergency medical communications ...eration from all levels of govern- ...as well as from the private sector. ...are in these counties will be more ...ate has helped by furnishing some ...ssary for the coverage of a large,

...ards for their operation has been ...om people throughout the state. ...n as well as my personal inspec- ...ention if our older citizens are to

...the highest of standards, but those ...upholding such standards so that ...ment of comfort and safety. The ...sing home ombudsman and the ...increased significantly during the ...future.

...were 355 nursing homes within ...rsee them, operating with some ... This level of staffing enables the ...ar times a year, but complaints ...which is desirable. Further, the ...hat the most effective improve- ...epartmental staff is able to take

the time to consult with nursing home employees about standards rather than merely to indicate their lack of compliance with such standards. However, there is not the staff to carry on this kind of educational program.

My Special Advisory Committee on Nursing Homes has uncovered other problems in addition to a lack of investigative staff. In the rare instance when a nursing home appears to be willfully violating state regulations, the state is now powerless to move quickly to see that the home corrects such violations or ceases to offer services. Kansas statutes are vague concerning the revocation of nursing home licenses when care is consistently below standards. Additionally, those statutes are not quickly enforceable. Revocation of a license may take 50 days, and this period is too long for residents to remain in a facility which is unsafe or unsanitary. Investigators also often find that bad conditions may be improved for a brief period and then allowed to deteriorate when the threat of inspection has passed.

If conditions are so consistently bad that a nursing home is closed, the residents must be moved and the state then has one less needed care facility. If inadequate managers could be replaced, however, the facility could remain in service and be brought up to standards.

These situations must be corrected so that our older citizens and all those requiring nursing care may be assured of a safe environment. The Special Advisory Committee has made some very positive recommendations in these areas.

Another consumer complaint consistently voiced to the Special Advisory Committee on Nursing Homes concerned the lack of available information about nursing home ownership and profits. This lack of information concerning Medicaid reimbursement rates, private versus public subsidy of nursing homes, reasonable profits, and transfers of nursing home ownership among other items has contributed to a general public misunderstanding of nursing home finances.

Because of these numerous complaints and apparent public confusion and because public funds finance more than 50 per cent of the nursing home beds in Kansas, I believe the public has the right to ask nursing homes to make full financial disclosure of their profits, losses, and ownership. In this way, nursing homes can show their efforts to give quality care at a reasonable cost while satisfying demands for accountability.

To achieve this end, I have moved to effect administrative changes which will require such financial disclosure and make this information available to the public in line with the recommendations of the Special Advisory Committee. I have also asked the Department of Social and Rehabilitation Services to make public an annual report comparing current medical assistance payment rates and the base rates for privately paying residents, so that consumers can satisfy themselves regarding the portion of the bill they pay for services received.

Kansas has not gone untouched by spiraling health care costs which have been experienced throughout the nation in recent years, and this inflation, coupled with the open-ended nature of eligibility for medical assistance, has made state payment for services to the medically indigent a problem of large financial proportions. We have moved in several ways to check the rapid growth of this program while still assuring that the most needy do not go without help.

This administration has devoted major efforts to cost containment and improved management. Kansas' program of benefits, which ranks as one of the more generous in the nation, has been narrowed by reducing the scope of services offered to those considered more essential. For instance, during the past year, payment for dental and optical coverage for adults has been limited to emergency treatment only, payment for chiropractic services has been deleted and payment for weekend hospital admission will not be made except in emergency situations in order to pay only for those days when patients are receiving full treatment.

Additionally, eligibility for medical assistance has been restricted to further assure that the state makes medical payments for none who can possibly cover their own expenses. These measures have already begun to slow the increase in state medical costs and will probably succeed in keeping this program within appropriation limits authorized by the Legislature for Fiscal Year 1978. A 55.7 per cent reduction in General Assistance-Medical only clients and a 36.3 per cent

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for themselves and remaining in their own homes—a cost effective yet compassionate approach to meeting this need.

7. *Improve the Quality of Health Care in Our Nursing Homes.* I am recommending that reimbursements paid to nursing homes by the Department of Social and Rehabilitation Services be increased in a way which will most directly affect the quality of health care and nutrition.

At present, the Department is purchasing care for residents receiving Medicaid at rates based on the nursing homes' costs for administration, health care, property, and room and board. The Department reimburses the homes at the level of the 75th percentile of each of these costs.

I am recommending that this percentile level be raised from the 75th to the 90th in the categories of room and board and health care. This action will allow improvements in services which are directly delivered to the residents as well as compensating management for inflation in costs. This change in the reimbursement formula will cost $2.4 million in Fiscal Year 1979.

While an increase in state support for our nursing home program should have a beneficial effect on care, such increased support must be accompanied by the improvement of our state regulations and the strengthening of our enforcement ability. My inspection tours and the correspondence which they have generated clearly indicate there is broad public concern for the care of older Kansans in nursing homes. More important, this concern indicates a strong consensus for the philosophy that when older Kansans must leave their homes for a more protected environment because of illness or incapacity, it is of the utmost importance that the facilities to which they go provide quality care. To better assure this, I am requesting that the Department of Health and Environment's inspection staff be increased by three public health nurses in Fiscal Year 1979. This staff, added to the 10 surveyors currently responsible for inspection, will enable the Department to handle the increasing number of complaints in a more timely manner and will help nursing homes achieve permanent improvement by educating nursing home administrators in the proper procedures for implementing the numerous federal regulations and new licensing standards.

Such additional personnel will also be able to help in guiding inspection by local departments of health and to encourage more local departments than the 30 now participating to relieve the state of some responsibility in this area.

In the rare instances when nursing homes appear to be disinterested in the welfare of their residents, the state needs more authority to cite and subsequently force them into needed compliance. I believe that in many instances a penalty in the form of a fine is the only way to effectively reform homes which do not provide adequate care and which consistently flout basic regulations. This kind of legislation has been considered in the past, and I am recommending that you delay no longer in passing such a measure.

I recommend the enactment of laws which will provide for a system which combines public citation with fines for those homes which make no move to remedy deficiencies affecting the health, safety, nutrition, or sanitation of their residents after they have been directed to do so by the Department of Health and Environment.

So that enforcement is fair, such a citation must follow repeated infractions by the nursing home, unless the deficiencies are life-threatening or endangering and require an immediate reprimand and correction. Also, the nursing home management should be provided with the right to a hearing on an appeal from any fine. It is not a desire of the state to interfere with the delivery of conscientious care, but only to assure that such care is guaranteed to those who need it.

In extreme cases, where disinterest and mismanagement by nursing home administrators results in an environment where the health and safety of residents is severely threatened, the state needs the authority to seek the appointment of a receiver for the home. This authorization would allow for the facility to stay in operation under proper management while improvements were being made in order that residents would not have to be dislocated. At present, there is no way to assure that nursing home residents receive adequate care during this interim period.

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I am recommending the passage of legislation which will authorize court appointment of a receiver for a nursing home in appropriate circumstances—when life-threatening conditions exist in the home, when it is insolvent, or when its license has been revoked. Again, care must be taken to be fair to management in this process while protecting the welfare of those who cannot protect themselves. Such legislation will avoid the unnecessary uprooting of nursing home residents, which has been found to be detrimental to both their physical and mental health.

The recommendations that I am making with reference to improving our support for nursing homes as well as improving our ability to effectively supervise them and assure the maintenance of adequate care are fully consonant with the unanimous recommendations of the special task force which I appointed last year to study these problems. The task force was representative of nursing home operators, nursing home consumer groups and the general public. Their well-studied and well-balanced recommendations are worthy of early legislative implementation.

8. *Improve Auditing of the Medical Assistance Program.* Because of the record for cost effectiveness which auditing activities in the medical assistance program have achieved, I am recommending that these activities be strengthened in the coming year in an effort to hold down costs and to insure that the state is not being victimized by unscrupulous medical providers.

The Medical Audits Unit of the Department of Social and Rehabilitation Services is responsible for auditing 1,097 providers of various services under the medical assistance program. While the Department has been able to keep generally within federal guidelines, some areas in the medical program have been neglected and increased federal audit requirements for the coming year will mean falling further behind. At present, our audits have been concentrated on giving only the larger hospitals and mental health centers and annual audit, but new regulations require all hospitals, regardless of size, to undergo at minimum an annual desk audit.

As well as improving the level of current activity, there are new areas where audit activities could bring large returns to the state. Prime among these is the state's spending for drugs under the medical assistance program. Pharmacy audits have never been made systematically, although Social and Rehabilitation Services has spent $40 million over the past six years for drugs—$12.1 million in Fiscal Year 1977 alone. The addition of auditing staff will enable us to exercise better oversight of this major commitment of public funds.

9. *Improve Our Programs for the Mentally Ill and Mentally Retarded.* In this important area of service I am making a number of recommendations which should address the previously identified needs.

First, I am recommending an increase in the level of formula funding for community mental health and mental retardation facilities. In the budget which is being submitted I have included funds to provide a 25 per cent matching level of eligible local income based upon the estimated budgets for these agencies in 1979. This amounts to an increased commitment in the next ensuing fiscal year of $1,100,177. Though I have recommended increased funding, I have not recommended full funding of these formulas for several reasons. First of all these recommendations together with recommendations to be discussed later relating to increased use of Title XX funds at the local level have increased total funds (federal-state bloc grant and purchase of service) available to local facilities for the retarded and the mentally ill from an estimated $11.3 million in Fiscal Year 1978 to an estimated $14.3 million in Fiscal Year 1979, an increase of 26 per cent. Second, full funding would be in excess of the local requests thus far received. Third, it appears to me that there is merit in the state supporting a program whereby some basic levels of assistance for these local agencies would be established to assure the continued availability of their services with additional state funding, over and above this basic level, being provided on a fee-for-service basis. I have instructed the Secretary of the State Department of Social and Rehabilitation Services to work with representatives of these local agencies in an effort to develop such a program.

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an absent parent *including any information concerning medical or health insurance coverage for dependents.*

(b) Information received by the secretary of social and rehabilitation services under this section shall be available upon request to persons authorized to receive such information in accordance with rules and regulations duly adopted by the secretary of social and rehabilitation services.

Sec. 2. K.S.A. 39-758 is hereby repealed.

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

Approved April 12, 1982.

Published in the *Kansas Register* April 15, 1982.

CHAPTER 189

Senate Bill No. 902

AN ACT concerning adult care homes; relating to licensure thereof; amending K.S.A. 39-923, 39-927, 39-930, 39-943 and 39-944 and repealing the existing sections.

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

Section 1. K.S.A. 39-923 is hereby amended to read as follows: 39-923. (a) The following words and phrases when used in this act shall, for the purposes of this act, have the meanings respectively ascribed to them in this section:

(1) "Adult care home" ~~shall mean~~ *means* all classifications of homes required to be licensed by the secretary of health and environment.

(2) "Skilled nursing home" ~~shall mean and shall be construed to include~~ *means and includes* any place or facility operating for not less than ~~twenty-four~~ ~~(24)~~ *24* hours in any week and caring for three ~~(3)~~ or more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage who by reason of aging, illness, disease~~,~~ or physical or mental infirmity are unable to sufficiently or properly care for themselves, and for whom reception, accommodation, board~~,~~ and skilled nursing care and treatment is provided, and which place or facility is staffed to provide ~~twenty-four~~ ~~(24)~~ *24* hours a day licensed nursing personnel plus additional staff, and is maintained and equipped primarily for the accommodation of individuals who are not acutely ill and are not in need of hospital care but who require skilled nursing care.

(3) "Intermediate nursing care home" ~~shall mean and shall be construed to include~~ *means and includes* any place or facility operating for not less than ~~twenty-four~~ ~~(24)~~ *24* hours in any week and caring for three ~~(3)~~ or more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage who by reason of aging, illness, disease or physical or mental infirmity are unable to sufficiently or properly care for themselves and for whom reception, accommodation, board~~,~~ and supervised nursing care and treatment is provided, and which place or facility is staffed to provide at least eight ~~(8)~~ hours a day — five ~~(5)~~ days a week licensed nursing personnel plus additional staff and is maintained and equipped primarily for the accommodation of individuals not acutely ill or in need of hospital care or skilled nursing care but who do require supervised nursing care.

(4) "Intermediate personal care home" ~~shall mean and shall be construed to include~~ *means and includes* any place or facility operating for not less than ~~twenty-four~~ ~~(24)~~ *24* hours in any week and caring for three ~~(3)~~ or more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage who by reason of aging, illness, disease~~,~~ or physical or mental infirmity are unable to sufficiently or properly care for themselves and for whom reception, accommodation, board, ~~or~~ personal care and treatment~~,~~ or simple nursing care is provided, and which place or facility is staffed, maintained~~,~~ and equipped primarily for the accommodation of individuals not acutely ill or in need of hospital care ~~or~~, skilled nursing home care~~,~~ or moderate nursing care but who do require domiciliary care and simple nursing care.

(5) "One-bed adult care home" and "two-bed adult care home" ~~shall mean and shall be~~ *means and is* any private residence operating for not less than ~~twenty-four~~ ~~(24)~~ *24* hours in any week and caring for one or two individuals not related within the third degree of relationship to the administrator or owner by blood or marriage, and can give whatever class of care it is capable of giving. When the home's capabilities are questioned in writing, the licensing agency shall determine according to its rules and regulations if any restriction will be placed on the care the home will give residents.

(6) "Boarding care home" ~~shall mean and shall be construed to include~~ *means and includes* any place or facility operating for not less than ~~twenty-four~~ ~~(24)~~ *24* hours in any week and caring for three ~~(3)~~ or more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage who by reason of aging, illness, disease~~,~~ or physical or mental infirmity are unable to sufficiently or properly care for themselves and for whom reception, accommodation, board and supervision is provided and which place or facility is staffed, maintained and equipped primarily to provide shelter to residents who require

some supervision, but who are ambulatory and essentially capable of managing their own care and affairs.

(7) "Place or facility" means a building or any one or more complete floors of a building, or any one or more complete wings of a building, or any one or more complete wings and one or more complete floors of a building, except that the term "place or facility" may include multiple buildings.

(8) "Skilled nursing care" ~~shall mean and shall be construed to include~~ *means and includes* services commonly performed by or under the immediate supervision of a registered professional nurse and additional licensed nursing personnel for individuals requiring ~~twenty-four (24)~~ *24* hour a day care by licensed nursing personnel including: Acts of observation, care and counsel of the ill, injured or infirm; the administration of medications and treatments as prescribed by a licensed physician or dentist; and other nursing functions requiring substantial specialized judgment and skill based on the knowledge and application of scientific principles.

(9) "Supervised nursing care" ~~shall mean and shall be construed to include~~ *means and includes* services commonly performed by or under the immediate supervision of licensed nursing personnel at least eight ~~(8)~~ hours a day — five ~~(5)~~ days a week including: Acts of observation, care and counsel of the ill, injured or infirm; the administration of medications and treatments as prescribed by a licensed physician or dentist; and other selected functions requiring specialized judgment and certain skills based on the knowledge of scientific principles.

(10) "Simple nursing care" ~~shall mean and shall be construed to include~~ *means and includes* selected acts in the care of the ill, injured or infirm requiring certain knowledge and specialized skills but not requiring the substantial specialized skills, judgment and knowledge of licensed nursing personnel.

(11) "Resident" ~~shall mean and shall be construed to include~~ *means and includes* all individuals kept, cared for, treated, boarded~~,~~ or otherwise accommodated in any adult care home.

(12) "Person" ~~shall mean~~ *means* any individual, firm, partnership, corporation, company, association~~,~~ or joint stock association, and the legal successor thereof.

(13) "Operate an adult care home" means to own, lease, establish, maintain, conduct the affairs of or manage an adult care home, except that for the purposes of this definition the word "own" and the word "lease" shall not include hospital districts, cities and counties which hold title to an adult care home purchased or constructed through the sale of bonds.

~~(13)~~ *(14)* "Licensing agency" ~~shall mean~~ *means* the secretary of health and environment.

(b) The terms "skilled nursing home~~,~~" or "adult care home" shall not include institutions operated by federal or state governments, hospitals or institutions for the treatment and care of psychiatric patients, boarding homes for children under the age of ~~sixteen (16)~~ *16* years, day nurseries, child caring institutions, maternity homes, hotels or offices of physicians.

(c) The licensing agency may by rule and regulation change the name of the different classes of homes when necessary to avoid confusion in terminology and the agency may further amend, substitute, change and in a manner consistent with the definitions established in this section, further define and identify the specific acts and services which shall fall within the respective categories of facilities so long as the above categories for adult care homes are used as guidelines to define and identify the specific acts.

Sec. 2. K.S.A. 39-927 is hereby amended to read as follows: 39-927. An application for a license *to operate an adult care home* shall be made in writing to the licensing agency upon forms provided by it and shall be in such form and shall contain such information as the licensing agency shall require, which may include affirmative evidence of the applicant's ability to comply with such reasonable standards and rules and regulations as are adopted under the provisions of this act. Such application, except an application for ~~"~~*a* one-bed adult care home~~"~~ and ~~"~~*a* two-bed adult care ~~homes,"~~ *home,* shall be accompanied by a certificate of need issued by the state agency authorized by law to issue such certificate. ~~Such~~ *The* application shall be signed by the ~~owner or person responsible for the operation of such adult care home~~ *person or persons seeking to operate an adult care home, as specified by the licensing agency,* or by a duly authorized ~~officer or responsible~~ agent ~~thereof~~ *of any person so specified.*

Sec. 3. K.S.A. 39-930 is hereby amended to read as follows: 39-930. The annual fee for license to ~~conduct~~ *operate* an adult care home shall be ~~five dollars ($5)~~ *$5* plus ~~one dollar ($1)~~ *$1* for each bed of such home which shall be paid to the secretary of health and environment before the license is issued, and shall be deposited in the *state treasury and credited to the state* general ~~revenue~~ fund unless the evaluation and inspection was made by a county, city-county or multicounty health department at the direction of the secretary of health and environment and the papers required are completed and filed with the secretary then ~~two-fifths (2/5)~~ *2/5* of whatever fee is collected shall be forwarded to such county, city-county or multicounty health department. If a facility has a change of administrator after the start of the licensing period, the fee shall be ~~fifteen dollars ($15)~~ *$15* which shall be

deposited in the *state treasury and credited to the state* general ~~revenue~~ fund.

Sec. 4. K.S.A. 39-943 is hereby amended to read as follows: 39-943. Any person ~~establishing, conducting, managing, or operating in the state any adult care home~~ *operating an adult care home in this state* without a license under this law shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than ~~one hundred dollars ($100)~~ *$100*, or by imprisonment in the county jail for a period of not more than six ~~(6)~~ months, or by both such fine and imprisonment. Any person who shall violate any other provision of this act or the requirements of any ~~rule or~~ *rules and* regulations promulgated hereunder shall be guilty of a misdemeanor and shall upon conviction thereof be punished by a fine of not more than ~~one hundred dollars ($100)~~ *$100*, or by imprisonment in the county jail for a period of not more than six ~~(6)~~ months, or by both such fine and imprisonment.

Sec. 5. K.S.A. 39-944 is hereby amended to read as follows: 39-944. Notwithstanding the existence or pursuit of any other remedy, the secretary of health and environment, as the licensing agency, ~~may~~ in the manner provided by law, *may* maintain an action in the name of the state of Kansas for injunction or other process against any person or agency to restrain or prevent the ~~establishment, conduct, management or~~ operation of an adult care home without a license under this act. In any such court proceedings, the secretary may apply for and on due showing be entitled to have issued the court's subpoena requiring forthwith the appearance of any defendant and such defendant's employees, and the production of documents, books, and records as may appear necessary for the hearing of such petition, to testify and give evidence concerning the acts or conduct of things complained of in such application for injunction. ~~In such action the equity courts shall have jurisdiction of the subject matter and a judgment may be entered awarding injunctions as may be proper.~~

Sec. 6. K.S.A. 39-923, 39-927, 39-930, 39-943 and 39-944 are hereby repealed.

Sec. 7. This act shall take effect and be in force from and after January 1, 1983, and its publication in the statute book.

Approved May 7, 1982.

INSURANCE

CHAPTER 190

House Bill No. 3101

AN ACT relating to insurance; concerning foreign companies; amending K.S.A. 40-209 and repealing the existing section.

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

Section 1. K.S.A. 40-209 is hereby amended to read as follows: 40-209. Any insurance company organized under the laws of any other country, state or territory, upon application, may be authorized to transact business in this state, when possessed of the required amount of paid-up capital and surplus, or surplus only if a mutual company, and has made the deposit required by this code with the department of insurance of this or any other state in the United States: ~~Provided, That such~~. *The* authority shall not be granted, continued, or renewed to any insurance company ~~owned or financially controlled, in whole or in part,~~ *which is controlled, as such word is defined in subsection (c) of K.S.A. 40-3302,* by another state of the United States or by a foreign government, or by any political subdivision of either. Every such company shall file a certified copy of its charter or deed of settlement with the commissioner of insurance, together with a statement, under oath of the president, vice-president or other chief officer and the secretary of the company for which they act, stating the name of the company, the place where located, and the amount of its capital, with a detailed statement of the facts and items required from companies organized under the laws of this state; also a copy of the last annual report, if any was made, under any law of the state or country in which such company was incorporated.

Upon the application of any such insurance company for a certificate of authority to transact business in this state, the commissioner of insurance shall ~~immediately satisfy himself~~ *be satisfied* that the company is possessed of money and other admitted assets in excess of its liabilities, as herein provided, and that it has otherwise complied with all the other requirements of this code. ~~He~~ *The commissioner* shall thereupon issue a certificate of authority to such company authorizing it to transact the classes of insurance permitted under its articles of incorporation and by the provisions of this code: ~~Provided, however, That~~. The funds of any such insurance company, in excess of the minimum paid-up capital required by this code, may at all times be invested in such securities as are or may be authorized by the laws of the state in which such company is organized or in which it has and maintains its United States deposit: ~~Provided further, That~~. The commissioner of insurance may, upon renewal of a certificate of

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HOUSE PUBLIC HEALTH & WELFARE COMMITTEE

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PHealth 2-27-90 Attm't #4

BILL NO.			
2135 - An act authorizing establishment of breast milk banks	2-17-81	Killed in House Committee	
2230 - An act providing state funding for local health departments	2-16-81	No action	
2355 - An act relating to life care agreements	Not heard		
2626 - An act concerning establishment and operation of hospitals in first and second class cities	1-27-82	Substitute bill passed and interim study requested	
2627 - An act concerning county hospitals	Not heard		
2654 - An act enacting the Thomas County Hospital transfer act	1-25-82	Passed both houses	2-25-82
2711 - An act relating to credentialing of health care personnel	2-2-82	Studied in subcommittee - No action taken	
2713 - An act relating to licensing of social workers	2-1-82	Passed both houses	3-31-82
2714 - An act relating to fees for duplicate licenses for social workers and psychologists	2-1-82	Passed both houses	4-8-82
2720 - An act relating to certification and registration of barbers	2-18-82	Passed both houses	4-21-82
2729 - An act relating to health facilities and certificate of need	2-9-82	Interim study requested	
2745 - An act relating to ambulance attendant's certificates	2-2-82	Passed House - Amended by Senate - In Conference Com.	
2749 - An act concerning medical care facilities and certificate of need	2-10-82 & 2-17-82	Substitute bill passed by House committee - Referred to Ways & Means from Floor	
2750 - An act relating to health facilities and certificates of need	2-9-82	Passed both houses	4-22-82
2805 - An act enacting the Kansas public health resources act and providing financial assistance for local health depts.	2-11-82 & 2-22-82	Passed by House committee - Withdrawn from Calendar and referred to Ways and Means	
2808 - An act relating to licensing of adult care homes	2-15-82	No action taken	

Bill Would Tighten Licens ing of Nursing Homes

4-29-82 Wich E.

United Press International

TOPEKA — The Legislature Wednesday whisked to the governor a bill to make owners of Kansas nursing homes more accountable for the quality of care provided at their homes.

Gov. John Carlin and Kansas Department of Health and Environment Secretary Joseph Harkins asked legislators to consider the bill during its wrap-up session.

The Senate approved the bill 30-9, and the House approved it 122-1.

Several legislators said the bill deserved more study than they could squeeze in during the twilight hours of the session, and they said they resented being confronted with it on such short notice.

Meyers . . . Situation "needs to be handled now"

However, Senate Majority Leader Robert Talkington, R-Iola, said an amendment to the bill would allow state officials to study the issue for the next eight months and make recommendations on ways to improve it to the 1983 Legislature. That provision would make the bill effective in January 1983, instead of this year.

Sen. Jan Meyers, R-Overland Park, said the need for the bill was so great that waiting until January could cause serious problems for the state Department of Health and Environment and for nursing homes in the state.

"I THOUGHT there was a real urgency in this regard," she said. "As I understand it, there's such a tangle of ownerships that you can't ever get the person who is responsible (for nursing home problems). I just hate to think we are delaying for eight months a situation that needs to be handled now."

The bill would require that all those involved in the ownership and operation of nursing homes have their names on the home's license, which is granted by the state. That way, the state could take action against all those involved in cases of violations of state nursing home standards.

HOWEVER, NURSING homes owned by cities, counties and hospital districts that use industrial revenue bonds for the construction or operation of the home would be exempt from the bill. Talkington said that if they were held liable for any problems at the home, they would run the risk of losing their funding source.

Harkins had said his department was having "severe" problems with out-of-state nursing home owners — usually corporations — that hire other parties to operate the homes.

Without the bill, the department can do little to prevent an owner from hiring a management group to run the nursing home, then violating the same standards the previous operators had violated under the owner's supervision.

Harkins said the license of a nursing home operator in Winfield was revoked, but the actual owners of the building and property could not be touched, even though they were suspected of playing a role in the management of the home. At least two other Kansas nursing homes are having similar problems that are so severe that the state is intervening.

Senate favors accountability at care homes

Top Cap 4/29/82

A bill that would make owners of Kansas nursing homes more accountable for the quality of care provided at their homes won last-minute approval by the Kansas Senate Wednesday on a 30-9 tally.

Gov. John Carlin and Kansas Department of Health and Environment Secretary Joseph Harkins requested the Legislature to consider the bill during its two-day wrap-up session.

Several senators said they resented being confronted with the bill during the twilight hours of the session because it deserved more study than legislators could squeeze in.

But Senate Majority Leader Robert Talkington, R-Iola, said an amendment to the bill would allow state officials to study the issue for the next eight months and make recommendations to the 1983 Legislature on how to improve it. That provision would make the bill effective in January 1983, instead of this year.

Sen. Jan Meyers, R-Overland Park, said the need for the bill was so great that waiting until January could cause serious problems for the KDHE and for nursing homes in the state.

"I thought there was a real urgency in this regard," she said. "As I understand it, there's such a tangle of ownerships that you can't ever get the person who is responsible (for nursing home problems). I just hate to think we are delaying for eight months a situation that needs to be handled now."

The bill would require that all parties involved in the ownership and operation of Kansas nursing homes have their names on the home's license, which would be granted by the KDHE. That way, the state could take action against all the parties involved, in case a lawsuit was filed for violation of state nursing home standards.

P. Hall 2-24-82 Letter to Sen. Hess

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

Held in Room 527-S, at the Statehouse at 11:00 a. m. on January 26, 1978.

All members were present except: Senator James Francisco (excused)

The next meeting of the Committee will be held at 3:30 p. m., on January 26, 1978.

These minutes of the meeting held on January 26, 1978 were considered, corrected and approved.

Wes Sowers
Chairman

The conferees appearing before the Committee were:

Raymond E. Briggs, Health Care Providers, Topeka, Kansas
Lila Hastings, Coffeyville, Kansas
Ron Hastings, Health Care Providers, Coffeyville, Kansas
Charles W. Wurth, Health Care Providers, Wichita, Kansas
Dick R. Hummel, Health Care Providers, Topeka, Kansas
R.O. Settle, M.D., Department on Aging, Topeka, Kansas
Senator Arnold Berman, Second District, Lawrence, Kansas
Charles Mullikin, American Association of Retired Persons & Retired Teachers Association, Wichita, Kansas
James Mankin, D.D.S., Department of Health and Environment, Topeka, Kansas
J.W. Wilson, M.D., Department of Health and Environment, Topeka, Kansas
Hazel Lee Simmons, Kansans for the Improvement of Nursing Homes, Lawrence, Kansas
Eleanor Smith, Kansans for the Improvement of Nursing Homes, Lawrence, Kansas
Harriet Nehring, Kansans for the Improvement of Nursing Homes, Lawrence, Kansas
Bill Hobbs, Kansas Association of Homes for the Aging, Topeka, Kansas
Ruth C. Dickinson, State Planning and Research Department, Topeka, Kansas
Judith C. Runnels, Kansas State Nurses Association, Topeka, Kansas
Dwight Metzler, Department of Health and Environment, Topeka, Kansas

Staff Present Were:
Emalene Correll, Legislative Research Department
Bill Wolff, Legislative Research Department

The meeting was called to order by the Chairman, Senator Wesley H. Sowers.

SB 339, SB 510, SB 652 - ADULT CARE HOMES-CITIATIONS AND PENALTIES FOR VIOLATIONS; and SB 646 - ADULT CARE HOMES-RECEIVORSHIPS: Senator Arnold Berman, a sponsor of SB 510, stated the intent of this bill is to eliminate violations of statutes and rules and regulations by adult care homes. An ideal fine bill would not produce a single fine during the life of the statute. This bill attempts to set up a schedule of fines for different types of violations ranging from a technical violation to a violation which would present an immediate danger to the life of the resident. He stated Section 7 was based on the belief that the best inspections are unannounced inspections and that any state employee giving advance notice of an inspec-

Approved 2-27-78 Attm. #4 pg. 43

CONTINUATION SHEET

Minutes of the Senate Committee on Public Health & Welfare Jan. 26, 19 78.

tion is violating the intent of the Legislature. Section 8 is based on the belief that residents of an adult care home should be able to live in an absence of fear. He stated that conversations with residents and employees indicated that they hesitate to report alleged violations for fear of retribution. In answer to a question, Senator Berman stated his concern is not to hit nursing home administrators over the head but to provide an environment in which senior citizens can live out their life in dignity and without fear.

In answer to a question, Senator Chaney, a sponsor of SB 510, stated the bill is addressed to the 15 percent of the homes that are bad. It does not speak to the issue of how and when nursing home administrators find out about violations. He noted the need to address the problem of administrators being told different things by different inspectors and to clarify rules and regulations at the same time a fine bill is considered.

Dwight Metzler, Secretary, Department of Health and Environment, explained the training program for inspectors, the inspection procedures and the procedure for checking to see that corrections have been made.

Speaking to SB 510, concern was expressed over the size of the fines, i.e., this will be passed on to the private paying resident who may not be able to afford it; implementation of assessing fines; administrative difficulties of carrying out the bill. It was noted that while a fine system would provide an effective tool, a greater deterrent would be decertification which would disqualify a home for SRS payments.

In answer to a question, it was noted that the use of "commissioner" in line 47 is a drafting error. Questions were raised about the requirement for filing the order with the district court. In other statutes the Secretary can do this direct and it does not require court enforcement.

James Wilson, M.D., Director, Division of Health, Department of Health and Environment, presented a written statement relating to all three fine bills. (Attachment A) He also noted that a home the Department had decertified in February of 1977 took the Department to court and it was January 1978 before the people were moved. The home had five attorneys and the Department had one. He emphasized that the Department has always favored a fine bill.

Charles Mullikin, Retired Teachers Association and American Association of Retired Persons, stated they favor SB 652 and SB 646 which follow recommendations of the Governor's Committee. Concern was expressed that SB 646 might create problems in small communities which had only one adult care home. In answer to a question, Dr. James Wilson stated they would call on the industry to send someone in to operate the home.

Dick Hummel, Health Care Providers, presented a written statement in opposition to SB 510 (Attachment B), a written statement endorsing the concept of SB 652 and making certain suggestions for amendments (Attachment C), and a written statement in opposition to SB 339 (Attachment D). He introduced Ron Hastings, an adult care home administrator from Coffeyville to assist in answering questions.

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CONTINUATION SHEET

Minutes of the Senate Committee on Public Health & Welfare Jan. 26, 1978.

In answer to a question relating to No. 4 of Attachment B, Mr. Hummel stated any type fine system will involve attorney and court fees, but based on the experience of other states, a class system of fines seems to create more such fees. In the discussion of the possible need to clarify the rules and regulations it was noted that the provision for a trial de novo would prevent the Department from fining for trivial violations. It was pointed out that this bill only sets up a fine system. Specificity of rules and regulations is another issue. In answer to a question, Mr. Hummel clarified that they endorse the fine concept but not any of the bills in their present form.

The meeting was adjourned.

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2-27-90
Attm. #4.
pg. 4 5.

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

Held in Room 527-S, at the Statehouse at 11:00 a. m./~~p.m.~~, on January 27, 1978.

All members were present except: Senator John Vermillion (excused)

The next meeting of the Committee will be held at 11:00 a. m./~~p.m.~~ on January 30, 1978.

These minutes of the meeting held on January 27, 1978 were considered, corrected and approved.

Wesley Sowers
Chairman

The conferees appearing before the Committee were:

James Mankin, D.D.S., Department of Health and Environment, Topeka, Kansas
Charles W. Wurth, Health Care Providers, Wichita, Kansas
Raymond E. Briggs, Health Care Providers, Topeka, Kansas
Harriet Nehring, Kansans for the Improvement of Nursing Homes, Lawrence, Kansas
Stewart Entz, Kansas Association of Homes for the Aging, Topeka, Kansas
Dr. Robert Harder, Department of Social and Rehabilitation Services, Topeka, Kansas

Staff Present Were:
Emalene Correll, Legislative Research Department
Bill Wolff, Legislative Research Department

The meeting was called to order by the Chairman, Senator Wesley H. Sowers.

MINUTES: The minutes for January 16 are to be corrected to show that Senator Morris made a motion to recommend SCR 1618 favorable for passage, and that the motion died for lack of a second. Senator Morris made a motion seconded by Senator Chandler to approve the minutes for January 16 as corrected. Motion carried.

SB 339, SB 510, SB 652 - ADULT CARE HOMES-CITATIONS AND PENALTIES FOR VIOLATIONS; and SB 646 - ADULT CARE HOMES-RECEIVORSHIPS: Stewart Entz, Kansas Association of Homes for the Aging spoke in favor of the fine concept and stated a preference for SB 652 recommended by the Governor's Committee. This bill would provide the Secretary of Health and Environment an alternative between doing nothing and closing a home. Referring to the date from which a penalty could be assessed, he asked the Committee to consider amending the bill to provide that the judge can determine whether a fine should be levied from the date of assessment or the date of final determination. He will provide the Committee with specific suggested language. In answer to a question, Mr. Entz stated that in cases which do not go to court, the Secretary would make this determination. In answer to questions, he stated that in two years no alternative to a fine system had been developed and he felt most homes were in favor of this approach.

Harriet Nehring, Kansans for the Improvement of Nursing Homes stated they support SB 652 and SB 646 although they are concerned about passing the

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cost of any fine on to private paying residents. However, they hope the provision for a citation before the fine will encourage homes to comply before a fine is levied. In answer to a question, Dr. Robert Harder, Department of Social and Rehabilitation Services, stated they would not include fines paid by a home in determining the rate of reimbursement for that home.

Dr. Harder, speaking to SB 646, Section 7, stated they had not submitted a fiscal note on this section because there was no past experience on which to base it. The Department feels it can probably absorb the costs or handle them through supplementary requests. He stated he felt the Department's increased effort relative to fraud coupled with a citation and fine bill would lessen the chances of a home going into receivorship. In answer to a question, he stated the Department would not necessarily have to authorize funds to operate the home. It would depend on the condition of the home and how soon the Department was involved in the receivorship. He noted that based on the SRS reimbursement side, he felt that not more than three or four homes would possibly go into receivorship.

James Mankin, D.D.S., Department of Health and Environment, presented a written statement in support of SB 646. (Attachment A)

Referring to SB 652, a Committee member asked Dr. Mankin if a physician did not sign a death certificate on the day of death would the adult care home be cited and fined. Dr. Mankin stated reason would have to be used. They estimate there would only be nine to ten hearings under this bill per year.

SB 505 - AUTHORIZING THE MANUFACTURE AND USE OF LAETRILE: The Chairman outlined three possible courses of action relative to this bill: (1) recommend it adversely (2) recommend it favorable; (3) ask the Kansas University School of Medicine to study the use of laetrile and to submit a progress report at the next session of the Legislature such report to also include a progress report on the research being done by the Federal Drug Administration and the American Cancer Society. In discussion the following concerns were expressed: if people using it now feel it helps them, it should be available for them; some physicians could be in trouble because they are helping patients get laetrile; people will use laetrile as a treatment of first choice rather than a treatment of last resort. Providing that a person could receive laetrile only if a physician had certified the presence of cancer and that the person was also receiving a medically accepted treatment was suggested as a compromise. It was noted that testimony indicated some laetrile users are told they must use only the laetrile treatment. In answer to a question, staff stated that it appears under the December 5, 1977, decision of Judge Bohanon a person who has been diagnosed as terminal can import leatrile for their personal use.

The Chairman stated that the Committee will consider taking action on this bill the middle of next week.

The meeting was adjourned.

*Attachment B - Statements of Kansas Association of Homes for the Aging on SB 339, SB 510, SB 652 and SB 646

Attachment C - Statement of Health Care Providers on SB 646

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Attachment A

State of Kansas . . . ROBERT F. BENNETT, Governor

DEPARTMENT OF HEALTH AND ENVIRONMENT

DWIGHT F. METZLER, Secretary

Topeka, Kansas 66620

TESTIMONY ON SENATE BILL #646

Presented January 26, 1978

to

Senate Committee on Public Health and Welfare

NEED FOR:

When a nursing home is in crisis, the state should have some mechanism to assume management of the home. This is necessary to ensure that the nursing home residents receive adequate care. The only enforcement tool the Depa.t-ment has at the present time is to revoke the license of the nursing home or to decertify a home from participating in the federal programs. The revocation of the license or the decertification of a nursing home are lengthy procedures and neither are adequate to deal with a crisis situation.

This bill would create a mechanism which would permit the state to assume temporary management of a home in a crisis situation. The appointment of an administrative receiver would make it possible to continue the operation of the nursing home on a temporary basis and would provide ample time to secure a licensee who could provide satisfactory operation of the home or move the residents to other locations if the home cannot be continued in operation.

This bill provides adequate protection for the rights of the owner of the nursing home because before a home can be placed in administrative receiver-ship approval must be received from the district court.

DEPARTMENT'S POSITION:

The Department strongly supports this bill and believes it would be an effective measure to ensure adequate care for nusing home residents when a nursing home is in a crisis situation.

Atch. A

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SB 646/PROVIDER COMMENT

Receivership of adult care homes:

COMMENT: This bill was prepared by the Governor's Advisory Committee. KAHA supports this bill.

With the one strong suggestion: The bill must insure that the Secretary of Health & Environment and the Secretary of SRS will insure that immediate funds are available to the Receiver. For example, if a Receiver assumes control of the facility, there may be immediate needs for food and additional nursing staff. If the facility is in financial difficulty, most suppliers will insist upon cash. Further, there may not be adequate funds to meet the payroll, which would result in a loss of staff rather than the ability of the Receiver to increase the staff.

Respectfully submitted,

Stewart L. Entz,
Kansas Association of Homes
for the Aging

KAHA

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Attachment C

TESTIMONY BEFORE THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

By Dick Hummel
Health Care Providers, Inc.
January 26, 1978

SENATE BILL 646

"AN ACT relating to adult care homes; providing for the appointment of receivers; granting certain powers and duties to the secretary of health and environment and the secretary of social and rehabilitation services."

Mr. Chairman and Committee Members:

Thank you for this opportunity to comment on SB 646. We believe the proposal has merit, but question the funding intent of New Section 7:

"The secretary of social and rehabilitation services, upon request of a receiver, may authorize expenditures from moneys appropriated for purposes set forth in this act if incoming payments from the operation of the adult care home are less than the cost incurred by the receiver in the performance of his or her functions as receiver or for purposes of initial operating expenses of the receivership."

The word "may" is discordant with the rest of the wording in the proposal. We would request to know the amount of funds allocated for this project.

Information from New York State, which has a "Protective Custodial Law", is that in the two instances whereby the state assumed receivership, it was extremely costly to them.

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Sec. 10. This act shall take effect and be in force from and after its publication in the statute book.

Approved May 11, 1984.

MENTALLY ILL, INCAPACITATED AND DEPENDENT PERSONS; SOCIAL WELFARE

CHAPTER 158

Senate Bill No. 656

AN ACT relating to adult care homes; concerning recovery of costs of receivership; amending K.S.A. 39-960, 39-961 and 39-963 and repealing the existing sections.

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

Section 1. K.S.A. 39-960 is hereby amended to read as follows: 39-960. The secretary of social and rehabilitation services, upon request of a receiver, may authorize expenditures from moneys appropriated for purposes set forth in this act if incoming payments from the operation of the adult care home are less than the cost incurred by the receiver in the performance of ~~his or her~~ *the receiver's* functions as receiver or for purposes of initial operating expenses of the receivership. *Any payments made by the secretary of social and rehabilitation services pursuant to this section shall be owed by the owner or licensee and repaid to the secretary of social and rehabilitation services when the receivership is terminated pursuant to K.S.A. 39-963 and amendments thereto and until repaid shall constitute a lien against all non-exempt personal and real property of the owner or licensee.*

Sec. 2. K.S.A. 39-961 is hereby amended to read as follows: 39-961. The personnel and facilities of the department of health and environment shall be available to the receiver for the purposes of carrying out ~~his or her~~ *the receiver's* duties as receiver as authorized by the secretary of health and environment.

The department of health and environment shall itemize and keep a ledger showing costs of personnel and other expenses establishing the receivership and assisting the receiver and such amount shall be owed by the owner or licensee to the department of health and environment. Such department shall submit a bill for such expenses to the receiver for inclusion in the receiver's final accounting. Any amount so billed and until repaid shall constitute a lien against all non-exempt personal and real property of the owner or licensee.

Sec. 3. K.S.A. 39-963 is hereby amended to read as follows: 39-963. (a) The court shall terminate the receivership only under any of the following circumstances:

(1) Twenty-four ~~(24)~~ months after the date on which the receivership was ordered;

(2) a new license, other than the license granted to the

receiver under K.S.A. 39-958 *and amendments thereto*, has been granted to operate the adult care home; or

(3) at such time as all of the residents in the adult care home have been provided alternative modes of health care, either in another adult care home or otherwise.

(b) At the time of termination of the receivership, the receiver shall render a full and complete accounting to the district court and shall make disposition of surplus money at the direction of the district court.

The court may make such additional orders as are appropriate to recover the expenses and costs to the department of health and environment and the secretary of social and rehabilitation services incurred pursuant to K.S.A. 39-960 or 39-961 and amendments thereto.

Sec. 4. K.S.A. 39-960, 39-961 and 39-963 are hereby repealed.

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

Approved April 10, 1984.

CHAPTER 159

Senate Bill No. 748

AN ACT concerning certain physically disabled persons; public accommodations; amending K.S.A. 39-1101 and repealing the existing section.

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

Section 1. K.S.A. 39-1101 is hereby amended to read as follows: 39-1101. It is hereby declared to be the policy of this state to encourage and enable the blind, the visually handicapped and persons who are otherwise physically disabled to participate fully in the social and economic life of the state and to engage in remunerative employment. Said persons shall have the same right as the able-bodied to the full and free use of the streets, highways, sidewalks, walkways, public buildings, public facilities and other public places; and said persons are entitled to full and equal accommodations, advantages, facilities and privileges of: ~~(1)~~ *(a)* All common carriers, airplanes, motor vehicles, railroad trains, motor buses, street cars, boats or any other public conveyances or modes of transportation; ~~(2)~~ *(b)* hotels, lodging places and places of public accommodation, amusement or resort, *including food service establishments and establishments for sale of food*; and ~~(3)~~ *(c)* other places to which the general

public is invited, subject only to the conditions and limitations established by law and applicable alike to all persons.

Sec. 2. K.S.A. 39-1101 is hereby repealed.

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

Approved May 7, 1984.

Approved March 1, 1984
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

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

10 a.m./p.m. on February 22 1984 in room 526-S of the Capitol.

All members were present except:
No absentees

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

Conferees appearing before the committee:
Lynda Crowl, Pioneer Village
Marilyn Bradt, Kansans for Improvement of Nursing Homes
Dick Hummel, Kansas Health Care Association
Joe Hollowell, Kansas Department of Health and Enviroment
John Schneider, Social Rehabilitation Services
Gary Pitz, Kansas Department on Aging

SB 656 - Senator Meyers reviewed the difference in HB 2368 and SB 656. Testimony was heard from KDHE, SRS, and Kansas Department on Aging, as well as Kansans for Improvement of Nursing Homes, all of whom supported the bill. Dick Hummel of KHCA did not oppose the bill, but questioned whether it would accomplish anything. Testimony is attached.

HB 2368 - KDHE suggested some amendments to HB 2368 and questioned whether surety bonds would be available in the market. SRS supported the bill. Dick Hummel, KHCA, ask the Chairman to distribute his testimony from last April opposing this bill. Lynda Crowl, Pioneer Village also opposed the bill. Testimony is attached.

Joe Hollowell, KDHE, offered testimony supporting SB 658, which eliminates the three day waiting period before marraige and provides for an expiration date of a marraige license when not used within six months.

Meeting adjourned.

Passed 2-27-90 Attm. # 4. pg. 53.

2-22-84

TESTIMONY S.B. 656
SENATE PUBLIC HEALTH AND WELFARE
By Kansas Department on Aging
February 22, 1984
10:00 A.M. Room 526-S

Bill Brief:

Permits the State (H & E and S.R.S.) to recover the costs of nursing home operation under receivership from the owner or licensee.

Bill Provisions:

Any payments made by S.R.S. to support operation of a nursing home in receivership are owed to S.R.S. by the owner or licensee.

Expenses of H & E are billable to the owner or licensee.

Any unpaid obligations to either department shall constitute a lien against personal and real property of the owner or licensee.

Testimony:

The Kansas Department on Aging endorses S.B. 656.

The Department thnks that Kansas' nursing home receivership law needs the improvement that this bill would make. Present law is a good law; it permits restoration of quality care or orderly transfer of nursing home residents who reside in dangerous or tumultous situations. But it places too much financial burden on the State and it does not sufficiently require owners and operators of nursing homes put into receivership to bear enough of the consequences of actions that brought about the receivership.

Current law allows the receiver to collect revenues from operating the nursing home. But is also requires the receiver to pay a monthly rent as well as to meet all contract obligations of the owner.

Most states that have receivership laws recognize that quality of care problems that caused a receivership may be due to misallocation of funds by the facility, and authorize the receiver to petition the court to set aside contracts with affiliates which require excessive prices for goods and services. And most states only permit the owner whatever profits are left once the receivership is terminated.

P.Neel
2-27-90
Attm. #4,
pg. 5 4.

The law sets up a fund within S.R.S. that can be used to pay expenses of receivership. But it is more reasonable and would allow for no hold back due to fiscal constraints in bringing receivership action if more of the financial responsibility could be placed on the owner, as proposed in this bill.

The measures proposed in this bill have also been recommended by the Commission on Legal Problems of the Elderly of the American Bar Association.

KDOA asks favorable consideration of the bill.

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2-22-84

Kansas Health Care Association ahca

TESTIMONY PRESENTED BEFORE THE
SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

By
Dick Hummel, Executive Director
Kansas Health Care Association

February 22, 1984

SENATE BILL 656

"AN ACT relating to adult care homes; concerning recovery of costs of receivership."

Senator Meyers and Committee Members:

On behalf of the Kansas Health Care Association, an organization that represents over 200 adult care homes, both proprietary and non-profit, thank you for this opportunity to appear before the committee.

S.B. 656 amends the adult care home receivership procedures to hold the owner or licensee liable for costs arising from receivership actions.

Receivership, an intermediate sanction short of closing a facility, has been used sparingly by the enforcement agency, but when it has it has been a costly proposition for the state.

Interestingly, state net expenditures have sometimes been double that of the adult care home's previous Medicaid rate.

Not here to oppose the bill, we rather question if anything really is going to be accomplished by making an insolvent operation liable for expenses; we also note that a prior secured creditor would have priority in the order of liens attached to a property (lines 0046-0048).

Perhaps it is time to evaluate the effectiveness and efficiency of the entire receivership process. We maintain that if an adult care home is in the due conditions enumerated in this Act (life-threatening situation, license is revoked, or is insolvent) it should be closed and operations ceased.

Thank you again for this opportunity.

221 SOUTHWEST [illegible]

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2-22-84

KINH

Kansans for Improvement of Nursing Homes, Inc.

913 Tennessee, #2 LAWRENCE, KANSAS 66044 842-3068 — Area Code 913

February 21, 1984

TESTIMONY SUBMITTED TO

THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

CONCERNING SENATE BILL 656

Kansas may take pride in being among the early states to adopt a nursing home receivership law in 1978. Further, the state has been ahead of the pack in designing the receivership statute not only as a final step in closing a nursing home and providing for an orderly relocation of residents, but also to be used as a means of improving the quality of care in a seriously deficient facility, thus enabling the home to remain in operation and avoiding the trauma that often occurs when elderly residents must be transferred to another facility.

Kansans for Improvement of Nursing Homes strongly supports the receivership concept. It has been a matter of some concern, however, that the state has been faced with a sizeable price tag for its efforts and that the costs of receivership have not been fully recoverable. Whether that price tag has had an inhibiting effect upon the state's readiness to undertake receiverships we cannot say, though that may well be the case. KINH believes SB 656 provides an appropriate and needed mechanism for recovering the costs of receivership for the state. We urge the committee to support this legislation.

PNW
2-27-90
Attm. #4,
pg. 5 of 7.

2-22-84

A POSITION PAPER AGAINST HB 2368 AND SB 656

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE HEARING 2-22-84

Pioneer Village, Inc., is an intermediate care facility for the mentally retarded. We are a residential training center for mentally retarded adults, admission ages 16 through 65. We are a private, not-for-profit corporation with 4, 15-bed residential units, an office and gym, and a work activity center. With the exception of two residents, all of our residents are funded by Title XIX and social security or other types of benefits. Our services include training in the following areas:

Personal development
Social development
Household management
Academics
At-home leisure
Community leisure
Work habits and attitude
Pre-vocational & vocational skills

Additionally, we have two full-time qualified mental retardation professionals with special education degrees, a social worker, a recreation director, a vocational director, two LPN's and an R.N. in addition to a professional consulting staff in psychology, occupational therapy, physical therapy, a physician and dentist, dietary, pharmacy, speech pathology, and audiology.

P&HW
2-27-90
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89.58

Because HB2368 affects not only Pioneer Village and other adult care homes already in operation, but the establishment of future facilities by small independent entities, it is extremely important that you not recommend this bill for approval by the Senate.

It is understood that HB2368 is intended to protect the state of Kansas, the employees and other affected parties when an adult care home fails to meet its financial obligations. The broader implications of this bill are alarming and must be considered.

1) The language in this bill is vague and leaves a high degree of latitude in making the judgement about whether or not to require the surety bond. The wording in line 0050 "insufficient net worth or inefficient operation and managment" does not specify exact criteria for requiring the bond.

2) The cost of a requirement such as this to the state will be high. We computed our monthly expenditures and contacted our insurer requesting the cost of such a bond. The first problem was that it is very likely that such a bond would require collateral. The only possible significant collateral we might be able to use would be the EDS payment that is always outstanding. This happens because service has been rendered before we bill EDS-Federal for reimbursement. The second problem was that such a bond would cost $70.00 per $1000.00. The approximate cost for Pioneer Village would be $7500.00 based on 2 months expenditures. This $7500.00 then becomes an allowable cost and the state would reimburse it as a cost of operation.

PK&LW
2-27-90
Attm. # 4,
Pg. 5 9.

3) In a facility with a large private pay population, Title XIX would, in effect, subsidize the private monies. Because these monies are a part of the expenditure of the facilities , the bonding would cover those expenditures, and, when being reimbursed allowable costs, it is assumed that the facility would recover this expense. Although this does not apply to Pioneer Village to any great degree, the bulk of the adult care homes are for the elderly generally and have a higher number of private pay residents.

4) My greatest concern is that when one requires such a large amount of money "up front" so to speak, small organizations such as Pioneer Village will not even be able to start operation. Although the prevailing attitude in the state seems to be a deep concern about large, out-of-state health care corporations buying adult care homes, this bill will allow only that kind of operation to open a home. This type of concern would likely be the only type that would have the capital to present this sort of bond.

We would also like to briefly present problems that we foresee with SB656. Although it seems just to expect a company to pay the cost of a receivership, the question arises that, in case of insolvency, from where would this money come? Again, it seems that a large corporation would be able to reimburse such a cost, but a small operation would probably not have the assets from which to draw. In the case of Pioneer Village, would the governing body be personally liable for the cost of receivership?

Thank you for your attention and careful consideration of HB2368 and SB656.

Lynda Crowl, ONRP
Pioneer Village, Inc.

PHCW
2-27-90
Attm. # 4.
Pg. 8 60

2-27-84

STATE DEPARTMENT OF SOCIAL & REHABILITATION SERVICES

Testimony on Senate Bill No. 656

Relating to Senate Bill 656, the Kansas Department of Social & Rehabilitation Services supports passage of this bill. This bill amends K.S.A. 39-960, 39-961 and 39-963. Under the present statute, the State Department of Social & Rehabilitation Services cannot collect any payments made when an adult care home is under a receivership by the Department of Health and Environment.

The amendment to K.S.A. 39-960, 39-961 and 39-963 would allow any payments made by the Secretary of Social & Rehabilitation Services to be owed by the owner or licensee and to be repaid to the Secretary of Social & Rehabilitation Services when the receivership is terminated. This amendment would allow that until payments were repaid that a lien against all personal and real property of the owner or licensee would exist.

Under the last receivership - Special Care Development Center of Winfield, the Department of Social & Rehabilitation Services paid out $394,048.75. This facility is a 96 bed Intermediate Care Facility for the Mentally Retarded (ICF-MR). The period of the receivership was 4-5-82 to 8-31-82. The receivership before Winfield was the Reno County Adult Care Facility leased to Boswell, Inc. The period of receivership was 9-18-80 to 3-18-81. The Department of Social & Rehabilitation Services paid out $77,111.46. This facility is a 50 bed Intermediate Care Facility (ICF).

Had the Department of Social & Rehabilitation Services been legally able to collect the payments made under these two receiverships, $473,160.21 could have been returned to the State.

John Schneider, Commissioner
Division of Income Maintenance
and Medical Services
Social & Rehabilitation Services
(913) 296-3271
February 22, 1984

P Hall
2-27-90
Attm # 4
Reg 561

2.22.84

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

TESTIMONY ON SENATE BILL NO. 656

PRESENTED FEBRUARY 22, 1984

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

This is the official position taken by the Kansas Department of Health and Environment on Senate Bill No. 656.

NEED FOR:

The Department of Health and Environment may petition a district court for receivership of an adult care home when life-threatening conditions are found in a home, when a home becomes insolvent, or when a home is operating without a license. In a receivership, the Secretary or the Secretary's designee actually assumes operational control of the home. Since the Kansas statutes authorizing receiverships in adult care homes were enacted in 1978, the Department of Health and Environment has operated three homes in receivership. The receivership authority has generally proved to be a useful tool to protect the residents of homes who are placed in jeopardy by the actions or inactions of a licensee.

Perhaps the most significant practical problem which has surfaced in the use of receivership has been the problem of cost. Often by the time receivership is invoked, both the physical plant and the staff of the facility are in an advanced state of deterioration and both capital and cash flow are insufficient to meet the facility's needs. Substantial funds may be necessary to keep the facility open even long enough to transfer residents in an orderly fashion. The Kansas statutes provide for this contingency by authorizing the Secretary of the Department of Social and Rehabilitation Services to approve expenditures for the purpose of operating a home in receivership. The last two receiverships by the department resulted in a net cost to the state of $67,000 and $126,000, respectively, over and above the amount payed by the state to purchase care for Medicaid clients. Both of these receiverships lasted approximately six months; however, the second was in a larger facility licensed to provide intermediate care for mentally retarded persons. However, the statutes do not provide a means for the state to recover the costs of a receivership that exceed the revenue generated by the home.

STRENGTHS:

Senate Bill No. 656 clearly establishes the responsibility of the licensee for the cost of a receivership for the licensee's facility. This proposal is consistent with actions in the 1982 and 1983 legislative sessions to focus on the accountability of licensees for the quality of care provided. Clearly, the taxpayers of Kansas should not be required to bear the cost of rehabilitating a delinquent nursing home.

WEAKNESSES:

None identified.

PHWW
2-27-90
Attm. # 4
09.62.

DEPARTMENT'S POSITION:

The Department of Health and Environment recommends that the committee report Senate Bill No. 656 favorably for passage.

PRESENTED BY: Barbara J. Sabol
Secretary of Health and Environment

PH&W
2-27-90
Attm #4,
Pg. 6B.

State of Kansas
Mike Hayden, Governor

Department of Health and Environment
Office of the Secretary

Stanley C. Grant, Ph.D., Secretary

Landon State Office Bldg., Topeka, KS 66612-1290

(913) 296-1522
FAX (913) 296-6231

Testimony Presented to

The House Public Health and Welfare Committee

by

The Kansas Department of Health and Environment

House Bill 2802

Background

House Bill 2802 would amend adult care home receivership law by exempting owners of property who lease such property for purposes of operating an adult care home from any obligation to repay the State of Kansas for costs incurred or payments made for the operation of a receivership.

In 1984, receivership statutes were amended to allow the State to recover from the owner or licensee the costs of operating and funding a facility in receivership.

Since 1984, two receivership actions have been filed. Upon termination of the first, the costs of the receivership were recovered from the owner. The owner was not involved in the day to day operation of the facility. The second receivership is still in effect. The cost recovery action will not be ripe until the receivership is closed.

Problems

Exempting the owner of property, acting as lessor, from responsibility to reimburse the state for costs associated with receiverships has several implications. Perhaps the most obvious is that taxpayers could ultimately bear the costs of receiverships. This is not appropriate given the fact that the lessor voluntarily agrees to become involved in the nursing home industry. The lessor gains benefit from the operation of the adult care home yet would be relieved of all responsibility when the operation of the adult care home sours.

It is not unusual for the receiver to expend considerable funds to renovate, clean and repair the physical plant when a receivership is commenced. The lessor thus ends up with a much improved physical plant funded by the taxpayers without cost recovery.

PHHW
2-28-90
attm # 5

Charles Konigsberg, Jr., M.D., M.P.H., Director of Health (913) 296-1343

James Power, P.E., Director of Environment (913) 296-1535

Lorne Phillips, Ph.D., Director of Information Systems (913) 296-1415

Roger Carlson, Ph.D., Director of the Kansas Health and Environmental Laboratory (913) 296-1619

The Legislature determined in 1984 that it was appropriate for lessors to be accountable in the operation of adult care homes. This, in part, was in recognition that the residents of adult care homes are dependent not only on the operator but on the physical plant owner for their well-being.

Department Position

The Department believes this proposal compromises the accountability of an adult care home provider. Lessors have every opportunity to protect themselves from inadequate operators when they enter into lease arrangements. Accordingly, the Department of Health and Environment respectfully requests that House Bill 2802 not be favorably passed.

Testimony Presented By

David M. Traster
Assistant Secretary and General Counsel
Kansas Department of Health and Environment
February 27, 1990

PH&W
2-27-90
Attm. #5
pg. 2.

STATE OF KANSAS

OFFICE OF THE ATTORNEY GENERAL

2ND FLOOR, KANSAS JUDICIAL CENTER, TOPEKA 66612-1597

ROBERT T. STEPHAN
ATTORNEY GENERAL

MAIN PHONE: (913) 296-2215
CONSUMER PROTECTION: 296-3751
TELECOPIER: 296-6296

House Committee on Public Health and Welfare
House Bill No. 2802

Testimony Presented on Behalf of
Attorney General Robert T. Stephan
Presented by
Theresa Marcel Nuckolls
Assistant Attorney General
February 27, 1990

Mr. Chairman and Members of the Committee:

On behalf of Attorney General Stephan, I am here to testify in favor of House Bill No. 2802.

This bill clarifies which entities are responsible for adult care home facilities. Attorney General Opinion No. 89-96, issued July 31, 1989, to the Honorable William W. Bunten, concluded that the mere lessor of a building does not, under current Kansas law, have the same responsibility as the operators of an adult care home business. It was our opinion that, under the current statutory scheme, a landlord/tenant relationship did not mean that landlord was automatically required to operate or be responsible for the adult care home operated on the landlord's property.

PH&W
2-27-90
Attm #6

House Bill No. 2802 would clearly define what the Attorney General believes the law to currently be. Such clarification appears necessary and would greatly assist in determining the intent of the legislature on this matter. For this reason, we support House Bill No. 2802.

Passed
2-27-90
attm #6
09.2

KINH Kansans for Improvement of Nursing Homes, Inc.

913 Tennessee, suite 2 Lawrence, Kansas 66044 (913) 842 3088

TESTIMONY PRESENTED TO
THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE
CONCERNING HB 2802
ADULT CARE HOME RECEIVERSHIPS

February 27, 1990

Mr. Chairman and Members of the Committee:

Kansas recognized the value of nursing home receivership as an enforcement tool back in 1978, when only a handful of states had such a sanction. It has been used as a means of enforcing compliance of regulations short of closing a home and compelling transfer of very fragile residents for whom relocation can have serious consequences. It is simply not desirable to close a nursing home if a less drastic method can be found to assure an acceptable level of care. Receivership is such a method. It has been used rarely, in limited circumstances, and generally as a next-to-last option before closing a seriously troubled home.

The federal government, in the Omnibus Budget Reconciliation Act of 1987, now requires every state to develop a receivership mechanism. We may be pleased that Kansas is ahead of the pack in that respect.

HB 2802 would amend Kansas' receivership statute in ways KINH finds questionable, exempting from all responsibility for the receivership costs those owners "whose only connection with the operation or management of the adult care home is the ownership of the facility and the receipt of lease payments and who is not otherwise involved in the management of the affairs or operation of the adult care home." The owner, then, would be entitled to receive full payment for the lease from either the licensee/operator or the state regardless of the quality of care or the condition of the property. If the state, taking the facility into receivership, must make improvements to the property in order to make it habitable for the residents, as is not infrequently the case, it would be of no concern to the owner. Indeed, when the receivership was terminated the owner would get back an improved facility without ever having to pay for the improvements. If I were an owner of a property valued at several millions of dollars I would be very pleased to have the state pay for its improvement. As a taxpayer, on the other hand, I must question the use of tax dollars for that purpose.

It would appear that owners whose only interest is the profit to be derived from lease transactions could easily insulate themselves through their corporate structure from financial responsibility without the protection in the present receivership law that holds the owner accountable in every instance. It should be noted that the owner/lessor is notified, as are all parties to the license, when the facility is in difficulty. At that point the owner/lessor would have

Attach 2-27-90 attm #7

the option of seeking more competent management and we would think he would wish to do so for the protection of his property.

When tax dollars are being spent, and fragile, vulnerable residents are affected by the ownership as well as by the management of the facility, we believe all parties to the licensure should, indeed, be held responsible. KINH opposes passage of HB 2802.

PHHD
2-27-90
attm. # 8
pg. 2.

The University of Kansas Medical Center

School of Allied Health
Department of Hearing and Speech

2415

January 3, 1990

Representative Nancy Brown
15429 Overbrook Lane
Stanley, KS 66224-9744

Dear Representative Brown:

I am writing to express my support for the proposed Kansas law to mandate early identification of hearing loss for high-risk infants. Although I am not a resident of Kansas, I am a speech-language pathologist and an employee of the University of Kansas Medical Center. This proposed law will have a positive impact on lives of some of the patients I serve.

Thank you for your thoughtful consideration.

Sincerely,

Beth Dalton Moffitt

Beth Dalton Moffitt, M.A., CCC-SLP
Speech Language Pathologist

BDM/jwr

PHSEC
2-27-90
Attm # 8

Box 142

College of Education
The Wichita State University, Wichita, Kansas 67208-1595

The
Wichita
State University
College of Education

Feb. 21, 1990

Rep. Nancy Brown
State House, Rm 183W
Topeka, KS 66612

Dear Rep. Brown;

I am writing as a member of the Kansas Commission for Deaf and Hearing Impaired and as a hearing impaired professional in education. I would like to express my support of House Bill No. 2915 which would establish a program of hearing impairment identification.

I believe this bill to be a very conservative approach to a serious problem. Early identification is a major problem in language and social development of hearing impaired children. It is imperative that children be identified and receive intervention early before their language skills are too far behind normal development.

Thank you for your efforts in this issue.

Sincerely,

Marsha A. Gladhart

Marsha A. Gladhart
Clinical Instructor

P&HealD
2-27-90
Attm #8-
pg 2.

DICK VALLANDINGHAM, PH.D.

11111 W. 59th Terr.
Shawnee, KS 66203
(913) 268-4101

PHWD
2-27-90
Attm. # 8
pg. 3

2-21-90

To: House Public Health and Welfare Committee

Re: H.B. 2915

I want to go on record as strongly supporting passage of H.B. 2915 - establishing a state-wide high-risk registry for hearing loss.

As a professional dealing with hearing loss as it affects communication on a daily basis, I am acutely aware of the effect of delayed identification of hearing loss. Language deficits which can not be eliminated, auditory skill development which can not be achieved, and family dysfunctions in communication which can only be partly resolved are all results of delayed identification.

Every professional I know working in the area of hearing loss agrees that early identification of hearing loss is of critical importance -

I hope you will send this bill on with your strong endorsement too!

Dick Vallandingham, PhD CCC-A

8-3

ASSOCIATED AUDIOLOGISTS
Comprehensive Hearing Care

James Wise, M.A.
Rod McLennan, Ph.D.

Certified by American Speech-Language-Hearing Association

Olathe Office
225 W. 151st St., Ste. 202
Olathe, Kansas 66061
913/829-0891 Voice/TTD

Prairie Village Office
7301 Mission Rd., Ste. 140
Prairie Village, Kansas 66208
913/262-5855

Services include: Diagnostic hearing evaluations, Electrophysiological Assessments, hearing aid dispensing, assistive communication devices and aural rehabilitation.

TO: Representative Nancy Brown
State House Room 183 West
Topeka, KS 66612

FROM: James A. Wise, Audiologist
225 W. 151st Street, Suite 202
Olathe, KS 66061

DATE: February 21, 1990

RE: House Bill No. 2915 by Representatives Brown, Blumenthal, Pottorff and Snowbarger

Dear Representative Brown:

I am writing in support of House Bill No. 2915, an act concerning hearing impaired infants establishing a program of hearing impairment identification providing for administration of the program by the Secretary of Health and Environment.

I am responding in support of this bill from two positions: one is as a parent and one is as a professional. First, as a parent of a child who is mentally retarded and has Down Syndrome, I know of the importance of early identification and intervention for children with handicapping conditions. Early intervention has made a tremendous difference in the ability of our child. However, he happened to have a known handicapping condition which was identified at birth. Hearing impaired infants, unfortunately, don't have such a visual indication to identify hearing loss at as early a stage. Hearing loss in children is a silent, hidden handicap and if undetected and untreated it can lead to delayed speech and language development and to social, emotional, and academic problems. It is not necessary for a child to suffer because of hearing impairment; if detected early, the problem can be effectively treated. The current reasons for delays in identification include a lack of awareness, a lack of in-hospital testing of high risk infants, misinformation and poor use of existing services. This problem is very significant and in the United States today the approximate delay between a parent's suspicion of a child's hearing loss and its clinical confirmation by means of formal hearing evaluation is nearly two years. This delay places the child beyond a critical period for normal speech and language development. Among all newborns, it is estimated that 7% to 12% are at risk for hearing impairment, approximately one child in 1,000 will be born with profound deafness. An additional two children in 1,000 will acquire deafness during early childhood. Newborns who need intensive medical care are also at higher risk for hearing loss; one child in 50 will have significant hearing impairment.

P&RW
2-27-90
Attm #8
pg. 1

From the standpoint of a professional audiologist, we know that severely hearing impaired children who escape detection until school age are confronted with the nearly impossible task of

trying to catch up with their normal hearing peer group, by telescoping four to five years of communicative development into a much shorter period. Delayed speech development is often the first indicator that draws parents' attention to their youngster's underlying hearing loss. However, waiting for demonstrated developmental failure to diagnose hearing impairment is inefficient and may severely limit the child's achievement potential.

During the past ten to fifteen years, much attention has been devoted to early identification and intervention programs for prelingually deaf children. High risk factors associated with prelingual deafness has been distilled from family histories, pregnancy and birth records, and neonatal histories to identify infants in need of special follow-up.

House Bill No. 2915 provides a start for a more efficient and improved way of beginning to identify infants with potential hearing impairment in hopes of identifying them at as early a stage as possible. The first step is identification; the next step is then providing a more effective rehabilitative track for making these Kansans more productive by providing them with the maximum rehabilitation available.

Thus, as a parent and as a professional, I wholeheartedly support the endeavors of this bill in hopes that this will provide a step in the right direction to work upon further development of additional services for the deaf and hearing impaired infants in the state of Kansas.

James A. Wise, M.A.
Audiologist

Attch. #8,
2-27-90
Attm. #8,
pg. 5.

Marnie Campbell
3408 West 74th Street
Prairie Village, Kansas 66208

February 19, 1990

Rep. Nancy Brown
State House, Room 183W
Topeka, KS 66612

Dear Nancy:

I am writing in support of H.B. 2915. As the Chair of the Task Force from the Kansas Commission for the Deaf and Hearing Impaired on Early Identification and Intervention for Hearing-Impaired Children and their Families, I can speak collectively for the approximately 100 people who have been involved on this project since May 1988. All individuals volunteered, investing themselves to ensure a better start in life for future Kansas families with hearing-impaired children.

I have worked in the area of parent education and deafness for more than 10 years. In 1983, when I wrote my master's thesis in special education, I surveyed Kansas families and replicated a national study, finding that Kansas is about average in identifying hearing loss: roughtly half of the children are misdiagnosed, and generally a correct diagnosis is finally reached by age 3. This age is too late. Technology exists to identify hearing loss in the first days of life, and at least 50% of hearing-impaired children have high-risk factors that would indicate possible hearing problems. By establishing a program to identify hearing loss early, Kansas would join several states who have successfully implemented such a program and improved the identification of hearing loss in babies.

As a parent, I can also tell you how much this law is needed. For almost 3 years, our profoundly deaf son Chris was misdiagnosed as having central processing dysfunction. The audiologist thought Chris could hear but sounds did not process to the brain. There was no test available such as the auditory brainstem response (ABR), as there is today. So it was not until Chris was old enough to be "conditioned" for pure-tone testing with earphones that he was correctly diagnosed. He began wearing a hearing aid, which has made a tremendous difference in his life. But for those first 3 years, he had no auditory input. Those 3 years, which we know are the most important years for learning speech and language, are lost forever -- they can never be made up, even with the best of educational programs. This situation must not continue, when there are methods to prevent the irreparable damage such misdiagnosis causes in children, and the anguish their parents experience. Families need to know if their child has a hearing problem as early as possible, and they can help their baby learn if they get the help they need.

Sincerely,

Marnie

Marnie Campbell

PH&W
2-27-90
Attm. #8
09-6

FEBRUARY 21, 1990

MR. & MRS BRIAN D. PEEL
7617 HAYES
OVERLAND PARK, KS. 66204

Dear Ms. Brown,

OUR DAUGHTER REGINA WAS DIAGNOSED AS HEARING IMPAIRED WITH A 3 YEAR DELAY IN SPEECH JUST LAST YEAR PRIOR TO HER 8TH BIRTHDAY. THE SCHOOL THAT SHE ATTENDED HAD WRITTEN HER OFF AS MENTALLY RETARDED.

WE TRANSFERRED REGINA TO SANTA FE TRAIL HEARING IMPAIRED PROGRAM. THEY HAVE DONE GREAT THINGS WITH REGINA THIS YEAR. SHE HAS MADE GREAT PROGRESS. PLEASE VOTE AGAINST ANY PROPOSALS TO CUT SPECIAL EDUCATION FUNDING.

PH&W
2-27-90
attm #8
pg. 7.

ALSO, WE ASK THAT YOU SUPPORT HB2915 - EARLY IDENTIFICATION AND INTERVENTION. OUR DAUGHTER WOULD HAVE BEEN SO MUCH BETTER OFF IF THE HEARING IMPAIRMENT COULD HAVE BEEN DETECTED SOONER.

Sincerely,
MR & MRS BRIAN D. PEEL
7617 HAYES
O.P. KS [illegible]

ADVOCATES OF BETTER COMMUNICATION, INC.

Serving the Deaf and Hard of Hearing Community
Since 1959

February 6, 1990

Representative Nancy Brown
15429 Overbrook Lane
Stanley, KS 66224-9744

Dear Representative Brown;

Please count me personally, and the agency in which I am employed, solidly in support of the Early Identification and Intervention Bill that you are introducing in the House of Representatives.

I'm deaf, recently Cochlear implanted and a strong supporter of the earliest possible start for language and communication instruction for children who are born deaf/ hearing impaired.

Please advise me of any service I can perform to support the passage of this much needed bill into law.

Sincerely,

Mike Nunn
Executive Director

MN/se

PH&W
2-27-90
Attm #4.
Cy. 8.

730 N. Main, Suite 6, Wichita, KS 67203 264-8881 (V/TDD)

STATE OF KANSAS
MIKE HAYDEN, GOVERNOR
STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

KANSAS COMMISSION FOR THE DEAF
AND HEARING IMPAIRED

WINSTON BARTON, SECRETARY

BIDDLE BLDG., 1ST FLOOR
300 S.W. OAKLEY
TOPEKA, KANSAS 66606-1861
(913) 296-2874 (VOICE/TTY)
800-432-0698 (VOICE/TTY)
KANS-A-N 561-2874

January 17. 1990

Rep. Nancy Brown
15429 Overbrook Lane
Stanley, KS 66224-9744

Dear Rep. Brown:

Please let me introduce myself as a member of the Kansas Commission for Deaf and Hearing Impaired and as a hearing impaired Kansan. I am also immediate past president of Wichita Self Help for Hard of Hearing. I also teach at Wichita State University.

As I have met hearing impaired children and adults in my various roles, I have been impressed again and again with the importance of early identification of hearing impairment. The personal stories of parents and children who have struggled to get an appropriate diagnosis are frightening to any parent and educator who sees the consequences of improper diagnosis. The proposed bill for establishing a program of hearing impairment identification and monitoring is one important step toward improving health care and education for children with hearing impairment.

Your work in co-sponsoring this bill is greatly appreciated. Kansas does not compare favorable to other states either in identification or services to deaf and hearing impaired. Recent efforts by KCDHI and Sec. Barton's staff indicate the state's willingness to address these issues.

Please accept my letter of support for this proposed bill. I will look forward to hearing of its progress.

Sincerely,

Marsha A. Gladhart

Marsha A. Gladhart

P&W
2-27-90
attn ~~HB~~
09.9.

STATE OF KANSAS

MIKE HAYDEN, GOVERNOR

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

KANSAS COMMISSION FOR THE DEAF
AND HEARING IMPAIRED

WINSTON BARTON, SECRETARY

BIDDLE BLDG., 1ST FLOOR
300 S.W. OAKLEY
TOPEKA, KANSAS 66606-1861
(913) 296-2874 (VOICE/TTY)
800-432-0698 (VOICE/TTY)
KANS-A-N 561-2874

January 20, 1990

Dear Rep. Nancy Brown,

Please help the proposed Bill (SRS 1527)

on the Early Identification / Early Intervention of Early Childhood Hearing Loss.

Thank You

Sincerely Yours,

Roberta J. Troy
KCDHI Board
R#1 Box 119B
Wilson, Kansas 67490

P Hall
2-27-90
Attm #4. (Four)
Pg. 10

The University of Kansas

Speech-Language-Hearing:
Sciences and Disorders

February 1, 1990

Nancy Brown, Representative
House of Representatives
State Capitol
Topeka, Kansas

Dear Representative Brown:

I am writing to inform you that I strongly support the House Bill that you are currently sponsoring related to hearing assessment of hearing impaired infants. This bill is needed to assure that all infants born in Kansas are pre-screened by a high-risk register for hearing loss. Equally important, the bill makes allowance for a follow-up hearing assessment for infants identified to be at-risk for hearing loss.

You and the members of the committee that developed this bill are to be commended for its content. Hopefully, any concerns related to availability of hearing services, costs, or patient care considerations will require only minor changes in the bill's wording.

Please let me know if I may be of any assistance in passage of this important legislation.

Sincerely yours,

Larry E. Marston

Larry E. Marston, Ph.D.
Associate Professor

LEM/mh

P&PC
2-27-90
Attm. # 4.

2101 Haworth Hall • Lawrence, Kansas 66045-2181 • (913) 864-4690 • TTD/TTY (913) 864-5094

KAN[illegible]OSPITAL ASSOCIATION

Memorandum

Donaid A. Wilson
President

February 26, 1990

TO: House Public Health and Welfare Committee

FROM: Kansas Hospital Association

RE: House Bill 2915

The Kansas Hospital Association appreciates the opportunity to comment regarding H.B. 2915. This bill would establish an early intervention screening program to identify infants who are at risk of being hearing impaired.

We recognize that the literature suggests such screening programs can be helpful in identifying hearing impaired infants. In addition, it is clear that the sooner such discoveries are made, the better chance those infants have of receiving effective medical help for their condition.

In light of these facts, Kansas hospitals are willing to cooperate in an efficient and effective program to provide such screening.

In developing new programs such as the one in H.B. 2915, the emphasis must be on ensuring effectiveness of the screening process, while making it as efficient as possible. At a time when medical assistance budgets are being cut, lawmakers should be careful not to create new cost and liability burdens on the state's health care providers. In order to promote this efficiency, we have attached several suggested amendments for the committee's consideration.

Thank you for your consideration of our comments.

/cdc

Attachment

P&HW
2-27-90
Attm. # 4
pg. 12

1263 Topeka Avenue • P.O. Box 2308 • Topeka, Kansas 66601 • (913) 233-7436 • FAX (913) 233-6955

Department of Social and Rehabilitation Services

Winston Barton - Secretary

Statement regarding House Bill 2915

1. Title — An act concerning hearing impaired infants; establishing a program of hearing impairment identification; providing for administration of the program by the secretary of health and environment.

2. Purpose — The purpose of this bill is to establish a program for the early identification of hearing-impaired infants and high-risk infants. The secretary, after consultation with the Kansas commission for the deaf and hearing impaired, shall establish by rules and regulations new-born infant hearing-impaired risk criteria and shall develop a questionnaire to identify high-risk infants.

3. Background — There are no programs currently in the state of Kansas that addresses identification of hearing impairment from the time the infant is born to the time the child begins public school education. Many parents are unaware of hearing loss until the time the child begins to develop speech skills. The first few years in the child's life is the most critical period in which communications, language, and cognitive development is learned. The child who escapes detection until he or she reaches school age is confronted with the nearly impossible task of trying to catch up with his normal-hearing peer group by compressing four to five years of communicative development into a much shorter period.

4. Effect of Passage — Passage of this bill will establish a program of early identification within the Department of Health and Environment. Criteria for identification of hearing loss in infants will be established by the Secretary after consultation with members of the Kansas Commission for the Deaf and Hearing Impairment, and a questionnaire will be developed to be issued to all expectant mothers at the hospitals or medical centers in order to identify potential risk for hearing impairment in the infant. This will provide much needed data which the state and school services can use for planning purposes. The sooner the infant is identified, the sooner the resources to assist parents and the infant can be made available which enhances the opportunity for communication development and success in the future.

5. SRS Reccomendation — The Department of Social and Rehabilitation Services urges favorable consideration of this Bill.

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David S. Rosenthal
Kansas Commission for the Deaf
and Hearing Impaired
296-2874

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Testimony in Support of House Bill 2915

Mr. Chairman, committee Members, I am testifying before you on behalf of the Kansas Commission for the Deaf and Hearing Impaired, which is within Rehabilitation Services, under the Social and Rehabilitation Services umbrella.

The Kansas Commission for the Deaf and Hearing Impaired coordinates services and disseminates information related to the well-being of Kansans who experience deafness or hearing impairment. The Commission serves as an advocate for services for the deaf and hearing impaired citizens of Kansas, collecting facts and statistics to encourage and assist public and private agencies and units of local, state, and federal government to cooperate in the delivery of services to respond to the needs of this population.

The Kansas Commission for the Deaf and Hearing Impaired supports H.B. 2915. Early identification of an educationally significant hearing impairment is an essential public-health priority. Gradual development of verbal communication skills during the critical preschool years lays the foundation for the child's academic growth during the initial grades of elementary school. The severely hearing impaired child who escapes detection until he or she reaches school age is confronted with the nearly impossible task of trying to catch up with his or her normal-hearing peer group by telescoping four to five years of communicative development into a much shorter period.

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pg. 1 of 1

Given the fact that only a few types of educationally significant hearing impairments are associated with obvious physical deformities, these disabilities generally constitute "invisible" handicaps at birth. Not until the age at which the child is expected to demonstrate communicative abilities in listening and speaking will his deficits become obvious. Delayed speech development is often the first indicator to draw the parents' attention to the youngster's underlying hearing loss. Diagnosis of hearing impairment in a child by waiting for a demonstrated developmental failure is a method fraught with inefficiency and risk for severe limitation of the child's developmental potential.

There is an average delay of nine to twelve months from the first suspicion of a severe to profound sensorineural hearing loss in the young child to the confirmatory diagnosis and institution of remediation. Even greater delays occur when the child has a moderate rather than severe hearing loss. Such a delay, with its resultant deleterious effects on the child's communicative development, is clearly unacceptable and demonstrates the imperative for a model of identification which this bill addresses.

We ask that you make a favorable recommendation of this bill. Thank you for the opportunity to testify on behalf of this bill.

David S. Rosenthal
Executive Director
Kansas Commission for the Deaf
and Hearing Impaired
296-2874

February 27, 1990

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HB 2915.

WICHITA
PUBLIC SCHOOLS

February 6, 1990

Rep. Nancy Brown
15429 Overbrook Lane
Stanley, Ks. 6224-9744

Dear Rep. Brown,

I am writing this letter to you to voice my strong support of the proposed bill regarding early identification and intervention services for hearing impaired children. As an audiologist, one who has been able to provide services to children from birth on up, I can tell you what a significant impact early intervention has on speech/language, cognition, hearing, family acceptance and involvement - the total habilitation process. The youngest child I have worked with has been age 7 months. The progress this child made is so much greater than the children I see who are age 3 or above and just being identified and served. I can't stress the importance of early identification enough! We must have these services provided across the State. I am very excited about this bill - I have long awaited its arrival! Please let me know if there is anything I can do to help the cause.

Sincerely,

Molly Pottorf

Molly Pottorf, M.A., CCC-A/SP
Audiologist, USD #259

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Allen Elementary School • 4814 East Mt. Vernon • Wichita, Kansas 67218

February 27, 1990

To: Legislative Committee Chairperson and Committee Members

From: Kenneth E. Clark, 18610 W. 170th Terr. Olathe, KS. 66062
Chairperson of Kansas Commission for the Deaf & Hearing Impaired

RE: HB 2915 (Early Identification bill)

From my own personal standpoint as a deaf man and from my experiences and observations in my entire lifetime, I view this Early Identification bill as the ticket to sparing our future new-born infants with hearing loss, their parents, family members, and community members the agony and complications that result from pure public ignorance and lack of preparedness on deafness or acquired hearing loss. Such apathy and ignorance that are evident in this disability area also result in huge mismanagement of family income as well as tax payers' monies in correcting the situation. The negative aspects and unpreparedness of recognizing hearing loss at the earliest age possible and doing something positively about it are unmeasurable and unbelievable! We need to correct this now!

The passage of this bill would not only bring solutions to the serious problems of infants whose hearing loss are identified, but to the hearing population who are associated with deafness or hearing impairment as well. Such awareness of everyone involved could become more noticable that would help to establish a more meaningful and purposeful life altogether. Above all, deaf and hearing impaired people, from birth through adulthood, will have a greater sense of direction in their preparedness for life as self-supporting and independent citizens. We are not asking for sympathy votes but for your full cooperation and support to make understanding between deaf/hearing impaired people and hearing people possible.

I personally want to thank Representative Nancy Brown and her constituents for introducing this bill. For myself as a representative for deaf people and on behalf of the members of the Kansas Commission for the Deaf and Hearing Impaired, I humbly ask that each of you give this bill full consideration and vote of support. Thank you very much.

Kenneth E. Clark

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attm. #9

James A. Wise, M.A., C.C.C.-A
Associated Audiologists, 225 W. 151st St., Ste. 202
Olathe, KS 66061 Phone: (913) 829-0891

TESTIMONY Re: HOUSE BILL No. 2915 - AN ACT concering hearing-impaired infants; establishing a program of hearing impairment identification; providing for administration of the program by the secretary of health and environment.

My name is James Wise. I have been an audiologist over 17 years and currently in private practice with offices in Olathe and Prairie Village, Kansas. As a clinician in the field, I have had the opportunity to evaluate infants and children who have varying degrees of hearing impairments, and developmental disabilities. During this time I have continued to see situations where the identification and diagnosis of childhood deafness is often inordinately delayed. National statistics also report infants with moderate to profound hearing loss that continue to go undetected until as late as 24 months. Lesser degrees of congenital hearing loss may not be diagnosed until 48 months of age.

Among all newborns it is estimated that 7 to 12% are at risk for hearing impairment. Approximately one child in 1,000 will be born with profound deafness. An additional two children in 1,000 will acquire deafness during early childhood. An equal number of children have permanent partial hearing loss of disabling proportions. The developmental and psychosocial impact of hearing

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loss can be devastating, particularly if hearing loss is accompanied by other developmental disabilities or if the diagnosis of hearing impairment is delayed. Children who escape detection until school age are confronted with the nearly impossible task of trying to catch up with their normal hearing peer group by telescoping four to five years of communicative development into a much shorter period.

We know that the first 36 months of life are a critical period for language learning; at no other time does language acquisition proceed as quickly and with such ease. Failure to identify hearing loss and provide intervention before this period lapses will needlessly prejudice language development beyond the effect of the hearing loss itself.

The failure in identifying these infants with hearing impairments is multifaceted. We currently have no systematic approach to early hearing assessment within the child healthcare system. While we now have the technology with advanced diagnostic tools to assess hearing as early as birth, many do not get access to such services. Other studies have shown that physicians often fail to refer at the earliest stages even when the risk of hearing loss is implied by craniofacial anomalies, there is a high risk medical history, or developmental delay. This also is coupled with physician overconfidence in their ability to detect hearing loss by routine physical examination and informal office assessment of hearing. This is but a part of the failure we see in our efforts to deal with a very complex issue.

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During the past 10 to 15 years, many progressive programs have been developed that are devoted to early identification and intervention for prelingually deaf children. Identified risk factors have been distilled from family histories, pregnancy, birth records, and neonatal histories for identifying infants in need of special follow-up.

Adherence to these specific historical, physical, or developmental risk criteria, regardless of an examiner's subjective impression of how a child seems to hear, offers a mechanism for a more timely diagnosis of hearing impaired infants and children.

House Bill 2915 provides one of the first steps in greatly improving our identification of hearing impaired infants in the State of Kansas at its earliest stages. This Bill is the beginning framework for a more systematic approach to early hearing identification within our child health care system.

Specifically, House Bill 2915 establishes a statewide high risk registry to identify those infants at greater risk for hearing impairment. It also provides an improved data base for educational program planning. The use of the high risk register has been proven successful in many states and, if implemented properly, has the capability of identifying up to 80% of all severe to profound hearing impaired newborns.

To date, almost half of our states currently have a mandated program or are in the process of development. The American Academy of Audiology has recommended a national mandate with the high risk register as a key component. We cannot afford to wait any longer.

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The time has come for Kansas to provide the needed framework for a more comprehensive early identification program for hearing impaired infants in Kansas that includes the education of health care professionals about the importance of early identification and greater awareness on the availability of methods to assess hearing after birth. It will also provide greater general public awareness regarding these issues. House Bill 2915 provides a much needed beginning that will enhance the lives of Kansans who are hearing impaired. I wholeheartedly support the endeavor of the Bill.

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Attm. #10-A
pg. 4.

Audiologic Screening of Newborn Infants Who Are At Risk for Hearing Impairment

The following guidelines were developed by the ASHA Committee on Infant Hearing and adopted by the ASHA Legislative Council in November 1988 (LC 28-88). Currrent and past members of the committee responsible for the development of the guidelines include Deborah Hayes (chair, 1988); Michael Sabo (chair, 1985-87); Fred Bess; Dianne Brackett; Frank Burns; Evelyn Cherow, ex officio; Brad Freidrich; Judith Gravel; Jack Kile; Marcia Kushner; Diane Meyer; Gary Thompson; James Thelin; and Ann Carey, ASHA vice president for professional and governmental affairs (1988-90) and Nancy Becker, vice president for professional and governmental affairs (1985-87).

Background

A Committee on Infant Hearing was established in 1984 by the Legislative Council (LC 27-84). The charge to that committee:

> To gather and synthesize information and policies generated by committees and Boards of ASHA which pertain to special aspects of hearing impairment in infants, models of service delivery to infants, and identification, diagnosis, and management of hearing disorders in infants; to identify and make recommendations on research needs regarding the development of auditory function and dysfunction in infants, prevention of hearing impairment in infants, and the identification, diagnosis, and management of hearing disorders in infants; to provide audiologic consultation to the Joint Committee on Infant Hearing on matters pertinent to prevention, identification, diagnosis, and management of infant hearing.

The initial activity of the committee was to determine procedures that, at the present time, are most appropriate for audiologic screening of infants at risk for hearing impairment. After consideration of the many issues related to infant hearing, the committee concluded that (a) all newborn infants who are at risk for hearing impairment should be identified, (b) infants identified at risk should receive audiologic screening by auditory evoked potentials prior to hospital discharge, and (c) those infants who fail initial audiologic screening or who fail to be screened should enter an audiologic evaluation, follow-up, and management system.

The purpose of this report is to set forth guidelines for the establishment of auditory screening programs for newborn infants who are at risk for hearing impairment.

Guidelines for audiometric evaluation, follow-up, and management of hearing-impaired infants will be considered in forthcoming activities of the Committee on Infant Hearing.

Definitions

Infants at risk: Infants who fall into one or more of the seven risk criteria identified in the 1982 position statement of the Joint Committee on Infant Hearing (1982) are considered at risk for hearing impairment and should receive audiologic screening.[1] The factors are:

1. A family history of childhood hearing impairment.
2. Congenital perinatal infection (e.g., cytomegalovirus (CMV), rubella, herpes, toxoplasmosis, syphilis).
3. Anatomic malformation involving the head or neck (e.g., dysmorphic appearance including syndromal and nonsyndromal abnormalities, overt or submucous cleft palate, morphologic abnomalities of the pinna).
4. Birthweight less than 1500 grams.
5. Hyperbilirubinemia at level exceeding indications for exchange transfusion.
6. Bacterial meningitis, especially H. influenza.
7. Severe asphyxia which may include infants with Apgar scores of 0-3 who fail to institute spontaneous respiration by 10 minutes and those with hypotonia persisting to two hours of age (Joint Committee on Infant Hearing, 1982).

For a more complete review of these risk criteria and their relation to hearing impairment, see Gerkin (1984).

Hearing impairment: Bilateral conductive and/or sensori-neural deficit in the frequency region important for speech recognition (approximately 1000 through 4000 Hz). Hearing impairment is defined as deficit in auditory sensitivity that interferes with speech recognition and for which intervention strategies are known and available.

The impact of childhood hearing impairment on speech and language development and academic achievement is well documented (Allen, 1986; Osberger, 1986). In general, hearing-impaired children demonstrate limited speech production skills (Osberger, Robbins, Lybolt, Kent, & Peters, 1986), significantly delayed receptive and expressive language skills (Moeller, Osberger, & Eccarius, 1986; Osberger, Moeller, Eccarius, Robbins, & Johnson, 1986), and reduced academic achievement, especially in language-related areas (Allen, 1986). To minimize these debilitating effects, professionals have urged early identification and habilitation of infants with hearing impairment. Efforts in both the public and private sector have been undertaken to develop screening, diagnostic, and habilitation programs to meet these goals.

In the public sector, passage of Public

[1] Investigators have also recommended audiologic screening of infants who manifest other health factors. These factors include: a) parent consanguinity (Coplan, 1987; Feinmesser & Tell, 1976), b) severe neonatal sepsis (Feinmesser & Tel, 1976), c) persistent pulmonary hypertension of the newborn [(PPHN) (Naulty, Weiss & Herer, 1986; Sell, Gaines, Gluckman, & Williams, 1985)], and d) length of stay in the intensive care nursery and gestational age (Halpern, Hosford-Dunn, & Malachowski, 1987). Some investigators have also advocated audiologic screening of all infants in neonatal intensive care units (Galambos, Hicks, & Wilson, 1984; Jacobson & Morehouse, 1984). In future risk registries, these additional factors and recommendations may be included. At this time, ASHA recommends, at a minimum, use of the Joint Committee on Infant Hearing 1982 risk criteria pending update of the register.

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Law 99-457, the Educaton of the Handicapped Amendment of 1986, created (in part) a new discretionary program to address the special needs of handicapped infants and toddlers from birth through 2 years of age and their families. By 1990-91, each state that wants to continue receiving federal financial assistance under the birth-through-2 program must have in place a policy to provide early intervention services to all handicapped infants and toddlers. Some components of this program include development of a Child Find system, referral to service providers, research and demonstration projects, and a comprehensive system of personnel development. Provision of services must be by qualified personnel meeting the highest state standards established for employment in each profession or discipline.

In the private sector, representatives from audiology and speech-language pathology, otolaryngology, pediatrics, and nursing have participated in a Joint Committee on Infant Hearing which, over the years, has developed a series of position papers. The most recent position paper (Joint Committee on Infant Hearing, 1982) states that "early detection of hearing impairment in the affected infant is important for medical treatment and subsequent educational intervention to assure development of communication skills." The Joint Committee recommended that infants at risk for hearing impairment be identified and that they receive appropriate evaluation and treatment.

Reliable data on incidence of significant hearing impairment in infants and young children are unavailable (Hotchkiss, 1987; Ries, 1986). National statistics indicate that approximately 3.7 million children are born in the United States each year (Wegman, 1987). Investigators estimate that 7 - 12% of all newborns are at risk for hearing impairment (Feinmesser & Tell, 1976; Jacobson & Morehouse, 1984; Mahoney & Eichwald, 1987). Moderate to profound hearing impairment is reported present in less than 2% to more than 4% of at-risk infants (Galambos et al., 1984; Jacobson & Morehouse, 1984; Mahoney and Eichwald, 1987; Stein, Ozdamar, Kraus, & Paton, 1983; Hosford-Dunn, Johnson, Simmons, Malachowski, & Low, 1987). Prevalence of milder degrees of hearing impairmnt in this population is unknown. Retrospective studies have shown that between 50 and 75% of hearing-impaired children were positive for at least one of the Joint Committee's risk criteria (Elssmann, Matkin, & Sabo, 1987; Feinmesser & Tell, 1976; Stein, Clark & Kraus, 1983).

In addition to infants who are at risk, infants with no known risk factors may have or develop hearing impairment (Feinmesser & Tell, 1976; Simmons, 1980). Prevalence of significant hearing impairment, including mild to moderate hearing impairment, for this population is not well defined.

The dearth of data on the prevalence of hearing impairment in both at-risk newborns and newborns with no known risk factors demonstrates the pressing need for well-controlled studies of the true impairment rate in these populations. Investigations on the prevalence of mild to moderate hearing impairment are especially needed.

Rationale

To prevent or reduce the debilitating effects of childhood hearing impairment, ASHA endorses an aggressive program of early identification and habilitation. Optimally, all newborn infants should receive audiologic screening to identify the majority of infants who require audiologic evaluation, follow-up, and management. At the present time, however, there are no data to indicate that newborn behavioral screening programs are sufficiently sensitive and specific (Durieux-Smith, Picton, Edwards, Goodman, & MacMurray, 1985; Feinmesser & Tell, 1976; Jacobson and Morehouse, 1984), or that evoked potential screening programs can be sufficiently low cost (Mahoney & Eichwald, 1987; Weber, 1987) to warrant mass screening. When cost-effective screening approaches are developed that are sensitive and specific, ASHA recommends evaluation of all newborn infants. In the interim, ASHA recommends audiologic screening of all infants at risk for hearing impairment.

Program Components

A successful program of early identification of hearing impairment in infants includes three components: (a) parent/caregiver education, (b) audiologic screening, and (c) evaluation, follow-up and management systems.

Parent/caregiver education. Parents/caregivers of all newborns should receive information about normal auditory and speech and language development, and should be informed of the importance of early audiologic evaluation of suspected hearing problems. They should receive information that will enhance their ability both to observe auditory and speech and language development, and to advocate prompt referral for appropriate audiologic evaluation (Elssmann et al., 1987).

Audiologic screening. All newborn infants at risk for hearing impairment by Joint Committee on Infant Hearing criteria (1982) should receive audiologic screening. Screening can occur prior to hospital discharge (Durieux-Smith et al., 1985; Galambos, Hicks & Wilson, 1982; 1984; Gorga, Reiland, Beauchaine, Worthington, & Jesteadt, 1987; Jacobson & Morehouse, 1984; Stein, Clark, & Kraus, 1983) or may be deferred until age 4 months (Alberti, Hyde, Riko, Corbin, & Fitzhardinge, 1985; Durieux-Smith, Picton, Edwards, MacMurray, & Goodman, 1987; Hyde, Riko, Corbin, Moroso, & Alberti, 1984) or even older (Mahoney & Eichwald, 1987). Screening prior to hospital discharge ensures access to all infants who are identified at risk for hearing impairment (Downs & Sterritt, 1967) and, under appropriate test conditions, does not result in a significantly higher failure rate than deferred screening (Durieux-Smith et al., 1987). Substantial loss-to-follow-up can occur if screening is deferred (Coplan, 1987; Downs & Sterritt, 1967; Mahoney & Eichwald, 1987; Stein, Clark, & Kraus, 1983). In the absence of systematic nursery-based screening programs, there are data indicating that hearing impairment is typically not identified until age 18 months and older, even for infants at risk for hearing impairment (Elssmann et al., 1987; Stein, Clark, & Kraus, 1983). Further, if screening is deferred until the infant can be tested with operant conditioning behavioral test procedures, then the goal of identification and habilitation by age 6 months cannot be met for many at-risk infants because developmental age may lag behind chronological age for premature and compromised infants. For these reasons, ASHA recommends audiologic screening prior to hospital discharge.

Screening at-risk newborns (approximately 7-12% of the newborn population) should result in earlier identification and habilitation of approximately 50-75% of hearing-impaired infants (Elssmann et al., 1987; Jacobson & Morehouse, 1984; Mahoney & Eichwald, 1987; Stein, Clark, & Kraus, 1983). It is important to recognize, however, that the remaining 25-50% of hearing-impaired infants will not receive audiologic screening in the newborn nursery and will not, therefore, be identified by these procedures.

Audiologic screening is performed by an audiologist or under the supervision of an audiologist in accordance with current standards (Committee on Audiologic Evaluation, 1987). ASHA recommends that at-risk newborns receive audiologic screening using auditory evoked potential measures prior to discharge from the newborn nursery. At the present time, auditory brainstem response (ABR) provides a reliable and valid estimate of peripheral auditory sensitivity in newborns (Galambos et al., 1982, 1984; Gorga et al., 1987; Jacobson & Morehouse, 1984; Lary, Briassoulis, de Vries, Dubowitz, & Dubowitz, 1985; Schulman-Galambos & Galambos, 1975, 1979).

In addition to technically appropriate application of the ABR test procedure, the

audiologic screening includes (a) professional interpretation of test results; (b) parent/caregiver counseling; and (c) when appropriate, guidance into an evaluation, follow-up, and management system.

Evaluation, Follow-up, and Management Systems. Development of programs for identification of hearing impairment in infants is not justified without immediate availability of an appropriate evaluation, follow-up, and management system. Definition of a specific system is outside the scope of this document. At a minimum, the system must include diagnostic and habilitative audiologic services, and general medical and otologic services as recommended by the Joint Committee on Infant Hearing (1982). These services require involvement of an interdisciplinary team.

Protocol for Audiologic Screening of At-Risk Newborn Infants

The recommended process for identification and audiologic screening of at-risk newborn infants is shown in Figure 1.

Population

ASHA recommends that all newborn infants receive evaluation for risk status by Joint Committee on Infant Hearing (1982) criteria prior to discharge from the newborn nursery (well baby nursery for healthy newborns; intensive care nursery for ill or compromised infants). Parents should receive information about expected milestones in auditory and speech-language development and should be informed of the importance of audiologic evaluation of suspected hearing problems. Those infants who have no known risk factors do not receive audiologic screening by ABR prior to discharge. An infant who exhibits abnormal auditory behavior or delayed speech and language development or whose parent/caregiver expresses concern about auditory responsiveness should receive audiologic evaluation.

Procedure

Infants at risk for hearing impairment should receive audiologic screening. The purpose of this screening is to identify those infants whose responses do not meet pass criteria and who therefore should enter an audiologic evaluation, follow-up, and management system.

The recommended procedure is ABR prior to discharge. If the infant is discharged prior to screening, or if ABR screening under audiologic supervision is unavailable, then the parent/caregiver should be informed of the importance of audiologic follow-up for the infant. The infant should be referred to an audiologist for determination of appropriate evaluation, follow-up, and management strategies.

The acoustic stimulus for ABR screening should contain energy in the frequency region important for speech recognition. Clicks are the most commonly used signal for eliciting the ABR (Committee on Audiologic Evaluation, 1987) and contain energy in the speech frequency region (Gorga, Abbas, & Worthington, 1985; Jerger & Mauldin, 1978). Other signals that may be used include tone pips or tone bursts, or clicks in the presence of masking noise.

Pass Criterion

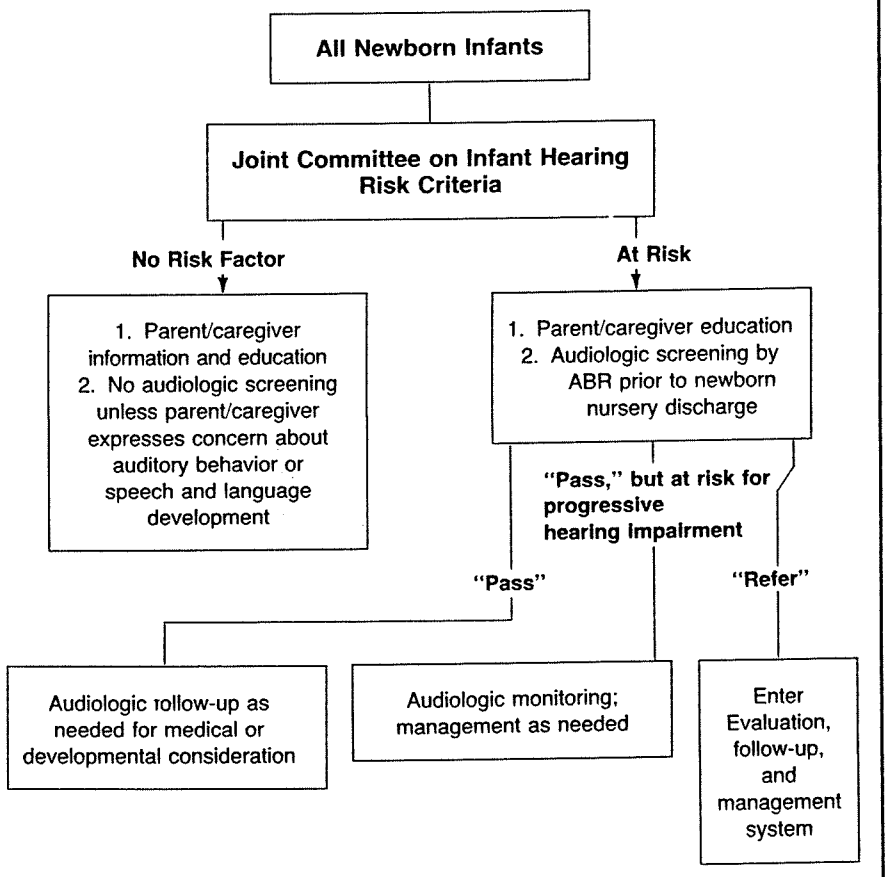
Pass criterion for ABR screening is a response from both ears at intensity levels 40db nHL or less. Infants whose responses meet this criterion should receive audiologic follow-up as necessary for medical evaluation and management and/or developmental evaluation. It is important that parents/caregivers and primary health care providers understand that "pass" on ABR screening does not rule out development of hearing impairment in infancy or early childhood (Nield, Schrier, Ramos, Platzker, & Warburton, 1986). Parents/caregivers and primary health care providers should remain vigilant to the infant's auditory behavior and speech and language development, and should be encouraged to advocate for audiologic evaluation if they are concerned about the infant's communication development.

Infants whose responses meet pass criterion and who are at risk for progressive hearing impairment should receive audiologic monitoring on a periodic basis and probably through the preschool years (Coplan, 1987). Factors that are known at the present time to place an infant at risk for progressive hearing impairment include family history of progressive hearing impairment (Konigsmark & Gorlin, 1976), congenital cytomegalovirus [(CMV) (Dahle, McCollister, Stagno, Reynolds, & Hoffman, 1979; Stagno et al., 1977)], and PPHN (Naulty et al., 1986; Sell et al., 1985).

Refer Criterion/Follow-Up

Infants who do not demonstrate responses at intensity levels 40 dB nHL or less in both ears should enter the audiologic evaluation, follow-up, and management system. Infants who demonstrate responses at 40dB nHL or less from only one ear should receive audiologic monitoring until either (a) both ears meet pass criterion or (b) stable

Figure 1



a. Pass = Response at 40dB nHL or less from both ears.
b. Refer = Failure to demonstrate response at 40dB nHL from either one or both ears.

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unilateral hearing impairment is confirmed and follow-up and management is initiated.

Comprehensive audiological evaluation may include additional evoked potential evaluation, behavioral testing, and acoustic immittance measures. These infants are also referred for medical evaluation specified by the Joint Committee on Infant Hearing (1982):

1. General physical examination and history including:
   a. Examination of the head and neck,
   b. Otoscopy and otomicroscopy,
   c. Identification of relevant physical abnormalities,
   d. Laboratory tests such as urinalysis and diagnostic tests for perinatal infections.

Habilitation of hearing-impaired infants should be initiated by age 6 months (Joint Committee on Infant Hearing, 1982). Estimates of peripheral sensitivity based on electrophysiologic procedures should be confirmed by behavioral techniques as soon as possible. Efforts to confirm electrophysiologic estimates of peripheral sensitivity may coincide with on-going habilitation. In general, precise behavioral estimates of hearing sensitivity can be obtained when the infant can respond to operant conditioning test procedures [(approximately 5-6 months developmental age) Thompson & Wilson, 1984)]. Management decisions made prior to defining the behavioral audiogram may require modification as more precise estimates of hearing sensitivity are obtained.

Summary

The importance of early identification of hearing impairment is well documented. The Joint Committee on Infant Hearing 1982 Position Statement established the goal of identification and habilitation of hearing-impaired infants by age 6 months but did not specify the procedure for initial audiologic screening. In these guidelines, ASHA specifies the recommended procedure for audiologic screening of infants at risk for hearing impairment that includes a) parent/caregiver education; b) audiologic screening by ABR; and c) referral to a comprehensive evaluation, follow-up, and management system for those infants who fail initial ABR screening. The procedures recommended in these guidelines are complex and require substantial involvement of a qualified audiologist. Identification programs should be instituted only when all components are available to provide appropriate services to the infant and his/her family. It is hoped that these guidelines will encourage implementation of programs for early identification of hearing impairment in at-risk infants.

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TESTIMONY IN SUPPORT OF H.B. 2915
Kansas House Health and Welfare Committee
February 27, 1990; Topeka, Kansas

Like most parents, my husband and I did not expect that our baby would be born with any problems. Neither were we prepared for Chris to be misdiagnosed until he was nearly 3 years old, and then to be told he was profoundly deaf. By that time, we felt great relief. We knew then that he could be helped, and so could we, once we had the right diagnosis. Those years lost can never be regained, and they are the most important ones for learning speech and language.

That was 17 years ago, before hearing tests for newborns were available. After we knew Chris was deaf, he was evaluated for a special preschool program and fitted for a hearing aid. Because of the early help we had after he was correctly diagnosed, he has been able to attend high school in his home district. Two years ago, he earned his Eagle Scout award, and he hopes to go to college. We have been very fortunate, but others have not.

When I was working on my master's degree in 1983, I did a survey of Kansas families with hearing-impaired children. I found that nearly half had gone through what we had: a long period of time when our children were either not identified, or were misidentified as having another disability. In Kansas, 82 percent of the families were first to suspect their child's hearing loss, 46 percent of the parents were not satisfied with their child's initial diagnosis, and 27 percent reported a family history of deafness -- nearly 3 times the national average for hereditary deafness. For 13 percent of the families, the length of time between suspicion and confirmation of hearing loss was more than 2 years. Most children were finally identified by age 3, although 8 percent were age 5 or older. Unfortunately, the Federal Commission on Education of the Deaf survey published in 1988 reports that nationally, the average for diagnosis of hearing loss in young children is still 2 and 1/2 years.

From our own situation with Chris, I can tell you that those years of misdiagnosis are very difficult. From my survey, I believe it may be even worse to know that your child has a problem, but you are unable to find out what it is. Comments on the survey included statements such as, "We lost 2 and 1/2 years due to the wrong diagnosis and no one would listen when we would ask why isn't he making progress." "My biggest fear was not my child being labeled but being mislabeled." "I felt lost, alone, and afraid."

As the parent representative on the Kansas Commission for the Deaf and Hearing Impaired from 1982 to 1988, I knew that situations like ours were still happening throughout Kansas. For nearly 2 years, I have worked with a committee set up by the Commission to study issues in early identification and

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intervention with hearing-impaired children and their families. Many people helped find out what screening procedures for high-risk infants and follow-up hearing evaluation and early education for families are available. To determine the status of Kansas programs, we have worked collaboratively with the Kansas Department of Health and Environment, Kansas State Department of Education, Kansas School for the Deaf, Kansas Speech-Language-Hearing Association, Kansas Educators of the Hearing Impaired, Kansas Division for Early Childhood, University of Kansas Medical Center Hearing and Speech Department, professionals, parents, and deaf adults. Because it was important to communicate our findings and develop a plan for our state, we have presented at several conventions and discussed proposed legislation. We reported about surveys showing that some areas of Kansas currently provide services to identify young hearing-impaired children, but most do not.

This is true even in Olathe, the largest concentration of the deaf community in the state. The audiologist in the public schools said last fall that after a regular preschool screening session, there were several youngsters to evaluate for hearing loss. Why? The families had been told their children were too young to test, or there was nothing to worry about -- not to be "overanxious" parents. And this is in Olathe, where awareness about deafness is probably the highest. Clearly, a state-wide program is needed for early identification of hearing-impaired children. That is why I support H.B. 2915.

The Kansas Legislature must respond to this need, so that parents will be able to find out -- even in the hospital before they go home -- if their baby is at risk for hearing problems. Then, they know what their situation is, and what to do about it. Please help Kansas set up a system to prevent what has been happening for years, to join other states across the nation who have established such a program, and thereby to get our families off to the best start they can. Thank you very much.

Marnie Campbell
Parent of a hearing-impaired son
Chair, Early Identification and Intervention Council of the
Kansas Commission for the Deaf and Hearing Impaired
3408 West 74th Street
Prairie Village, KS 66208
(913) 236-4431

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February 27, 1990

To the Members of the House Public Health and Welfare Committee,

The Kansas Educators of the Hearing Impaired come to you today to support HB2915. KEHI is a professional organization which takes an active role in advocating for Hearing Impaired Children and their families, as well as Deaf Consumer's issues. We provide inservice programs and continued professional development for our members. The membership of KEHI supports early identification and intervention services to children with hearing impairments and their families.

KEHI members encourage the support of HB2915 by the members of the House Public Health and Welfare Committee. Early intervention promotes the development of basic skills that enhance language, academic and a social functioning of children with hearing impairments. Young children with hearing impairments are better able to communicate with family, peers and teachers as well as perform higher academically when their families receive early intervention.

There are several factors that contribute to their success:

1. Parents learn about hearing impairment and as a result feel more comfortable in dealing with the loss and interacting with the child.
2. Parents are allowed to "mourn" the loss while being supported by professionals and fellow parents.
3. Children who are identified (as having a hearing loss) as close to birth as possible, begin to acquire language during the first critical years of life.
4. Parents learn how to manage hearing aids and ensure consistent amplification usage.
5. Parents learn how to enhance language development.

The earlier intervention is received, the better children with hearing impairments will perform on language, academic and social variables. Thus Early Identification is essential for any hope of normalcy.

Early Intervention <u>cannot</u> be achieved without Early Identification. In the field of deafness, a child with a severe to profound hearing loss who is identified at 30 months of age or even 24 months is considered <u>late</u>!

We hope you will support HB2915, the Early Identification of Hearing Loss Bill and "Make a Difference" in the lives of children with hearing impairments in Kansas.

Sincerely,

Tina K. Owsley

Tina K. Owsley, President

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12-A

Kansas Division for Early Childhood

Council for Exceptional Children

February 27, 1990

To the Members of the House Public Health and Welfare Committee,

The Kansas Division for Early Childhood is an affiliate of the Division for Early Childhood of the Council for Exceptional Children. KDEC provides a newsletter quarterly and a conference with professional growth opportunity annually. KDEC also advocates for young handicapped and at risk children at professional conferences across Kansas on Infants, Toddlers, and Preschool Children and their families.

As we enter the last decade of this century we must courageously take a stand to promote Early Intervention in Kansas. Only with Early Intervention can "our children" develop the personal and social freedom and experience independent participation in all aspects of life enjoyed by their non-handicapped peers.

We would like to take the opportunity today to speak in support of HB2915: Infant Hearing Screening. Infant hearing screening must become an established reality!

Hearing loss causes profound disorders of language development. If undetected in infancy, spontaneous language is not developed and the parents and child spend the educational years in grueling therapeutic language work. Language development for the hearing impaired child is often remedial in nature due to a delay between the time a hearing loss is suspected and the time it is detected. It is often further delayed by the time lost before intervention begins.

You can promote natural language development for hearing impaired children by eliminating the time lost due to late identification of hearing loss in children. We encourage your support of HB2915.

Sincerely,

Tina K. Owsley

Tina K. Owsley, President

Valerie McNay, Vice-President

PH&W 2-27-90

Attm # 12-B

KANSAS HOSPITAL ASSOCIATION

Memorandum

Donald A. Wilson
President

February 26, 1990

TO: House Public Health and Welfare Committee

FROM: Kansas Hospital Association

RE: House Bill 2915

The Kansas Hospital Association appreciates the opportunity to comment regarding H.B. 2915. This bill would establish an early intervention screening program to identify infants who are at risk of being hearing impaired.

We recognize that the literature suggests such screening programs can be helpful in identifying hearing impaired infants. In addition, it is clear that the sooner such discoveries are made, the better chance those infants have of receiving effective medical help for their condition.

In light of these facts, Kansas hospitals are willing to cooperate in an efficient and effective program to provide such screening.

In developing new programs such as the one in H.B. 2915, the emphasis must be on ensuring effectiveness of the screening process, while making it as efficient as possible. At a time when medical assistance budgets are being cut, lawmakers should be careful not to create new cost and liability burdens on the state's health care providers. In order to promote this efficiency, we have attached several suggested amendments for the committee's consideration.

Thank you for your consideration of our comments.

/cdc

Attachment

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Attm #13

1263 Topeka Avenue • P.O. Box 2308 • Topeka, Kansas 66601 • (913) 233-7436 • FAX (913) 233-6955

HOUSE BILL No. 2915

By Representatives Brown, Blumenthal, Pottorff and Snowbarger

2-7

AN ACT concerning hearing-impaired infants; establishing a program of hearing impairment identification; providing for administration of the program by the secretary of health and environment.

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

Section 1. As used in this act: (a) "Hearing-impaired infant" means an infant who has an impairment that is a dysfunction of the auditory system of any type or degree which is sufficient to interfere with the acquisition and development of speech and language skills with or without the use of sound amplification.

(b) "High-risk infant" means a child at birth who is at a higher risk than normal of being hearing impaired.

(c) "Followup hearing evaluation" means determination of the presence of hearing impairment through the application of audiological tests.

(d) "Infant" means a child under one year of age.

(e) "Medical care facility" means a medical care facility as defined under K.S.A. 65-425 and amendments thereto.

(f) "Physician" means a person licensed to practice medicine and surgery.

(g) "Program" means the program that the secretary, with the assistance of the Kansas commission for the deaf and hearing impaired, establishes to provide for the early identification of hearing impaired infants and high-risk infants.

(h) "Risk screening" means the identification of infants who are at risk for hearing impairment, through the use of a questionnaire developed by the secretary with the assistance of the Kansas commission for the deaf and hearing impaired.

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

Sec. 2. (a) The secretary shall establish a program for the early identification of hearing-impaired infants and high-risk infants. The secretary, after consultation with the Kansas commission for the deaf and hearing impaired, shall establish by rules and regulations newborn infant hearing-impaired risk criteria and shall develop a questionnaire to identify high-risk infants. (Such questionnaire shall be one that can normally be completed quickly and easily during the course of the delivery and care of a newborn infant in a medical care facility.

(b) The secretary, after consultation with the Kansas commission for the deaf and hearing impaired, shall adopt rules and regulations as part of the program established under subsection (a) that requires risk screening of each infant in a medical care facility nursery to determine if the infant meets the hearing-impairment risk criteria established by the secretary under subsection (a). ----------newborn

Sec. 3. (a) Each medical care facility, in accordance with rules and regulations adopted under section 2 and amendments thereto, shall provide risk screening of newborn infants and shall notify promptly the parent or guardian of any infant who is identified by a risk screening as a high-risk infant. In addition, the medical care facility shall notify the infant's primary care physician and the secretary of the name of any infant who is identified by a risk screening as a high-risk infant under criteria established by the secretary under section 2 and amendments thereto and of the name and address of the infant's parent or guardian and the risk factors present. ----------newborn ----------newborn

~~(b) Each medical care facility shall provide to the parents or guardian of an infant identified by a risk screening as a high-risk infant a list of medical care facilities, clinics or other facilities located within a reasonable distance of the parents' or guardian's address that provide followup hearing evaluation.~~ } strike

(b) ~~(c)~~ Information reported to the secretary under this section shall not be required to be reported under K.S.A. 1989 Supp. 65-1,142 and amendments thereto.

Sec. 4. The secretary, after consultation with the Kansas commission for the deaf and hearing impaired, shall prepare and distribute to all medical care facilities required to provide infant risk screenings under section 3 and amendments thereto ~~information describing factors or conditions of hearing loss and the affect of such a loss on an infant or child's language development.~~ Upon the discharge of a hearing-impaired or high-risk infant, each such medical care facility shall provide the infant's parent or guardian with this ~~hearing loss~~ information. This information shall be updated as the secretary determines necessary, with the advice of the Kansas commission for the deaf and hearing impaired. ----------(the following information: (1) a description of the (factors or conditions of hearing loss and the effect (of such a loss on an infant or child's language develop- (ment; and (2) a listing of medical care facilities, (clinics or other facilities in this state that provide (follow-up hearing evaluation.

Sec. 5. (a) The secretary shall establish the newborn infant hearing-impairment risk criteria and questionnaire required by subsection (a) of section 2 and amendments thereto within 120 days after the effective date of this act. The secretary shall adopt rules and regulations to establish the risk screening program required under section 2 and amendments thereto no later than November 30, 1990. The secretary, prior to January 1, 1991, shall prepare and distribute to all medical care facilities that are required to provide infant risk

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screenings under section 2 and amendments thereto, the information required by section 4 and amendments thereto. The medical care facilities shall provide this information to parents of newborn infants discharged on and after January 1, 1991.

(b) In administering the provisions of the program established under this act, the secretary shall:

(1) Develop a system to gather and maintain data, including a statewide registry to include, but not be limited to, the identification of high-risk infants;

(2) develop methods to contact parents or guardians of high-risk infants and to refer the parents or guardians to appropriate services;

(3) enter into contracts which may be necessary to administer the program;

(4) adopt rules and regulations as necessary to implement the program; and

(5) take such other action as may be necessary in the administration of the program.

Sec. 6. Any person or entity who reports in good faith and without malice, or who in good faith and without malice fails to report, the information required to be reported under this act shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed in an action resulting from such report. Any such person or entity shall have the same immunity with respect to participation in any judicial proceeding resulting from such report.

Sec. 7. (a) Information obtained by the secretary under this act is confidential and shall not be disclosed except as provided in this section.

(b) The secretary may disclose information obtained under this act: (1) Upon consent, in writing, of the person who is the subject of the information, or if such person is under 18 years of age, by such person's parent or guardian; or (2) upon the request of an organization or individual conducting a scholarly investigation for legitimate research or data collection purposes, so long as such information is disclosed in a manner which will not reveal the identity of the persons who are the subject of the information or the identity of the officer or employee of the medical care facility reporting such information.

(c) The secretary may disclose information obtained under this act to officers and employees of the department of education who are designated by the state board of education to receive such information. Officers and employees of the department of education who receive such information shall be subject to the same degree of confidentiality as the secretary with respect to such information.

(d) The secretary shall remove the records of a child whose parents or guardian request in writing such action.

Sec. 8. Any person, association, firm, corporation, organization or other agency willfully or knowingly permitting or encouraging the disclosure of information obtained under this act and not otherwise authorized to be disclosed under this act shall be guilty of a class C misdemeanor.

Sec. 9. Nothing in this act shall be construed or operate to empower or authorize the secretary to restrict in any manner the right of a physician or other health care professional to recommend a mode of treatment for hearing impairment or to restrict in any manner an individual's right to select the mode of treatment of such individual's choice.

Sec. 10. This act shall take effect and be in force from and after its publication in the statute book.

Passed
2-27-90
Attn: 4-13-90

Lori M.

State of Kansas
Mike Hayden, Governor

Department of Health and Environment
Division of Health

Stanley C. Grant, Ph.D., Secretary

Landon State Office Bldg., Topeka, KS 66612-1290

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Testimony presented to

House Public Health and Welfare Committee

by

The Kansas Department of Health and Environment

House Bill 2915

Congenital hearing impairment/deafness is most often a hidden disability. It can, unfortunately, remain undetected beyond the child's first, third and even fourth birthday. The severity of the problems resulting from hearing loss increases the longer the disability remains undetected. As noted in Promoting Health/Preventing Disease: Year 2000 Objectives for the Nation, "The ramifications of auditory handicaps are seen in developmental, educational, cognitive and emotional aspects of human life. Language delay and poor understanding of spoken speech...are invisible barriers that can be insurmountable for people with hearing impairments without early diagnosis and...support services."[1] To have a hearing loss go undetected is especially tragic since there are procedures available to help identify hearing loss even in newborns. We do not need to wait a year or several years. We do not need to wait until this hidden disorder becomes obvious to everyone because of severe delay in language development.

In 1986 Congress passed P.L. 99-457, the Education of the Handicapped Act Amendments,[2] that states "there is an urgent and substantial need...to minimize the potential for developmental delay." One of the key goals of P.L. 99-457 Part H, which pertains to Handicapped Infants and Toddlers, is the early identification of handicapping conditions and developmental delays. Hearing loss and speech-language delays and disorders are two of the targeted areas in this law. The early identification of hearing impairments and subsequent early intervention during the critical language acquisition stage result in: 1) reductions in the need for special education; 2) eventual increase in employment and earnings; 3) a decrease in dependence on governmental assistance programs; and 4) enriched educational attainment and lifestyle. Dollar savings can be estimated for some of these areas. No dollar values can be placed on other of these outcomes. However, hearing impaired/deaf persons, their families, and the taxpayers all gain from the early identification and intervention of hearing impairment.

Former Surgeon General C. Everett Koop, in his position paper Early Identification of Hearing Problems in Children Essential (see attachment) stated a national goal: that no child should reach the first birthday with an undetected hearing impairment. To attain this goal, he called on State agencies to help by initiating high risk screening programs for infants.[3]

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James Power, P.E., Director of Environment (913) 296-1535

Lorne Phillips, Ph.D., Director of Information Systems (913) 296-1415

Roger Carlson, Ph.D., Director of the Kansas Health and Environmental Laboratory (913) 296-1619

While incidence figures vary, it is estimated that one infant in 500 live births has a mild to severe sensorineural hearing loss and one in 1000 live births has a profound sensorineural hearing loss. The incidence of hearing loss in infants in neonatal intensive care units (NICU) increases sharply, with figures ranging from one in 25 to one in 50 births. This identification of high risk factors (such as prolonged stays in the NICU, and family history of congenital hearing loss) provides the opportunity to increase the early identification of hearing impairment. Approximately 10% of infants can be identified as high risk for hearing impairment. Of this high risk population, statistically 2.5% will have a hearing loss. Based on the 1988 figure of 37,574 live births in Kansas hospitals, 3757 infants would have been identified as high-risk for hearing impairment (10%), and 94 of those infants (2.5% of high-risk), statistically, would have a hearing loss.

At present, Kansas does not have a program in place for the early identification of infants at risk for hearing impairments. Having such a program in place would provide the opportunity for greater attention to the need for: 1) informational materials to families concerning the ramifications of hearing loss; 2) follow-up hearing assessment procedures to determine the presence of a hearing loss as soon as possible; 3) early intervention programs for the infant's language, speech, and psycho-social development, use of residual hearing, and other areas of need.

HB 2915 proposes a Kansas program to screen infants for high risk for hearing impairment. This program would be of greater long term benefit if it included follow-up of high risk infants to identify those with hearing impairments. With follow-up services, the opportunity is presented to develop early intervention programs appropriate for the needs of the hearing impaired infants and their families.

HB 2915 cannot be effective without adequate start up and maintenance funding. This bill was developed after the Department of Health and Environment's 1991 budget was developed. KDHE supports in concept the early identification of infants at risk for hearing loss, follow-up assessment to determine the presence of hearing loss, and early intervention for hearing impaired children to ameliorate problems and prevent an increase in the severity of these problems. However, no funds for the initiation of this proposed program are included in the Governor's Budget for the Department of Health and Environment and the agency can not support its funding for FY 1991.

Testimony presented by: Lorraine I. Michel, Ph.D.
Coordinator, Speech-Language-Hearing-Vision
Bureau of Family Health
Kansas Department of Health and Environment
February 27, 1990

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Bibliography

1. Promoting Health/Preventing Disease: Year 2000 Objectives for the Nation. Draft for Public Review and Comment; Public Health Service; U.S. Department of Health and Human Services; September 1989, p 17-4.

2. Public Law 99-457, Part H -- Handicapped Infants and Toddlers; Section 671. (a) (1).

3. Koop, C. Everett. Early Identification of Hearing Problems in Children Essential. Department of Health and Human Services, 1989.

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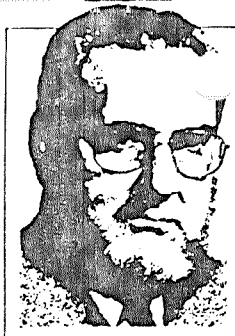

FROM THE SURGEON GENERAL OF THE U.S. PUBLIC HEALTH SERVICE

C. Everett Koop, M.D.

Department of Health and Human Services

Early Identification of Hearing Problems in Children Essential

The harmful effects of childhood deafness are given little thought by many people because deafness is largely an invisible handicap. Most deaf infants are otherwise healthy-looking babies who develop relatively normally during the first year of life. But if deafness is not discovered in that first year . . . and the earlier the better . . . it can interfere tragically with the ability to learn to speak, to do well in school and to contribute productively to society. Helen Keller, who was born without sight or hearing, observed that she regretted her deafness more than her blindness.

Deafness in infants is a serious concern because it interferes with the development of language—that which sets humans apart from all other living things. The longer a child's deafness goes undiscovered, the worse the outcome is likely to be. Language remediation, which is what specialists call the process of teaching hearing impaired children to communicate, must begin as early as possible, because language develops so rapidly in the first few months of life. For example, by six weeks, a normally hearing infant is more attracted to human speech than to any other sound. A six-month-old baby already has an ability to analyze language—to break it down into its parts—to put those parts back together again and to store language in its brain and retrieve it. By 18 months, most children are producing simple sentences.

Fortunately, many of the negative results of deafness in babies can be prevented or substantially lessened. Many research studies have demonstrated that early intervention with hearing impaired children results in improved language development, increased academic success and increased lifetime earnings. Early intervention actually saves money, since hearing-impaired children who receive early help require less costly special education services later.

If it is to be effective, early intervention with deaf children should begin before the child's first birthday. Unfortunately, we are not doing very good job of detecting infant deafness in the United States. A recent report to Congress and the President by the Commission on Education of the Deaf pointed out that the average age at which profoundly deaf children in this country are identified is 2½ years. In contrast, the average age at which such children are identified in Israel and Great Britain is 7 to 9 *months*.

Clearly, we must do a much better job of early identification if we are to reduce the unnecessary suffering, poor educational performance and lack of productivity that so often accompany deafness. Three groups of people must work together.

Parents are in the best position to identify their child's hearing difficulties. We need to do a better job of making parents aware of the danger signals and of the sources of help that are available to them.

Physicians need to become more responsive to parents' concerns about their child's hearing. Too often, those concerns are brushed aside or ignored. Yet, a recent study found that parents of hearing-impaired children knew about their baby's hearing loss an average of seven months before it was diagnosed and that almost half of them were given poor advice, such as "don't worry about it" or "wait until the child starts school," when they told their doctors about their concerns.

State agencies can help by initiating high-risk screening programs, such as those currently in operation in Utah, Colorado, Oklahoma, Tennessee and several other states. Research indicates that such programs are able to identify up to 75 percent of infants who are born deaf or with hearing impairments.

Many others can help, too, of course, from older brothers and sisters to grandparents and baby sitters. We in the federal government are committed to doing our part. The 1986 Education of the Deaf Act, which authorized the creation of the Commission on the Education of the Deaf, was a first step. At the National Institutes of Health, a new research institute, the National Institute of Deafness and Communication Disorders, has been authorized and is now in formation.

I am optimistic. I foresee a time in this country, in the near future, in fact, when no child reaches his or her first birthday with an undetected hearing impairment. It's a tall order, yes, but if we all work together, I believe we can fill it.

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TESTIMONY IN SUPPORT OF HB 2915: TO ESTABLISH A PROGRAM FOR EARLY IDENTIFICATION OF HEARING IMPAIRMENTS

By Valerie J. McNay, Vice President
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The KANSAS DIVISION FOR EARLY CHILDHOOD (KDEC) is an organization representing many disciplines and approximately 800 members. We are an adovocacy group that is dedicated to working for comprehensive services for all special needs or disabled children and their families from birth through five years who reside in Kansas.

Did you know that there are a number of different testing techniques valuable in screening, testing and assessing hearing in infants and young children? Behavioral observation audiometry (BOA), visual reinforcement audiometry (VRA), auditory brainstem response testing (ABR) and the Crib-O-Gram are highly beneficial in the detection of hearing loss in very young children. I ask this question because most parents, physicians and professionals do not seem to be aware of this fact. In the Stanford University nurseries, it was possible in 1978 to estimate the presence or absence of even a mild hearing loss with at least 95% accuracy in 90% of the babies who have reached 7 months of age. Unfortunately, there is often an extensive delay in identifying hearing-impaired children. There seems to be a reluctance by physicians to refer young children for evaluations by pediatric audiologists and otologists. One recent study indicated that physicians delayed in referring children for audiologic evaluation an average of 7.8 months after parents first expressed concern about their children's hearing. The problem is compounded for children with developmental disabilities. Data indicate that between 32% and 78% of these children also have some degree of hearing loss.

Hearing loss in infants is one of the most common disabilities in the U.S. Mild to severe sensorineural hearing loss is reported to occur in 1 in 380 to 750 births while profound deafness occurs in 1 in 1,000 births. In graduates of neonatal intensive care units (NICU) hearing loss is present in 1 in 25 to 50. With the exception of NICU infants, it may appear that the incidence figures do not justify efforts to screen for hearing loss in the general population (which is beyond the scope of this bill which deals with high risk infants; though I must admit that I would like to see this kind of bill expanded in the future to include hearing and vision testing for all newborns; for the committee members information we do have a tool for testing vision in newborns as well). In comparison with other screening procedures however, these incidence figures for hearing impairment are relatively high. For example, in screening for metabolic disorders in infants, the incidence of PKU is 1 in 16,500; in galactosemia 1 in 85,000; and in hypothyroidism 1 in 5,750.

In 1972 (with modifications in 1982), the Joint Committee on Infant Hearing (composed of representatives from the American Academy of Pediatrics, the Academy of Otolaryngology--Head and Neck Surgery, the American Nurses' Association and the American Speech-Langauge and Hearing Association) recommended peforming hearing screenings on at least those infants who were at high risk for hearing impairment and the initiation of habilitation by 6 months of age.

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The national average for identification of deafness is between 2 1/2 and 3 years of age. In a 1983-1984 survey of all educational programs serving

hearing impaired children in the U.S., only 4% of the children were younger than 3 years of age; 10% were older than 3 but younger than 6 years of age. The under-representation of children at the youngest ages reflects both a paucity of educational programs for children below the age of 3 and the difficulties of achieving early diagnosis.

The basic premise underlying the rationale for early detection of hearing loss is that such identification results in early intervention. The child who is identified as being hearing impaired in the first year of life will presumably have better linguistic and learning skills with appropriate intervention than the child who is identified at 3 to 4 years of age. Obviously, reduced ability to hear adversely affects the development of speech and language skills. The concept of a "critical period" for language acquisition is considered by many to be the basis for early intervention efforts. As a speech pathologist, I can testify that communication and language-learning begins at birth not when the child produces her first at 15-18 months of age. Efforts to teach language to older hearing impaired children is generally met with limited success. It is logical to begin intervention strategies early in teh critical period of language acquisition to augment the natural process. Even children with mild hearing loss and no other handicapping condition frequently dispaly communciative and academic problems. The impetus for early intervention is further derived from the reports that early hearing loss has a substantial impact on emotional, intellectual and social development.

Detecting a hearing loss is only the first step. Follow-up, medical intervention, surgical and prosthetic intervention, hearing aids, FM systems and other appropriate habilitation programs should be implemented within a few weeks of the time the loss is identified. While delay in diagnosis of hearing loss is tragic in all cases, it is even worse knowing that the data continues to indicate that in spite of early detection, hearing aids and other forms of habilitation are not initiated until the child is almost 2 years old! To identify an infant as being hearing impaired and not intervene until the child is 1 1/2 to 2 years of age is unacceptable.

Approximately 65% of all hearing impaired children will qualify for a hearing screening with the high risk register that is proposed in this bill. The remaining 35% will need to be identified by informed and astute parents, physicians and other professionals. The informational/educational component of this bill will hopefully help regions in Kansas to do a better job of referring children for hearing testing. Many pediatric hearing losses occur as a result of diseases such as menengitis and other factors. So even if a child initially passes a hearing screening, she may develop a hearing loss that may go undetected for a long period of time. A "wait-and-see" approach to the child whose parents raise questions regarding her hearing or speech is not appropriate. If anyone questions the hearing of an infant, testing should be initiated as soon as possible.

Kansas needs to take this important first step of establishing a program of hearing impairment identification. Such legislation will help assure that more children will have the opportunity to become all that they are capable of becoming.

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Attached: ASHA Guidelines on "Audiological Screening of Newborn Infants who are At Risk for Hearing Impairment" March 1989, ASHA Magazine

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Audiologic Screening of Newborn Infants Who Are At Risk for Hearing Impairment

committee concluded that (a) all newborn infants who are at risk for hearing impairment should be identified, (b) infants identified at risk should receive audiologic screening by auditory evoked potentials prior to hospital discharge, and (c) those infants who fail initial audiologic screening or who fail to be screened should enter an audiologic evaluation, follow-up, and management system.

The purpose of this report is to set forth guidelines for the establishment of auditory screening programs for newborn infants who are at risk for hearing impairment.

Guidelines for audiometric evaluation, follow-up, and management of hearing-impaired infants will be considered in forthcoming activities of the Committee on Infant Hearing.

Definitions

Infants at risk: Infants who fall into one or more of the seven risk criteria identified in the 1982 position statement of the Joint Committee on Infant Hearing (1982) are considered at risk for hearing impairment and should receive audiologic screening.[1] The factors are:

1. A family history of childhood hearing impairment.
2. Congenital perinatal infection (e.g., cytomegalovirus (CMV), rubella, herpes, toxoplasmosis, syphilis).
3. Anatomic malformation involving the head or neck (e.g., dysmorphic appearance including syndromal and nonsyndromal abnormalities, overt or submucous cleft palate, morphologic abnomalities of the pinna).
4. Birthweight less than 1500 grams.
5. Hyperbilirubinemia at level exceeding indications for exchange transfusion.
6. Bacterial meningitis, especially H. influenza.
7. Severe asphyxia which may include infants with Apgar scores of 0-3 who fail to institute spontaneous respiration by 10 minutes and those with hypotonia persisting to two hours of age (Joint Committee on Infant Hearing, 1982).

For a more complete review of these risk criteria and their relation to hearing impairment, see Gerkin (1984).

Hearing impairment: Bilateral conductive and/or sensori-neural deficit in the frequency region important for speech recognition (approximately 1000 through 4000 Hz). Hearing impairment is defined as deficit in auditory sensitivity that interferes with speech recognition and for which intervention strategies are known and available.

The impact of childhood hearing impairment on speech and language development and academic achievement is well documented (Allen, 1986; Osberger, 1986). In general, hearing-impaired children demonstrate limited speech production skills (Osberger, Robbins, Lybolt, Kent, & Peters, 1986), significantly delayed receptive and expressive language skills (Moeller, Osberger, & Eccarius, 1986; Osberger, Moeller, Eccarius, Robbins, & Johnson, 1986), and reduced academic achievement, especially in language-related areas (Allen, 1986). To minimize these debilitating effects, professionals have urged early identification and habilitation of infants with hearing impairment. Efforts in both the public and private sector have been undertaken to develop screening, diagnostic, and habilitation programs to meet these goals.

In the public sector, passage of Public

[1]Investigators have also recommended audiologic screening of infants who manifest other health factors. These factors include: a) parent consanguinity (Coplan, 1987; Feinmesser & Tell, 1976), b) severe neonatal sepsis (Feinmesser & Tel, 1976), c) persistent pulmonary hypertension of the newborn [(PPHN) (Naulty, Weiss & Herer, 1986; Sell, Gaines, Gluckman, & Williams, 1985)], and d) length of stay in the intensive care nursery and gestational age (Halpern, Hosford-Dunn, & Malachowski, 1987). Some investigators have also advocated audiologic screening of all infants in neonatal intensive care units (Galambos, Hicks, & Wilson, 1984; Jacobson & Morehouse, 1984). In future risk registries, these additional factors and recommendations may be included. At this time, ASHA recommends, at a minimum, use of the Joint Committee on Infant Hearing 1982 risk criteria pending update of the register.

Law 99-457, the Educaton of the Handicapped Amendment of 1986, created (in part) a new discretionary program to address the special needs of handicapped infants and toddlers from birth through 2 years of age and their families. By 1990-91, each state that wants to continue receiving federal financial assistance under the birth-through-2 program must have in place a policy to provide early intervention services to all handicapped infants and toddlers. Some components of this program include development of a Child Find system, referral to service providers, research and demonstration projects, and a comprehensive system of personnel development. Provision of services must be by qualified personnel meeting the highest state standards established for employment in each profession or discipline.

In the private sector, representatives from audiology and speech-language pathology, otolaryngology, pediatrics, and nursing have participated in a Joint Committee on Infant Hearing which, over the years, has developed a series of position papers. The most recent position paper (Joint Committee on Infant Hearing, 1982) states that "early detection of hearing impairment in the affected infant is important for medical treatment and subsequent educational intervention to assure development of communication skills." The Joint Committee recommended that infants at risk for hearing impairment be identified and that they receive appropriate evaluation and treatment.

Reliable data on incidence of significant hearing impairment in infants and young children are unavailable (Hotchkiss, 1987; Ries, 1986). National statistics indicate that approximately 3.7 million children are born in the United States each year (Wegman, 1987). Investigators estimate that 7 - 12% of all newborns are at risk for hearing impairment (Feinmesser & Tell, 1976; Jacobson & Morehouse, 1984; Mahoney & Eichwald, 1987). Moderate to profound hearing impairment is reported present in less than 2% to more than 4% of at-risk infants (Galambos et al., 1984; Jacobson & Morehouse, 1984; Mahoney and Eichwald, 1987; Stein, Ozdamar, Kraus, & Paton, 1983; Hosford-Dunn, Johnson, Simmons, Malachowski, & Low, 1987). Prevalence of milder degrees of hearing impairmnt in this population is unknown. Retrospective studies have shown that between 50 and 75% of hearing-impaired children were positive for at least one of the Joint Committee's risk criteria (Elssmann, Matkin, & Sabo, 1987; Feinmesser & Tell, 1976; Stein, Clark & Kraus, 1983).

In addition to infants who are at risk, infants with no known risk factors may have or develop hearing impairment (Feinmesser & Tell, 1976; Simmons, 1980). Prevalence of significant hearing impairment, including mild to moderate hearing impairment, for this population is not well defined.

The dearth of data on the prevalence of hearing impairment in both at-risk newborns and newborns with no known risk factors demonstrates the pressing need for well-controlled studies of the true impairment rate in these populations. Investigations on the prevalence of mild to moderate hearing impairment are especially needed.

Rationale

To prevent or reduce the debilitating effects of childhood hearing impairment, ASHA endorses an aggressive program of early identification and habilitation. Optimally, all newborn infants should receive audiologic screening to identify the majority of infants who require audiologic evaluation, follow-up, and management. At the present time, however, there are no data to indicate that newborn behavioral screening programs are sufficiently sensitive and specific (Durieux-Smith, Picton, Edwards, Goodman, & MacMurray, 1985; Feinmesser & Tell, 1976; Jacobson and Morehouse, 1984), or that evoked potential screening programs can be sufficiently low cost (Mahoney & Eichwald, 1987; Weber, 1987) to warrant mass screening. When cost-effective screening approaches are developed that are sensitive and specific, ASHA recommends evaluation of all newborn infants. In the interim, ASHA recommends audiologic screening of all infants at risk for hearing impairment.

Program Components

A successful program of early identification of hearing impairment in infants includes three components: (a) parent/caregiver education, (b) audiologic screening, and (c) evaluation, follow-up and management systems.

Parent/caregiver education. Parents/caregivers of all newborns should receive information about normal auditory and speech and language development, and should be informed of the importance of early audiologic evaluation of suspected hearing problems. They should receive information that will enhance their ability both to observe auditory and speech and language development, and to advocate prompt referral for appropriate audiologic evaluation (Elssmann et al., 1987).

Audiologic screening. All newborn infants at risk for hearing impairment by Joint Committee on Infant Hearing criteria (1982) should receive audiologic screening. Screening can occur prior to hospital discharge (Durieux-Smith et al., 1985; Galambos, Hicks & Wilson, 1982; 1984; Gorga, Reiland, Beauchaine, Worthington, & Jesteadt, 1987; Jacobson & Morehouse, 1984; Stein, Clark, & Kraus, 1983) or may be deferred until age 4 months (Alberti, Hyde, Riko, Corbin, & Fitzhardinge, 1985; Durieux-Smith, Picton, Edwards, MacMurray, & Goodman, 1987; Hyde, Riko, Corbin, Moroso, & Alberti, 1984) or even older (Mahoney & Eichwald, 1987). Screening prior to hospital discharge ensures access to all infants who are identified at risk for hearing impairment (Downs & Sterritt, 1967) and, under appropriate test conditions, does not result in a significantly higher failure rate than deferred screening (Durieux-Smith et al., 1987). Substantial loss-to-follow-up can occur if screening is deferred (Coplan, 1987; Downs & Sterritt, 1967; Mahoney & Eichwald, 1987; Stein, Clark, & Kraus, 1983). In the absence of systematic nursery-based screening programs, there are data indicating that hearing impairment is typically not identified until age 18 months and older, even for infants at risk for hearing impairment (Elssmann et al., 1987; Stein, Clark, & Kraus, 1983). Further, if screening is deferred until the infant can be tested with operant conditioning behavioral test procedures, then the goal of identification and habilitation by age 6 months cannot be met for many at-risk infants because developmental age may lag behind chronological age for premature and compromised infants. For these reasons, ASHA recommends audiologic screening prior to hospital discharge.

Screening at-risk newborns (approximately 7-12% of the newborn population) should result in earlier identification and habilitation of approximately 50-75% of hearing-impaired infants (Elssmann et al., 1987; Jacobson & Morehouse, 1984; Mahoney & Eichwald, 1987; Stein, Clark, & Kraus, 1983). It is important to recognize, however, that the remaining 25-50% of hearing-impaired infants will not receive audiologic screening in the newborn nursery and will not, therefore, be identified by these procedures.

Audiologic screening is performed by an audiologist or under the supervision of an audiologist in accordance with current standards (Committee on Audiologic Evaluation, 1987). ASHA recommends that at-risk newborns receive audiologic screening using auditory evoked potential measures prior to discharge from the newborn nursery. At the present time, auditory brainstem response (ABR) provides a reliable and valid estimate of peripheral auditory sensitivity in newborns (Galambos et al., 1982, 1984; Gorga et al., 1987; Jacobson & Morehouse, 1984; Lary, Briassoulis, de Vries, Dubowitz, & Dubowitz, 1985; Schulman-Galambos & Galambos, 1975, 1979).

In addition to technically appropriate application of the ABR test procedure, the

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audiologic screening includes (a) professional interpretation of test results; (b) parent/caregiver counseling; and (c) when appropriate, guidance into an evaluation, follow-up, and management system.

Evaluation, Follow-up, and Management Systems. Development of programs for identification of hearing impairment in infants is not justified without immediate availability of an appropriate evaluation, follow-up, and management system. Definition of a specific system is outside the scope of this document. At a minimum, the system must include diagnostic and habilitative audiologic services, and general medical and otologic services as recommended by the Joint Committee on Infant Hearing (1982). These services require involvement of an interdisciplinary team.

Protocol for Audiologic Screening of At-Risk Newborn Infants

The recommended process for identification and audiologic screening of at-risk newborn infants is shown in Figure 1.

Population

ASHA recommends that all newborn infants receive evaluation for risk status by Joint Committee on Infant Hearing (1982) criteria prior to discharge from the newborn nursery (well baby nursery for healthy newborns; intensive care nursery for ill or compromised infants). Parents should receive information about expected milestones in auditory and speech-language development and should be informed of the importance of audiologic evaluation of suspected hearing problems. Those infants who have no known risk factors do not receive audiologic screening by ABR prior to discharge. An infant who exhibits abnormal auditory behavior or delayed speech and language development or whose parent/caregiver expresses concern about auditory responsiveness should receive audiologic evaluation.

Procedure

Infants at risk for hearing impairment should receive audiologic screening. The purpose of this screening is to identify those infants whose responses do not meet pass criteria and who therefore should enter an audiologic evaluation, follow-up, and management system.

The recommended procedure is ABR prior to discharge. If the infant is discharged prior to screening, or if ABR screening under audiologic supervision is unavailable, then the parent/caregiver should be informed of the importance of audiologic follow-up for the infant. The infant should be referred to an audiologist for determination of appropriate evaluation, follow-up, and management strategies.

The acoustic stimulus for ABR screening should contain energy in the frequency region important for speech recognition. Clicks are the most commonly used signal for eliciting the ABR (Committee on Audiologic Evaluation, 1987) and contain energy in the speech frequency region (Gorga, Abbas, & Worthington, 1985; Jerger & Mauldin, 1978). Other signals that may be used include tone pips or tone bursts, or clicks in the presence of masking noise.

Pass Criterion

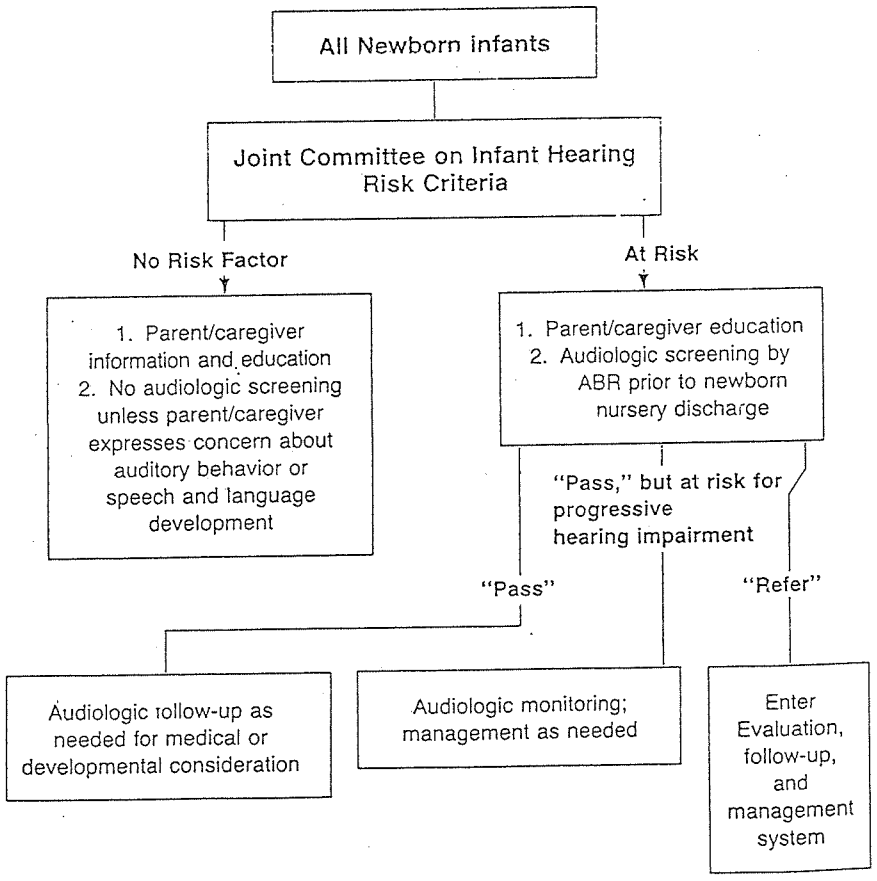
Pass criterion for ABR screening is a response from both ears at intensity levels 40db nHL or less. Infants whose responses meet this criterion should receive audiologic follow-up as necessary for medical evaluation and management and/or developmental evaluation. It is important that parents/caregivers and primary health care providers understand that "pass" on ABR screening does not rule out development of hearing impairment in infancy or early childhood (Nield, Schrier, Ramos, Platzker, & Warburton, 1986). Parents/caregivers and primary health care providers should remain vigilant to the infant's auditory behavior and speech and language development, and should be encouraged to advocate for audiologic evaluation if they are concerned about the infant's communication development.

Infants whose responses meet pass criterion and who are at risk for progressive hearing impairment should receive audiologic monitoring on a periodic basis and probably through the preschool years (Coplan, 1987). Factors that are known at the present time to place an infant at risk for progressive hearing impairment include family history of progressive hearing impairment (Konigsmark & Gorlin, 1976), congenital cytomegalovirus [(CMV) (Dahle, McCollister, Stagno, Reynolds, & Hoffman, 1979; Stagno et al., 1977)], and PPHN (Naulty et al., 1986; Sell et al., 1985).

Refer Criterion/Follow-Up

Infants who do not demonstrate responses at intensity levels 40 dB nHL or less in both ears should enter the audiologic evaluation, follow-up, and management system. Infants who demonstrate responses at 40dB nHL or less from only one ear should receive audiologic monitoring until either (a) both ears meet pass criterion or (b) stable

Figure 1



a. Pass = Response at 40dB nHL or less from both ears.
b. Refer = Failure to demonstrate response at 40dB nHL from either one or both ears.

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unilateral hearing impairment is confirmed and follow-up and management is initiated.

Comprehensive audiological evaluation may include additional evoked potential evaluation, behavioral testing, and acoustic immittance measures. These infants are also referred for medical evaluation specified by the Joint Committee on Infant Hearing (1982):

1. General physical examination and history including:
   a. Examination of the head and neck,
   b. Otoscopy and otomicroscopy,
   c. Identification of relevant physical abnormalities,
   d. Laboratory tests such as urinalysis and diagnostic tests for perinatal infections.

Habilitation of hearing-impaired infants should be initiated by age 6 months (Joint Committee on Infant Hearing, 1982). Estimates of peripheral sensitivity based on electrophysiologic procedures should be confirmed by behavioral techniques as soon as possible. Efforts to confirm electrophysiologic estimates of peripheral sensitivity may coincide with on-going habilitation. In general, precise behavioral estimates of hearing sensitivity can be obtained when the infant can respond to operant conditioning test procedures [(approximately 5-6 months developmental age) Thompson & Wilson, 1984)]. Management decisions made prior to defining the behavioral audiogram may require modification as more precise estimates of hearing sensitivity are obtained.

Summary

The importance of early identification of hearing impairment is well documented. The Joint Committee on Infant Hearing 1982 Position Statement established the goal of identification and habilitation of hearing-impaired infants by age 6 months but did not specify the procedure for initial audiologic screening. In these guidelines, ASHA specifies the recommended procedure for audiologic screening of infants at risk for hearing impairment that includes a) parent/caregiver education; b) audiologic screening by ABR; and c) referral to a comprehensive evaluation, follow-up, and management system for those infants who fail initial ABR screening. The procedures recommended in these guidelines are complex and require substantial involvement of a qualified audiologist. Identification programs should be instituted only when all components are available to provide appropriate services to the infant and his/her family. It is hoped that these guidelines will encourage implementation of programs for early identification of hearing impairment in at-risk infants.

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February 28, 1990

Dear Members of the Public Health and Welfare Committee:

Thank you for this opportunity to share my experiences in working with hearing impaired and deaf children from birth to three years old. I represent the Kansas School for the Deaf's Outreach Services to all of the public schools, agencies, and developmental programs in Kansas. It is my responsibility to provide technical assistance, resources, and information to families and teachers working with deaf and hearing impaired children.

Consequently, when a family contacts a school about a child under the age of three my name is referred to them. KSD's Outreach Program receives eight to ten phone calls a day from families and teachers asking for technical assistance. Approximately one-third of these calls are concerning infants and toddlers from birth to age three. I then refer families and schools to the nearest resources available to them. Unfortunately, families are usually required to drive great distances for services if they live outside of the few metropolitan areas.

Our state needs to improve statewide public awareness programs for early education, identification and referral. Improved identification and referral procedures could mean that more early intervention programs would be developed. A major challenge to the field of working with deaf/hearing impaired infants and toddlers is to develop a means to fill the training needs of professionals currently working with this population. It is very difficult to locate programs for infants and toddlers, especially programs that have personnel trained to work with deaf/hearing impaired children and their families.

PSHHC
2-27-90
Attm. #16

the Deaf report of 1988, the average age at identification of hearing loss is between 2 and 2 1/2 years. The average age of referral to programs for deaf and hearing impaired children was 25 and 1/2 months.

These first few years of life are critical to language development. Children do not "make-up" for this time lost when they do enter a program. They are classified "language delayed, or developmentally delayed, or learning disabled". This time lost forever indicts a child's future well-being. The critical years of language acquisition are well documented, and the technology for identification of hearing loss is available. However, less than half of the states have a program in place to assist this population. The Commission report stated that more than 75% of newborns with severe hearing loss could be identified during the first months of life.

Perhaps the greatest challenge and responsibility for early intervention programs is to comply with the federal mandate which states that programs must be family focused. Parent involvement, family wellness, and empowerment have become the new goal. This is necessary for families so that they can assume more responsibility and understanding of their child's growth and development.

I challenge each of your consciences to consider the great loss to deaf and hearing impaired Kansans already incurred. It is time to bring the state of Kansas to the forefront of early identification so that early intervention programs can be established in order to meet these childrens' basic needs. Without identification and intervention the future potential of each child is struggling to be heard. For you with ears to hear, please hear their cry.

Sincerely,

Jacqui Jones

P. Hall
2-27-90
attm. #16.
89.2.

Department of Social and Rehabilitation Services

Winston Barton - Secretary

Statement regarding House Bill 2915

1. Title — An act concerning hearing impaired infants; establishing a program of hearing impairment identification; providing for administration of the program by the secretary of health and environment.

2. Purpose — The purpose of this bill is to establish a program for the early identification of hearing-impaired infants and high-risk infants. The secretary, after consultation with the Kansas commission for the deaf and hearing impaired, shall establish by rules and regulations new-born infant hearing-impaired risk criteria and shall develop a questionnaire to identify high-risk infants.

3. Background — There are no programs currently in the state of Kansas that addresses identification of hearing impairment from the time the infant is born to the time the child begins public school education. Many parents are unaware of hearing loss until the time the child begins to develop speech skills. The first few years in the child's life is the most critical period in which communications, language, and cognitive development is learned. The child who escapes detection until he or she reaches school age is confronted with the nearly impossible task of trying to catch up with his normal-hearing peer group by compressing four to five years of communicative development into a much shorter period.

4. Effect of Passage — Passage of this bill will establish a program of early identification within the Department of Health and Environment. Criteria for identification of hearing loss in infants will be established by the Secretary after consultation with members of the Kansas Commission for the Deaf and Hearing Impairment, and a questionnaire will be developed to be issued to all expectant mothers at the hospitals or medical centers in order to identify potential risk for hearing impairment in the infant. This will provide much needed data which the state and school services can use for planning purposes. The sooner the infant is identified, the sooner the resources to assist parents and the infant can be made available which enhances the opportunity for communication development and success in the future.

5. SRS Reccomendation — The Department of Social and Rehabilitation Services urges favorable consideration of this Bill.

David S. Rosenthal
Kansas Commission for the Deaf
and Hearing Impaired
296-2874

PANEL
2-27-90
attm # 17

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Testimony in Support of House Bill 2915

Mr. Chairman, committee Members, I am testifying before you on behalf of the Kansas Commission for the Deaf and Hearing Impaired, which is within Rehabilitation Services, under the Social and Rehabilitation Services umbrella.

The Kansas Commission for the Deaf and Hearing Impaired coordinates services and disseminates information related to the well-being of Kansans who experience deafness or hearing impairment. The Commission serves as an advocate for services for the deaf and hearing impaired citizens of Kansas, collecting facts and statistics to encourage and assist public and private agencies and units of local, state, and federal government to cooperate in the delivery of services to respond to the needs of this population.

The Kansas Commission for the Deaf and Hearing Impaired supports H.B. 2915. Early identification of an educationally significant hearing impairment is an essential public-health priority. Gradual development of verbal communication skills during the critical preschool years lays the foundation for the child's academic growth during the initial grades of elementary school. The severely hearing impaired child who escapes detection until he or she reaches school age is confronted with the nearly impossible task of trying to catch up with his or her normal-hearing peer group by telescoping four to five years of communicative development into a much shorter period.

PHEW
2-27-90
Attm. #17,
pg. 2.

Given the fact that only a few types of educationally significant hearing impairments are associated with obvious physical deformities, these disabilities generally constitute "invisible" handicaps at birth. Not until the age at which the child is expected to demonstrate communicative abilities in listening and speaking will his deficits become obvious. Delayed speech development is often the first indicator to draw the parents' attention to the youngster's underlying hearing loss. Diagnosis of hearing impairment in a child by waiting for a demonstrated developmental failure is a method fraught with inefficiency and risk for severe limitation of the child's developmental potential.

There is an average delay of nine to twelve months from the first suspicion of a severe to profound sensorineural hearing loss in the young child to the confirmatory diagnosis and institution of remediation. Even greater delays occur when the child has a moderate rather than severe hearing loss. Such a delay, with its resultant deleterious effects on the child's communicative development, is clearly unacceptable and demonstrates the imperative for a model of identification which this bill addresses.

We ask that you make a favorable recommendation of this bill. Thank you for the opportunity to testify on behalf of this bill.

David S. Rosenthal
Executive Director
Kansas Commission for the Deaf
and Hearing Impaired
296-2874
February 27, 1990

KANSAS MEDICAL SOCIETY
1300 Topeka Avenue • Topeka, Kansas 66612 • (913) 235-2383
Kansas WATS 800-332-0156 FAX 913-235-5114

February 27, 1990

TO: House Public Health and Welfare Committee

FROM: Kansas Medical Society Chip Wheelen

SUBJECT: House Bill 2915; Screening for Detection of Hearing Impairment

Thank you for this opportunity to express our support of the concept of screening newborn infants for purposes of detecting possible hearing impairment. We believe that screening newborn infants can assist physicians and other specialists who might intervene early and provide treatment necessary to correct the hearing impairment or to minimize any disabilities that result from such impairment.

We must stress, however, that the provisions of HB 2915 do not directly affect the practice of medicine. They do impose a number of requirements on the Department of Health and Environment, as well as Kansas hospitals. For this reason, we have collaborated with the Kansas Hospital Association in an effort to streamline what is obviously a very well-written, but perhaps too extensive, measure. We endorse the amendments to HB 2915 recommended by the Kansas Hospital Association. Assuming adoption of those amendments, we urge you to recommend HB 2915 for passage. Thank you for considering our comments.

CW:lg

support Hospital Assn. Amendments.

PHWD
2-27-90
Attm # 18

Christian Science Committee on Publication For Kansas

820 Quincy Suite K
Topeka, Kansas 66612

Office Phone
913/233-7483

To: House Committee on Public Health and Welfare

Re: House Bill No. 2915

We respectfully request that accommodation be made in this bill for those whose religious beliefs are opposed to screening as described in the bill. The following amendment would provide the requested accommodation:

On page 2, after line 6, add:

> No risk screening shall be provided to an infant whose parent or guardian objects on the ground that such screening is contrary to the religious beliefs of such parent or guardian.

The present form of the bill requires removal of a child's records upon proper request. The bill also allows individual choice in selecting a mode of of treatment. These are important safeguards in the protection of family and individual rights. We believe that the adoption of our proposed amendment would not significantly alter the impact of the bill but would allow those with religious objections to avoid the initial screening.

Your consideration of this request is appreciated.

Keith R. Landis
Committee on Publication
for Kansas

PHeW
2-27-90
Attm # #19

STATE OF KANSAS

CAROL H. SADER
REPRESENTATIVE, TWENTY-SECOND DISTRICT
JOHNSON COUNTY
8612 LINDEN DR.
SHAWNEE MISSION, KANSAS 66207
(913) 341-9440

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
RANKING MINORITY MEMBER:
PENSIONS, INVESTMENTS AND BENEFITS
MEMBER: ECONOMIC DEVELOPMENT
ELECTIONS
PUBLIC HEALTH AND WELFARE
JOINT COMMITTEE ON ECONOMIC
DEVELOPMENT

February 27, 1990

TESTIMONY TO HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE HB 2878

Mr. Chairman and Members of the Committee:

I introduced this bill to prevent social workers from refusing to accept court appointments to provide family assessments for fear of being sued or subjected to administrative disciplinary proceedings. The former district attorney of Johnson County, who is now in the private practice of law in Overland Park, KS., brought this situation to my attention after he was asked to represent a social worker, who will testify before you today. This legislation provides a similar type of immunity from liability for social workers acting pursuant to a court order, which our statutes presently extend to others, such as reporters of child abuse and adult abuse. It would remove the chilling effect presently being felt by social workers who are experiencing threats of litigation which prove groundless but are nevertheless intimidating. This bill would provide just one more needed protection to those children whose interests might not otherwise be fairly served.

Thank you,

Carol Sader

Carol H. Sader
State Representative
22nd District

PH&W
2-27-90
Attm #20

STATE OF KANSAS

MARVIN A. KAISER, Ph.D., *Chairperson*
MARY ANN GABEL, *Executive Director*

BOARD MEMBERS:
Public Members
BETTIE E. DUNCAN
DELBERT L. POTTER
JOHN PREBLE

Psychology
WILLIAM L. ALBOTT, Ph.D.
C. ROBERT BORRESEN, Ph.D.

Social Work
CLARICE HARRIS, MSW
MARVIN A. KAISER, Ph.D.

BEHAVIORAL SCIENCES REGULATORY BOARD

Landon State Office Building
900 S.W. Jackson, Room 855-S
Topeka, Kansas 66612-1220
913/296-3240 KANS-A-N 561-3240

LICENSED PROFESSIONALS:
Psychologists
Social Workers

REGISTERED PROFESSIONALS:
Master Level Psychologists
Professional Counselors

TESTIMONY BEFORE THE HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

H.B. 2878

FEBRUARY 27, 1990

CHAIRPERSON LITTLEJOHN, VICE-CHAIRPERSON BUEHLER AND COMMITTEE MEMBERS:

I am Mary Ann Gabel, Executive Director of the Behavioral Sciences Regulatory Board, appearing before you today on behalf of the Chaiperson of the board, Dr. Marvin A. Kaiser, who is unable to appear. The board is opposed to H.B. 2878 in its current form on the basis of protection of the public health, safety and welfare.

This legislation provides protection from civil action for damages or from administrative disciplinary proceedings for a court appointed licensed social worker who provides family assessments. The board is concerned with the inclusion of "subject to any administrative disciplinary proceeding" because it appears the court appointed social worker could perform incompetently or could practice in a negligent manner and at the same time be exempt from practice standards required of his or her peers or colleagues. The public does not appear to be well served or protected by creating a potential dual standard of practice.

P&W
2-27-90
Attm # 21

The board's concern is reflected in the attached copy of the response from the Attorney General's Office to the board's request for a legal interpretation of this legislation.

The board requests the committee consider taking one of the following actions on this legislation:

1) Amend the bill to remove "or subject to any administrative disciplinary proceeding," (lines 15-16);

2) refer the bill for interium study in the judiciary to determine whether a problem exists (or the nature of the problem) and if so, whether this type of legislation addresses the problem; or

3) recommend the bill not be passed.

Thank you for allowing me to appear before you today. I will be happy to attempt to answer questions you may have.

Attachment

PNRW
2-27-90
Attm. #21
SB 9.2.

STATE OF KANSAS

OFFICE OF THE ATTORNEY GENERAL

2ND FLOOR, KANSAS JUDICIAL CENTER, TOPEKA 66612-1597

ROBERT T. STEPHAN
ATTORNEY GENERAL

MAIN PHONE: (913) 296-2215
CONSUMER PROTECTION: 296-3751
TELECOPIER: 296-6296

February 23, 1990

Mary Ann Gabel, Executive Director
Behavioral Sciences Regulatory Board
Landon State Office Building, Room 855
Topeka, Kansas 66612

Re: 1990 House Bill No. 2878

Dear Mary Ann:

On behalf of the Board, you have asked us to review 1990 House Bill No. 2878 to determine whether it divests the Board of jurisdiction to discipline a social worker acting pursuant to a court order but in a negligent or incompetent manner.

The proposed legislation states in relevant part:

> "No licensed social worker appointed by a court of this state to provide family assessments pursuant to the order of a court shall be liable in a civil action for damages, or subject to any administrative disciplinary proceeding, arising from any report, recommendation or testimony provided by such social worker acting in good faith and without malice within the scope of such social worker's appointment by the court." 1990 House Bill No. 2878, § 1.

The term "good faith" generally means honesty in-fact, while "malice" is a state of mind characterized by an intent to do a harmful act without justification or excuse. Most grounds for disciplinary action against a social worker by definition involve a lack of good faith or some degree of malice. However, two areas of conduct do not involve a factual analysis of the presence of good faith or malice. A social worker licensee may be disciplined for negligence, K.S.A. 1989 Supp. 65-6311(a)(5), and practicing in an incompetent manner, K.S.A. 1989 Supp. 65-6311(a)(40, as defined by K.A.R. 102-2-7(b)(44).

PNew
2-27-90
Attm. #21
pg. 3.

You ask whether it is possible to act in good faith and without malice and still practice in an incompetent or negligent manner. We believe that incompetence does not refer to a state of mind, nor is competence necessarily affected by the presence of good faith or malice. Competence or incompetence is determined by the degree to which a professional possesses the necessary skills to practice. Negligence involves practicing those skills within the standard of care appropriate under the circumstances. Negligence is an "unintentional" tort.

In summary, if 1990 House Bill No. 2878 were enacted in its present form, a social worker could perform incompetently or provide services to the court in a negligent manner, but do so with subjective honesty in-fact and without malice. Under a specific set of facts, the board may not be able to discipline the individual.

Very truly yours,

OFFICE OF THE ATTORNEY GENERAL
ROBERT T. STEPHAN

Mark W. Stafford
Assistant Attorney General

MWS:bas

PH+W
2-27-90
Attn: #21
89.4.

HOUSE BILL No. 2878

Dear Committee Members;

Please consider this written testimony in favor of House Bill No. 2878 by Debra Courtney. I am a practicing clinical social worker licensed in the State of Kansas. One of my areas of specialty is treating children including children involved in custody cases. On two occasions I have been reported to the Social Work Licensing Board in relation to child custody and/or visitation issues. On one occasion I was court appointed and on the other, I was recommended by family court services. Both incidents the licensing board dismissed the complaints. There was no validity or accuracy to themcomplaints.

I am presently not wanting to work with these cases due to the potential liability and inconvenience if that happens. It is a financial burden for legal representation and it has been difficult to collect any fees from these cases.

My concerns are what I fear maybe seeing as a trend in these cases. I am concerned that for any social worker appointed by a court to assess and evaluate the facts and make recommendations concerning child custody or visitation issues for whatever reason, may be setting themselves up as a target for a professional complaint. These cases are very emotional and a party may resort to filing an unjustified complaint either from misinformation or as an intimidation tactic. If and when that happens the innocent social worker becomes a victim and ultimately the child suffers.

Respectively;
Debra Courtney

H Jud
2-27-90
attm# 22

STATE OF KANSAS

MIKE HAYDEN, *Governor*

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Docking State Office Building, Topeka, Kansas 66612-1570

☎ (913) 296-3271

YOUTH SERVICES
SMITH-WILSON BLDG.
300 SW OAKLEY
TOPEKA, KS 66606
(913) 296-4653
KANS-A-N 561-4653

November 20, 1989

The Honorable Bernard D. Kanan
1420 Kansas Avenue
Kansas City, Kansas 66105

Dear Senator Kanan:

This letter responds to the recent inquiry regarding Mike Moreno, II, you made to Allyn Lockner at the statehouse. As you requested, I talked to Mr. Moreno prior to contacting our local staff. This also confirms our telephone conversation of November 15, 1989. The Department of Social and Rehabilitation Services has no objection to Mike returning to the home of his parents at the time he is released from the Youth Center at Atchison. Both the Kansas City Area Office and the Youth Center at Atchison share this view.

Mike is both, a juvenile offender and a child in need of care. Because of the child in need of care adjudication, the Department is not authorized to return him to his parents' home without the written permission of the court. It is our understanding that the guardian ad litem is strongly opposed to his returning to the home of his parents. In order for Mike to return home, it will be necessary for the family to obtain the written permission of the court in the child on need of care case.

If I may be of other assistance, please let me know. I may be reached by phone at 913-296-4648 or 561-2018.

Sincerely,

James P. Trast, Director
Juvenile Offender Programs

JPT:wfb

cc: Winston Barton/Robert Barnum/Allyn Lockner/
Robena Farrell/Fernando Bozzoli/Phil Knapp

Mike Moreno
2031 S. Mill, #10
Kansas City, Kansas 66103

PHPW
2-27-90
attn. #23

STATE OF KANSAS

B. D. KANAN
SENATOR, FIFTH DISTRICT
WYANDOTTE COUNTY
STATE CAPITOL BUILDING, ROOM 462-E
TOPEKA, KANSAS 66612
(913) 296-7357

TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNMENTS
MEMBER: CONFIRMATIONS
GOVERNMENTAL ORGANIZATION
PUBLIC HEALTH AND WELFARE
TRANSPORTATION AND UTILITIES

February 5, 1990

Dear Friends and Constituents:

I introduced a bill on January 18, in the Senate to roll back taxes to the 1988 level. The bill was Senate Bill 1633. It is in the Taxation Committee now.

I believe the great shift in taxes was the constitutional amendment we voted on in 1986 which exempted railroads, utilities, cattle and farm machinery, and merchants and manufacturer's inventories from the tax rolls. In Wyandotte County the inventory tax alone came to about 25 million. Senate Bill 1633 will return the exempt back to the tax rolls. It just isn't fair for home owners and small businesses to pay taxes for large companies. We, here in Wyandotte County have been the leaders in protest rallies and now the whole state has followed our leadership.

So again, I ask you to help me and yourself. I am sending out about 300 letters to you, asking you to contact your friends and neighbors to write a letter to the Honorable Senator Dan Thiessen, asking the Chairman to hear our Bill 1633, and to move it from his committee to the Senate floor.

Senator Dan Thiessen
Statehouse, Room 143-N
Topeka, Kansas 66612

This is really very important at this stage. So please, send a letter and have your friends and neighbors do likewise.

This is a follow-up on last week's letter to Secretary Winston Barton of the Social and Rehabilitation Services. I have not received a reply as of February 5, 1990. At our regular Public Health and Welfare Committee meeting on Wednesday, the Chairman, Senator Roy Ehrlich, appointed me and four other Senators to a Sub-committee chaired by Senator Langworthy.

PHW
2-27-90
Attm. #23
pg. 2.

This sub-committee will propose changes in the law to protect both the parents and their children. The bill is being drawn up now. I asked that before children could be separated from their parents that the parents could ask for a trial by jury. The way it is now, the parents have no rights. So Mrs. Cosgrove, Mrs. Moreno and other mothers who testified at the hearing, I am not going to rest until your children are home with you where they belong.

Sincerely,

B. D. Kanan, Senator
5th District

BDK:cm

P. H+W
2-27-90
Attn. #23
pg. 3.

KANSAS
TRIAL LAWYERS ASSOCIATION

Jayhawk Tower, 700 S.W. Jackson, Suite 706, Topeka, Kansas 66603
(913) 232-7756 FAX (913) 232-7730

TESTIMONY
of the
KANSAS TRIAL LAWYERS ASSOCIATION
before
HOUSE COMMITTEE ON PUBLIC HEALTH & WELFARE

HB 2878

The Kansas Trial Lawyers Association opposes HB 2878 because of the provision in the bill which grants to licensed social workers a full and complete immunity from civil liability for any negligent acts which they may commit against another person arising out of any report, recommendation or testimony provided by such social worker.

We believe there are good reasons why persons should be held accountable for their negligent acts when performing professional duties which, if done in a negligent manner, could cause great personal injury to another person.

The function of providing family assessments to a court is one which can have a dramatic and long term impact upon a person and that person's relationship with other family members. It is possible that a poorly done family assessment could result in the loss of custody of children in a child custody case or in severance of parental rights in a child in need of care case.

There are many social workers who are willing and able to conduct the type of investigation necessary to produce top quality family assessments in a responsible manner. There does not appear to be an insurance availability or affordability crisis nor does it appear that there has been a noticeable increase in the number of suits which have been filed against licensed social workers who do this kind of work.

In order to successfully prosecute a claim against a person for damages it is necessary that the action be proven to have directly caused the injury that the person is complaining of and it must be proven that the person negligently caused the injury. It is simply not enough to prove that there is an injury.

In the case of family assessments written by licensed social workers, it seems highly unlikely that a report which is prepared and submitted to the court will cause the kind of injury that will result in liability of the social worker for negligent work. All reports are usually made available to the parties and to the judge. The judge can hear further evidence

2-27-90
attm. #24

on the report if there are any questions raised by any of the parties and those who could be damaged by a faulty, negligently done assessment would have the opportunity to be heard in court if objections are raised. The possibility of damage is slight but it is nonetheless possible and thus important that these reports be done in the best possible professional manner.

The Kansas Trial lawyers Association respectfully urges this committee to use caution in entering into this area. The granting of immunity, while it may appear attractive on first glance, may actually increase injuries to people who rely on others to do the best job possible. If licensed social workers are granted immunity from liability, they will have much less incentive to do a good job and, thus, are more likely to cause reports to be written which could cause damage to an innocent person.

We urge that this bill not be passed.

PNLL
2-27-90
Attm. #24
pg. 2.

Metro New-- August 24, 1989

Fate of Pioneer Village still unsettled

By BILL CRAVEN
Topeka Metro News Staff

It is a truism in legal circles that litigation seldom resolves all the issues in a controversy. Recent developments in the legal whirlwind surrounding Pioneer Village are creating the possibility for resolution of some of the issues, but the "big picture"—what will happen to the buildings, what will happen to the clients of the intermediate care facility that houses up to 60 mentally retarded adults—remains clouded.

Two major developments to date would include the following: (1) On March 1, 1989, Pioneer Village, Inc., the former operator of the facility, declared bankruptcy. (2) The Kansas Department of Health and Environment was appointed receiver, and in that capacity refused to make monthly lease payments to First Rule Properties, a partnership that owns the real estate and the buildings. The partnership included local investors Howard Paul and Randy Adams. KDHE believed that state law allowed it to charge the partnership for receivership costs and since those might exceed the rent, it decided to withhold the rent payments (almost $13,500 monthly) and credit that amount to the receivership debt. The landlord, not surprisingly, was not pleased with that interpretation and initiated litigation to require KDHE to make lease payments.

The landlord, not surprisingly, was not pleased with that interpretation and initiated litigation to require KDHA to make lease payments.

Since then, attempts have been made—and are still being made—to resolve the dispute between the parties. One development is the issuance of an Attorney General's opinion on July 31, 1989, which was requested by Rep. Bill Bunten. Bunten, following a session in which KDHE, SRS, and First Rule attorneys were "very far apart" in settlement talks, sought an Attorney General's opinion on some important interpretations of state law. Bunten told the Metro News that KDHE's refusal to pay rent was creating "a hardship for the landlord, and that their position of holding Paul and Adams liable for the costs of the receivership were also a hardship." He estimated that those costs would be between $400,000 and $1 million. That range is computed by measuring the difference in the per diem SRS paid to Pioneer Village, Inc., for each resident—$67—and the per diem SRS pays to KDHE as receiver, approximately $100 per day, according to Bunten.

KDHE relied on statutes which require the landlord of a facility to be a co-licensee of the program and which also allows the receivership costs to be taxed to such a co-licensee. Bunten, in his request for an Attorney General's opinion, queried whether a landlord with absolutely no interest in the business or the program was intended to be within that statute. The Attorney General's opinion declared, "Where an owner of a building... does not have an express or implied interest in the business of operating the adult care home, it is our opinion that the Legislature did not intend to impose a duty upon the owner to assume such an interest."

The question then becomes one of determining whether the Attorney General's opinion really affects the parties or what weight to accord his opinion. The conclusion is that Attorney General opinions are non-binding. But attorneys for First Rule have plead in court documents that KDHE "has failed to abide" by that opinion which is one way to re-state their view that KDHE should begin making lease payments to First Rule and should not adhere to the position of attempting to assess the costs of the receivership to the partnership.

An interesting sidelight to all this is the normal practice of the Attorney General's office not to issue opinions in matters where litigation is likely or ongoing. Attorneys for First Rule dismissed their lawsuit on July 6, 1989 "without prejudice" meaning it could reinstate the litigation at a later time.

During this interim period, Bunten requested the Attorney General's opinion. Theresa Marcel Nuckolls, the Assistant Attorney General who drafted the opinion, conceded that whether to proceed with an opinion in this matter—which was obviously headed back to court—"was a close question." Nevertheless, the Attorney General's office determined to proceed.

An interesting sidelight to all this is the normal practice of the Attorney General's office not to issue opinions in matters where litigation is likely or ongoing.

KDHE attorneys told the Metro News that the department is "still evaluating the Attorney General's opinion," but that progress is being made in other areas. First, the chief counsel for KDHE, David Traster, confirmed that negotiations are ongoing with First Rule to commence lease payments. These lease payments may or may not be in the same amount as Pioneer Village, Inc. was paying pursuant to its lease. Second, because the costs of the receivership are an unknown sum until the receivership has ended, KDHE is reconsidering whether its initial policy of viewing the rent/costs issue was correct. It may well conclude that its attempt to collect the costs of the receivership should wait until after the litigation is concluded, Traster noted. The clear implication, however, is that the Department may conclude that it is not be in agreement with all of the Attorney General's opinion.

Meanwhile, Rep. Bunten noted that SRS has decided to move the residents of Pioneer Village elsewhere by May of 1990. That decision, Bunten says, is in keeping with the SRS policy of favoring smaller residential facilities for retarded adults. He noted that smaller facilities are more expensive with the daily costs per resident in the $130-150 range.

Bunten has an interest in learning why the larger, five building facility at Pioneer Village was licensed in the first place if SRS favors more family- oriented, smaller placement, but that question has almost become academic.

From the perspective of the landlord, the more pressing question is this: If the original tenant (Pioneer Village, Inc.) is bankrupt and is thus relieved of its responsibility to pay the rent, and if the receivership of KDHE is terminated by closing the facility and therefore KDHE is also relieved of its rent-paying responsibilty, who will pay the rent?

As Bunten said, "I don't have the slightest idea. If no other use for the buildings are found, the partnership may be stuck."

That is what was meant by referring to the fact that litigation does not resolve all the issues in a given case.

Rep. Hensley

P Hall
2-27-90
Attm. #25

Kansas Association of the Deaf

Founded 1909
Chartered by State of Kansas in 1910
Cooperating with the National Association of the Deaf Since 1911

February 27, 1990

To whom it may concern:

On behalf of the Kansas Association of the Deaf, Inc., we strongly support the Early Identification Bill Act of 1990 (HB2915) to promote the establishment of a program for the early identification of hearing loss.

This bill, introduced by State Representative Nancy Brown and co-sponsored by Representatives Gary Blumenthal, James Pottoff, and Vince Snowbarger, will ensure necessary help to parents and deaf children by providing information, resources, and appropriate services. Many of these parents and children are denied a full access to the appropriate resources and services which are so routinely taken for granted by the hearing population. We, as deaf citizens, wish to see better programs and treatments for the child and parents in order to grow as "normally" as possible and avoid the frustration and mistreatment that so many of us experienced in the past.

This legislation addresses this situation by establishing a program for early identification of hearing loss. It would help to educate health care professionals about the importante of early identification of hearing loss and availability of methods to test shortly after birth, make the general public more aware of these issues, and establish a state-wide high-risk registry, which if implemented successfully would result in an improved data base for educational program planning by many agencies/organizations.

The Early Identification Act goes hand-in-hand with the deaf services/education program as a whole to break down the barriers and to provide full accessibility to the American society for all citizens. If we can be any assistance as you move forward on this legislation, please let us know.

Sincerely,

Terry D. Hostin, President
Kansas Association of the Deaf

Pottoff
2-27-90
attm. #26