Approved 4-1-91
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Carol H. Sader at
Chairperson

1:30 ~~a.m.~~/p.m. on March 25, 1991 in room 423-S of the Capitol.

All members were present except:

Representative Praeger, Representative Samuelson, both excused

Committee staff present:

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

Conferees appearing before the committee:

Representative Jack Wempe
Robert Mullen, Administrator of Hospital District #1, Lyons, Kansas
John Alquest, Acting Commissioner of Income Support/Medical Services, Department of SRS
Barbara Gibson, member of Ex Governor's Commission on Health Care

Chair called meeting to order drawing attention to **SB 314,** and requested a staff briefing.

Mr. Furse gave a detailed explanation of the bill.

HEARINGS BEGAN ON SB 314.

Representative Jack Wempe offered hand-out Attachment No. 1). He explained the need for consideration of **HB 314.** The hospital in its desire to build assisted living units shows continued efforts to be proactive and flexible in finding answers to financial problems that most small hospitals must face. Sixteen units are proposed, with more than half already contracted for by potential residents. The economic benefit to the small hospital in Lyons will benefit both hospital and residents, some of whom had comtemplated leaving the area since no housing of this kind is presently available. This project is important to the economic future of Rice County. He answered questions. He urged support.

Robert Mullen, Hospital Administrator in Lyons, Kansas, offered hand-out (Attachment No. 2). He explained the independent-style apartments would be constructed on the hospital site, would be operated by the hospital district, would be designed for persons over the age of 55 with an income too high for them to qualify for assisted housing. There is an exodus of citizens of this age bracket from the area since there are not enough apartments in Rice County to fill a need for those who choose to move into smaller more convenient housing. They were made aware existing statutes would need to be amended in order to allow a hospital the flexibility to construct such a complex. Any projects such as this would still be subject to public vote. He answered questions, i.e., it is felt this project would be self-supporting; the aging population is growing which indicates a growing need for this type of facility; units will be built with tax exempt bonds; income is not a qualification for potential residents; monthly rent for 1 bedroom is $650 to $700, 2 bedroom would be an additional more per month.

HEARINGS CLOSED ON SB 314.

Chair drew attention to **HB 2565** and requested a staff briefing. Ms. Correll explained the bill in detail.

HEARINGS BEGAN ON HB 2565.

John Alquest, Acting Commisisoner of Income Support/Medical Services, Department of SRS offered hand-out (Attachment No. 3). He gave background information regarding current health benefits programs in the state. As extensive as health coverage is in Kansas, there still are a substantial number of Kansans who have no health coverage through either public or private insurance sources.

He noted there are three main issues that surfaced while working on **HB 2565,** i.e., hospital services to be limited to emergency services only; authority under federal Medicaid regulations to gain approval for a demonstration project is severely limited; fiscal impact of this program's implementation. He stated that in light of the agency's project funding for the coming year, and the multiple demands being placed on limited available resources, the Department cannot recommend passage of **HB 2565.** If such a program is established, there is danger that other needed programs operated by Department of SRS would have to be cut further or eliminated. Mr. Alquest gave a detailed explanation of informational data in his hand-out quoting statistics i.e., numbers of the potential group not now on medicaid as 23,352. He answered numerous questions, i.e., there is dovetailing of services between the hospitals and local health departments; language in **HB 2565** stipulates a premium will need to be paid; explanation on how **HB 2565 and SB 162** interface.

Barbara Gibson, member of Ex-Governor Hayden's Health Care Commission gave background information relating to the recommendation of the proposed legislation in **HB 2565.** Ms. Gibson stated they have tried to maintain the focus that the principle of access to health care is not just governmental or a private sector responsibility, but that every individual should contribute to this health care as well. Long discussions were held on prioritizing. The decisions reached were not rational decisions, yet when you run out of funding, it is the rational decisions that must be made. She noted they looked a long time also at how to deal with the hospital services. It is ridiculous not to look at life threatening situations. They did make decisions on what would not have high priority because of trying to save dollars, i.e., high tech services such as organ transplants. She noted she feels the fiscal impact will be significant since it is believed the number of participants will continue to grow. Ms. Gibson answered numerous questions, i.e., she does support the idea that a broad range of medical services should be made available in insurance coverage, and she agreed it would not be an easy task.

Chair stated, one other conferee who was unable to appear in person today, is former Representative Jessie Branson. The Chair indicated Rep. Branson's support for **HB 2565.**
Chair noted Representative Branson had worked very hard over the years on the concept proposed in the bill.

Chair announced Committee will convene again at 5:00 p.m. in room 254-E.

Chair adjourned the meeting.

GUEST REGISTER

1:30 pm

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 3-25-91

NAME	ORGANIZATION	ADDRESS
Tom Bell	Ks. Hosp. Assn.	Topeka
Bob Mullen	Hospital Dist. #1, Rice County	Lyons
Charles Simpkins	KS Foundation for Medical Care	Topeka
Ken D. Hyson	AARP Capital City Task Force (KS)	K.C.
Michelle Siesteo	Johnston Lesson & Associates	Topeka
Chip Wheelen	KS Medical Society	Topeka
ALAN COBB	WICHITA HOSPITALS	WICHITA
Ken Bahr	Ks. Hospital Assn.	Topeka
GARY Robbins	KS Optometric Assn	Topeka
Barbara Gibson	For mandated Commission on Access to Services for the Medically Indigent	Topeka
John Alquest	SRS	Topeka
Sherri Tollidg	Budget Division	"
GREG RESSE	KDHE	TOPEKA
Linda Lukensky	KS Home Care Assoc	Lawrence
J.R. Wempe	Ricedia	Little River
KEITH R. LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS	TOPEKA
Jerry Slaughter	KS Medical Society	Topeka

TO: Carol Sader, Chairman

FROM: Jack Wempe, Executive Director, Rice County Economic Development Corporation

SUBJECT: Testimony on SB 314

DATE: March 22, 1991

This bill developed out of an effort by the district hospital at Lyons, Kansas to develop an assisted living unit on hospital grounds. The Lyons hospital has been very pro-active and flexible in finding answers to the financial problems which beset all small hospitals. To this point they have been largely successful.

They have developed swing-beds, have developed a specialty in obstetrics, have levied taxes and have leased space for a county ambulance service and a county health office. This move toward assisted living service is a continuation of their creativity and progressive stance. They propose sixteen units and more than half are contracted by potential residents.

This project is important to the economic future of Rice County. It represents a self-help, grass roots approach to economic development. I urge your support of this bill.

P+W
3-25-91
Attm # 1.

TESTIMONY ON SENATE BILL # 314

before the

HOUSE COMMITTEE ON PUBLIC HEALTH & WELFARE

March 25, 1991

Ladies and gentlemen of the committee, I am Robert Mullen, Administrator of Hospital District #1, at Lyons, and I appreciate the opportunity to testify in favor of Senate Bill 314.

Approximately three years ago, our hospital began exploring the feasibility of building a limited care residential retirement facility, to be located on land owned by, and adjacent to the hospital. The independent-style apartments would be operated by the hospital district and would be designed to cater to persons over the age of 55 who make too much income to qualify for other apartments in our community. We were seeing an exodus of citizens from the area to larger, neighboring communities because there were not enough apartments in Rice County to fill this need.

Our plans are to build a 15-unit complex with such services as lawn care, building maintenance, housekeeping, basic utilities, and one meal a day to be included in the monthly rent. There will be call buttons in each apartment that are connected to the nurses station at the hospital. Planned social and recreational activities will also be available to the residents.

As we began to investigate the statutory authority for a district hospital to construct such a project, we found that there was nothing in the law that specifically addressed this issue. A law firm we have been working with sought an opinion from the Kansas Attorney General's Office and the result of that opinion

PHWC
3-25-91
Attmt 2

was that there was no statutory authority to build such an apartment complex. The next logical step was to amend the existing statutes (K.S.A. 80-2501 and 80-2525) in order to allow a district hospital the flexibility to construct such a complex.

It is our opinion that the proposed changes in the bill will serve to clarify the existing language, as well as providing enough flexibility to allow district hospitals to expand services while filling a need in the community. These changes, if adopted, should not create any problems for district hospitals in Kansas. I would point out, also, that passage of this bill will not place a "blank check" in the hands of district hospital boards and administrators. Any projects constructed under the provisions of this bill would still be subject to a public vote.

Once again, thank you for the opportunity to appear before the committee. I would be glad to respond to any questions that you may have.

PH&W
3-25-91
Attm 2-2

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Robert C. Harder, Acting Secretary

House Public Health and Welfare Committee
Testimony Regarding: House Bill 2565

This bill establishes a Kansas Health Benefits program which is designed to serve persons who do not otherwise have health coverage through either private or government sources. The program would replace the current MediKan program and provide limited health coverage to those individuals and families whose income does not exceed 85% of the federal poverty level. Only physician, pharmacy, and limited emergency hospital services would be provided in the first two years.

Before looking more closely at the program being proposed in this bill, it is important to note what medical coverage currently exists through the Department. Medicaid benefits are available to individuals and families who are eligible for cash assistance under the federal Aid to Families With Dependent Children (AFDC) and Supplemental Security Income (SSI) programs. This includes families where one or more children are deprived of parental support due to the absence, disability, or unemployment of one of the parents, and individuals who are aged (65 and older), blind, or disabled based on Social Security criteria. The program also covers children in foster care and subsidized adoptions, pregnant women and infants up to age 1 whose family income does not exceed 150% of the federal poverty level, and children ages 1 to 6 whose family income does not exceed 133% of poverty. Effective July 1, 1991, coverage will become available to children ages 6 and above who were born on or after October 1, 1983 and whose family income does not exceed 100% of poverty.

For those persons who are ineligible for AFDC or SSI benefits because of excess income and who do not fall under one of the poverty level groups described above, Medicaid coverage is still potentially available based on what is called a "spenddown" procedure. This allows the individual to reduce his or her excess income by deducting medical expenses. The person's income is compared to an income standard and the amount by which the income exceeds the standard creates the spenddown. The spenddown is similar to an insurance deductible in that the person does not gain eligibility until he or she has medical expenses which meet the spenddown amount. The income standards currently used in this program are approximately 50% of poverty for a family of three and approximately 42% of poverty for a family of four.

The Medicaid program provides coverage of most medical services including hospitalization, physician and pharmacy services, and mental health and substance abuse treatment. It is approximately 59% funded by the federal government.

The State has also provided medical coverage to its General Assistance cash population through the State-funded MediKan program. The General Assistance (GA) program serves those individuals who do not qualify for the federal AFDC or SSI programs and who meet certain eligibility criteria. This primarily includes single adults and childless couples where the individuals are age 55 or older or are physically or mentally incapacitated. However, the program also serves families where neither parent meets AFDC qualifications (i.e. both parents are present and neither meet the AFDC disability or unemployment criteria). Single

PH&W
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Attm# 3

adults and childless couples who are otherwise employable do not qualify for the GA program.

The MediKan program provides coverage of most medial services including hospitalization and physician and pharmacy services but to a more limited degree than Medicaid. It is totally state-funded. Only those persons who are eligible for a GA cash grant can receive Medikan currently. The standards used in the program are fairly low equating to approximately 36% of poverty for a single incapacitated person and 44% of poverty for a family of three. If the person's or family's income exceeds these standards, there is no further medical coverage available.

As extensive as these programs have been, there is still a substantial number of Kansans who have no health coverage either through public or private sources. The State Commission on Access to Services for the Medically Indigent and Homeless has estimated that as many as 400,000 Kansans are without health insurance coverage either because of cost or the lack of available health plans through the work place. Most of these individuals are unable to obtain basic health care services and generally wait until they are acutely ill before presenting themselves or their children at the hospital emergency room where they presume they cannot be turned away. This not only leads to a decline in the health and well-being of our population but also leads to increased costs for the physicians, hospitals, and the State as acute care is more expensive to fund than preventive medicine.

House Bill 2565 addresses these problems by providing an opportunity for Kansas residents whose incomes do not exceed 85% of the federal poverty level to obtain limited medical coverage geared toward preventive care as well as emergency acute care needs. Besides the current General Assistance population, the program would also be available to any individual or family whose income falls within the 85% of poverty level. That level equates to the following standards:

Household Size	Amount Income 85% of Poverty	Amount Income 100% of Poverty
1	$ 5,627	$ 6,620
2	$ 7,548	$ 8,880
3	$ 9,469	$11,140
4	$11,390	$13,400

Individuals participating in the program would be required to pay monthly premiums and meet certain copay requirements. In addition, the Secretary has the authority to also establish deductible requirements.

For the most part, this bill is identical to a similar measure which was introduced in the last legislative session, Senate Bill 444. There were primarily three main issues which surfaced in working with that bill over the course of the session and which apply equally to this bill.

The first was in regards to the services to be covered in the program. Hospital services were to be limited to emergency services only and we would recommend this for House Bill 2565 as well. The attached information sheet explains this in more detail. Pharmacy services were not defined last year but should remain as currently covered for MediKan, which is more restrictive than Medicaid.

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Attach #1
3-7

Physician services were very restricted during the discussion of Senate Bill 444 and as an alternative we would recommend preventive and primary care.

Preventive and primary care provided by a physician means care which avoids illness or complication of illness through early intervention and which alleviates uncomplicated presenting illnesses or other medical conditions.

This care encompasses services such as periodic history and physical examinations, immunizations, health education, office visits, basic laboratory and radiology, surgical procedure or pharmaceutical treatment.

Second, the authority under federal Medicaid regulations to gain approval for a demonstration project is severely limited. Prior to passage of the Omnibus Budget Reconciliation Act (OBRA) of 1990, there were no provisions for pursing a federally funded demonstration project regarding this new program. OBRA 1990 does allow for the funding of 3 or 4 state projects to serve the medically indigent and the Kansas Health Benefits program could potentially qualify. However, in order to apply for funding the State must first provide Medicaid coverage to infants up to age 1 and pregnant women at 185% of the federal poverty level. This would add substantially to the fiscal impact of this proposal. In addition, even if the State did so there is no guarantee that the project would be approved since only 3 or 4 programs are to be funded. No other authority exists for demonstration project funds for this type of program.

Finally, is the issue of the program's fiscal impact. While SRS has long recognized the need for a medical program to meet the needs of the State's medically indigent population, we cannot ignore the budgetary constraints that the agency is facing in the coming fiscal year. In terms of the budget limitations being specified in S.B. 162 for the agency, there are not sufficient funds for this program. As such, in light of the agency's projected funding for the coming year and the multiple demands being placed upon the limited resources which will be available, we cannot recommend passage of H.B. 2565. If such a program was established, there is a danger that other needed programs operated by SRS would have to be cut or eliminated altogether.

John W. Alquest
Acting Commissioner
Income Support/Medical Services
(913) 296-6750

3-22-91

PNWU
3-25-91

attmt 2-3

Senate Bill 444 - Emergency Hospital Services

Limited hospital services, to include emergency services, have been defined by the Department to cover inpatient and outpatient emergency services for one of the following diagnoses or conditions.

Emergency Services

Services provided in a hospital emergency room after the sudden onset of a medical condition manifested by symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: 1. placing the patient's health in serious jeopardy, 2. serious impairment to bodily functions, or 3. serious dysfunction of any bodily organ or part.

Covered Services for the Following Conditions:

Diabetic/hypoglycemic coma
Retinal detachment
Myocardial infarction
Pulmonary embolism
Cerebrovascular accident (stroke)
Ruptured aortal aneurysm
Esophageal varices
Spontaneous pneumothorax
Perforation of esophagus
Gastric ulcer with hemorrhage/perforation
Duodenal ulcer with hemorrhage/perforation
Acute appendicitis
Perforation/obstruction of colon
Acute cholecystitis
Perforation/obstruction of gallbladder
Kidney stone not passed
Twisted ovarian cyst
Vaginal hemorrhage
Emergency labor and delivery
Comatose when admitted
Convulsions-undetermined cause and first time
Fracture
Intracranial injury
Internal injury of chest, abdomen and pelvis
Ruptured spleen
Open wound of head, neck or trunk
Open wound of upper limb
Open wound of lower limb
Injury to blood vessels
Crushing injuries
Second or third degree burns
Injury to spinal cord
Poisoning or drug overdose
Meningitis/Encephalitis
Critical medical condition such as adrenal crisis, systemic infection, ventricular tachycardia
Strangulated hernia

Limitation of hospital days allowed or level of reimbursement may be imposed to stay within a target of $5,000,000.

EXHIBIT
3-25-91
Attn 3-4

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ESTIMATED COST OF THE KANSAS HEALTH BENEFITS PROGRAM
AS DEFINED IN HOUSE BILL # 2565

AT 85% FPL MAXIMUM

	TOTAL POTENTIAL POPULATION	PROBABLE PARTICIPATION LEVEL	CURRENT ANNUAL $ PER M'KAN ADULT	FY 1991 ESTIMATED COST
*EMERG HOSPITAL	23,352	17,514	?	$5,000,000
PHYSICIAN SVS	23,352	17,514	$460	8,056,440
PHARMACY	23,352	17,514	$190	3,327,660
BENEFIT COST	23,352	17,514	?	$16,384,100

ADMINISTRATIVE COST (Includes 26 Field Staff, Space and Equipment, and Fiscal Agent contract modifications.)	1,340,523
TOTAL COST	$17,724,623
LESS 20% CO-PAY	(3,276,820)
LESS 17,514 ANNUAL PREMIUMS @ $360	(6,305,040)
NET SGF COST UNDER ABOVE CO-PAY/PREMIUM SCENARIO....	8,142,763

* Emergency Hospital includes very limited inpatient and outpatient care and are capped at $5,000,000 by way of example.

CALCULATION OF POTENTIAL PARTICIPANTS

1980 85% OF POVERTY FOR AGES 18-65	103,352
8.4 % FACTOR FOR KANSAS POP GROWTH	2,000
ESTIMATED PRESENT DAY POTENTIAL POP	105,352
NUMBER AGES 18-65 NOW ON MEDICAID	(82,000)
POTENTIAL GROUP NOT NOW ON MEDICAID	23,352
PROBABLE PARTICIPATION LEVEL (75%).....	17,514

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Attm 3-5

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ADMINISTRATIVE COSTS ASSOCIATED WITH A POVERTY
LEVEL BASED MEDICAL PROGRAM FOR THE UNINSURED

HB 2565-85% FPL

IT IS ASSUMED THAT THE 12,514* NEW PARTICIPANTS WILL COME IN THE FORM OF APPROXIMATELY 6,000 CASES. THE ELIGIBILITY DETERMINATION PROCESS AND THE ONGOING MONITORING OF CONTINUED QUALIFICATION FOR THIS PROGRAM WILL HAVE THE SAME DEGREE OF DIFFICULTY AS A GA CASELOAD. THIS MEANS THAT EACH NEW IM WORKER SHOULD BE RESTRICTED TO 300 CASES. THIS IS ESPECIALLY TRUE WHEN CONSIDERING THE POTENTIAL FOR PROBLEMS AND FREQUENT CASE TURNOVER ASSOCIATED WITH PAYING A MONTHLY PREMIUM.

6,000 DIVIDED BY 300 YEILDS A IM WORKER NEED OF 20 NEW POSITIONS. AT A MINIMUM THERE SHOULD BE ONE CLERICAL SUPPORT STAFF FOR EACH 7 POSITIONS AND ONE SUPERVISOR FOR EACH 7 POSITIONS. THIS WOULD DICTATE THE FOLLOWING EXPENSES:

(* There are only 12,514 new clients because 5,000 adults are already on current GA program.)

PERSONNEL	
IMW I- 20 x $20,544 (18C)	$410,880
OA II-3 x $14,256 (11B)	42,768
IMW III- 3 x $25,596 (22D)	76,788
FRINGE BENEFITS @ 20%	106,087
	$636,523
EQUIPMENT/ SPACE	
DESK, CHAIRS, ETC 26 x $500	$13,000
CAECSES ELIGIBILITY TERMINALS/DESK PRINTERS @ $2500	65,000
FLOOR SPACE 100 sq ft x 26 x $7.00	18,200
	$96,200
TRAVEL/TRNG/ETC AT $300	$7,800
CONTRACT MODIFICATIONS TO FISCAL AGENT CONTRACT	$500,000
CONTRACT MODIFICATION TO UTIL REVIEW CONTACT	$100,000
TOTAL	$1,340,523 (ALL SGF)

FHSC
3-25-91
Attm # 3-6

Kansas Department of Social and Rehabilitation Services
Income Support and Medical Services
Robert C. Harder

GENERAL ASSISTANCE/MEDIKAN REDESIGN

Temporary rules and regulations have been prepared and are scheduled to be published ~~February 21~~ to make modifications to the General Assistance (GA) and accompanying MediKan program effective ~~May 1~~ July 1, 1991.

The current GA and MediKan programs would serve approximately 7,000 persons each month in FY 1992 at an annual cost of $12.5 million in cash assistance and $23.0 million in state funded medical assistance. The redesigned program is expected to serve appropriately 6,000 persons each month at annual cost of $9.3 million in cash assistance and $3.9 million in medical assistance.

General Assistances/MediKan Eligibility

Eligibility will be limited to the following groups:

- Persons with physical or mental disabilities expected to continue six months or more. Currently the expected disability is 30 days. The majority of these persons will be awaiting approval of federal SSI benefits.

- Families who do not qualify for AFDC Benefits. This continues the current coverage. Children and pregnant women are eligible for Medicaid benefits.

- Persons returning to the community from our state psychiatric Hospitals. This continues current coverage. This group is being expanded to include persons being released from the Extended Care Unit of the Kansas State Penitentiary.

In addition, cash standards will be modified to correspond more closely to AFDC:

- The program will be simplified to apply the shared and non-shared living concepts used for AFDC and GA families to all GA cases. This eliminates the more complex proration concept previously used for GA individuals. GA benefits for single persons or couples with no children will be budgeted at 77% of total budgetary requirements. Standards and benefits for families and pregnant women will be unchanged.

- The standards in GA are being reduced by $9 per person to correspond to the AFDC standards. Final action is pending legislative consideration of the Governor's budget recommendations.

MediKan Coverage

The redesigned MediKan Program deletes coverage of hospital and all other services, except the following:

- Physician office visits. This continues current coverage of 12 office visits a year, but deletes coverage of surgical and diagnostic procedures which may be a part of the physician services.

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- Prescription Drug. The current MediKan Drug Formulary will continue.

- Community Mental Health Service. Limited services will be covered as shown:

  - Targeted case management for the long term mentally ill to a maximum of 80 hours per year. This is the same as previous coverage.

  - Partial Hospitalization Activity will be reduced from a maximum of 720 hours per year to 400 hours per year.

  - Medication review will be reduced to a maximum of 2 times per month. Previously coverage was once weekly.

  - Individual, group or family therapy, or any combination of these, will be reduced from a total of 48 hours per year to 10 hours per year.

Questions concerning these changes may be directed to:

John Alquest, Commissioner of Income Support and Medical Services, (296-6750)
Carla Nakata, Director of Income Maintenance, (296-3349)
Katie Klassen, Director of Medical Services, (296-3981)

1/25/91

Placed
3-25-91
Attm 3-8