Approved: 1-25-96
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chair Sandy Praeger at 10:00 a.m. on January 17, 1996 in Room 526-S of the Capitol.

All members were present except:

Committee staff present: Emalene Correll, Legislative Research Department
Bill Wolff, Legislative Research Department
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:

Dr. Steve Potsic, Director of Health, KDHE
Richard J. Morrissey, Director of Bureau of Local and Rural Health, KDHE

Others attending: See attached list

Approval of Minutes

Senator Papay made a motion to approve the Committee minutes of January 16 and 17, 1996, seconded by Senator Harrington. The motion carried.

Nursing Home Safety

Dr. Steve Potsic, Director of Health, KDHE, briefed the Committee on the workload summary of Health Facility Licensure/Certification. He noted that the state is divided into six regions and supervised by a regional manager who is responsible for 10 to 16 surveyors. The remainder of staff in Topeka provide administrative support, review plans of corrections, monitor enforcement actions, and supervise quality assurance. Written testimony from Secretary O'Connell, KDHE, on nursing home safety regulations was also provided. (Attachment 1)

Rural Health Initiatives

Richard J. Morrissey, Director, Bureau of Local and Rural Health, KDHE, presented an overview of the department's programs and activities to improve access to health care in rural Kansas. Information presented to the Committee related to Community and Migrant Health Centers, Small Cities Community Development Block Grant Program, Rural Health Primary Care Recruitment and Retention Program, Local Public Health Cooperatives, Community Health Assessment Program, the Kansas EACH Project, Community Based Primary Care Clinics, Medical Shortage and Underserved Areas Program, and EMS/Trauma Planning Project. (Attachment 2)

Committee discussion related to access to rural health clinics, rural health outreach grants, consolidation of health services, data collection, EACH/RPCH networks, private clinics and rural health care policy issues.

Adjournment

The meeting was adjourned at 11:00 a.m.

The next meeting is scheduled for January 23, 1996.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 1-17-96

NAME	REPRESENTING
Steven A. Potter	KDHE
Richard Morrissey	KDHE
Melissa Wangemann	Helm, Ebert & Weir
Rich Guthrie	Health Midwest
Tara Kiehl	KHOA
Leslie Kaufman	Kansas Farm Bureau
Tina Barker	JC Crossroads Class
Karen Jameson	JC Crossroads Class

State of Kansas

Bill Graves *Governor*

Department of Health and Environment

James J. O'Connell, Secretary

Testimony Presented to

The Senate Public Health and Welfare Committee

by

The Kansas Department of Health and Environment

NURSING HOME SAFETY

As Secretary of the Kansas Department of Health and Environment, I appreciate this opportunity to speak to the committee regarding the issue of nursing home safety. My responsibility to assure that residents of Kansas nursing homes live in safe surroundings and receive appropriate care is second to none in KDHE, but that importance does not make it immune from the need to be prudent and efficient in the resources devoted to that responsibility, and to use resources where they will do the most good.

KDHE is the agency responsible to evaluate compliance with Medicare and Medicaid requirements, as well as a number of independent licensure programs. Utilizing the various funding sources to assure all mandated state and federal survey activity is accomplished has been problematic for years. This past year has seen a number of funding factors merge. A brief explanation of how survey activity is funded will be helpful.

Essentially, survey activity is funded by a blend of federal Medicare money, federal/state Medicaid money, and the state general fund. Medicare and Medicaid funds are earned based

on detailed time records kept by survey staff. Medicare is direct federal funding. Medicaid requires a state match, which is provided through the SRS budget process. The actual amount of Medicare reimbursement is ever changing and is based upon the particular mix of facilities and beds at any given time. Medicaid funding is not an issue, but Medicare is. State general fund support for licensure activities only provides approximately 34 percent of the costs called for in state statute. Historically, federal dollars obtained through earned indirect overhead funds were combined with state funds to carry out the services called for in state statutes.

Traditionally, federal funding for this program has been relatively unlimited, but that has changed within the past year. Coupled with the 34% state general fund support, limited federal funds have meant that KDHE had to work hard and creatively in order to assure that the available dollars are spent on those activities that are most focused on assuring that resident health and safety are not compromised. There has, on the one had, been inappropriate criticism that we are too lax in enforcing standards, and on the other had, too zealous in implementing the new OBRA'87 survey process.

Nursing facilities must comply with both state licensure regulations and federal Medicare or Medicaid regulations. Both state and federal law are parallel in that they require a comprehensive, onsite inspection for a facility at least once each 15 months. The result of this comprehensive evaluation almost always results in the identification of some deficiencies, for which a variety of follow-up actions become options, but one near certainty is that the facility will be re-inspected within several weeks with a focused evaluation of corrective action taken. In addition, the average facility is visited approximately four times each year to respond to specific complaints that have been brought to our attention. A facility, therefore, is inspected on the average at least six times each year. This does not include visits by the Department on Aging's ombudsman, case managers from SRS, guardians, etc.

Significant federal funding issues became an issue in March of 1995 when the Health Care Financing Administration (HCFA) notified KDHE that federal funding limitations, dictated that Medicare survey activities needed to be re-prioritized. While this reprioritization would provide full survey services for nursing facilities, it would defer qualifying (or initial) surveys for new Medicare providers and would curtail maintenance of the nurse aide registry and nurse aide training and suggested that complaint investigations would need to be restricted. We did defer initial surveys for a period of time and some on this committee may have received complaints about that. It is decidedly not acceptable to curtail the nurse aide registry or nurse aide training programs, but we did feel confident, based on experience, that amendments to the survey protocol for nursing facilities and complaint investigations could be safety accomplished and this has been the focus of our efforts to live within available federal funds.

Funding limitations for state licensure activity is also a significant issue, but because we are in virtually all nursing facilities for federal certification purposes, those limitations are not directly pertinent to nursing home safety. I do want you to know that survey protocols for state licensed-only facilities, such as assisted living, residential care, and some home health agencies have been streamlined and available funds will meet the needs for the time being. However, future needs

for state funding may increase depending on a combination of factors, including availability of federal funds and growth in the number of these facilities.

Certainly, the frequency of our visits to nursing facilities, which average slightly over six per facility each year, and the record of corrective actions we have ordered, and sanctions we have issued when appropriate, confirm our commitment to assuring nursing home safety. The changes we have made in survey protocol are prudent and carefully thought out for the purpose of allowing resources to be directed where they are most effective. I am here with the director of the Bureau of Adult and Child Care, Joseph Kroll. We will be pleased to answer any specific questions or concerns you have. Thank you for the opportunity to address you on this very important topic.

Presented by: James J. O'Connell, Secretary
Kansas Department of Health and Environment

Date: January 16, 1996

attachment

Health Facility Licensure/Certification

Workload Summary

Survey responsibility for all health facilities (except those for mental health or mental retardation) are within the Field Services Program of the Bureau of Adult and Child Care. Field Services is authorized 97 FTEs.

The state is divided into six regions supervised by regional manager, who is responsible for 10-16 surveyors, for a total of 80 Field "inspectors." The reminder of staff in Topeka provide administrative support, review plans of corrections, monitor enforcement actions, and supervise quality assurance.

The Mental Health/Mental Retardation Program has ten positions assigned field inspection responsibility.

Provider Type	Number*	Responsibility
Long Term Care Units	478	State licensure, Medicaid, Medicare
10 beds or fewer facilities	72	State licensure only
Hospitals	149	State licensure, Medicare
Home health agencies	298	State licensure, Medicare
Ambulatory Surgical Centers	26	State licensure, Medicare
Other Medicare**	221	Medicare
Mentally Retarded	47	State licensure, Medicaid

*Number can vary

**Includes Physical Therapy, End State Renal Dialysis, Rural Health Clinics, other Medicare providers

State of Kansas

Bill Graves Governor

Department of Health and Environment

James O'Connell, Secretary

Testimony presented to

Senate Committee on Public Health and Welfare

by

The Kansas Department of Health and Environment

Rural Health Briefing

I appreciate the opportunity to appear before the Committee and provide information on the Department's programs and activities to improve access to health care in rural Kansas. I understand that there have been some questions raised relative to support that may be available for establishing rural clinics, so I will begin with some information about relevant federal programs.

Community/Migrant Health Centers

The Community/Migrant Health Center programs make grants to public and nonprofit private entities for the development and operation of Community/Migrant Health Clinics. These entities are located in areas throughout the country where there are financial, geographic and cultural barriers to primary health care for a substantial portion of the population. Community/Migrant Health Centers seek to improve access by supporting local, community based health care systems and providers.

In order to qualify, a site must be located or serve populations in federally designated medically underserved areas. Currently Kansas has five federally funded Community Health Centers and one Migrant Health Program. Our understanding is that the federal program does not plan on funding any new clinics in FFY 1996.

Small Cities Community Development Block Grant Program

Administered by the Kansas Department of Commerce and Housing, the Community Development Block Grant Program will provide up to $400,000 for a project grant for development of public facilities or for loans to economic development initiatives.

There is an annual grant cycle based upon an announced solicitation with

Bureau of Local and Rural Health Systems
LSOB, 900 SW Jackson, Rm. 665, Topeka, KS 66612-1290

application deadlines in June and awards announced in September. The 1995 distribution totaled $21,365,000 with between $9 and $10 million for public facility grants. At this point, the same dollar amount is anticipated to be available this year.

Rural Health Initiative Funding

Governor Graves requested and the legislature appropriated $200,000 in the current fiscal year for rural health initiatives. The **Kansas Rural Primary Care Recruitment and Retention Program** has provided grants totaling $73,500 to 14 rural communities for training and consultation in organizing effective community based recruitment and retention programs. In addition, the seven county Southcentral Kansas Coalition for Public Health has been awarded a $100,000 grant to support the establishment of a **Local Public Health Cooperative**. The goal of this program is to support local planning and implementation of shared public health services to cost effectively improve access.

Community Health Assessment Program

Last year KDHE initiated the Kansas Community Health Assessment Process (CHAP) in cooperation with the Kansas Association of Local Health Departments and the Kansas Hospital Association. While the process was designed to allow small rural communities to complete an assessment with minimal expense, some costs are involved. The Kansas Health Foundation has provided $100,000 to support grants to communities engaged in the CHAP process. We have recently announced the availability of these grants and anticipate awarding grants to between 10 and 15 communities.

The Kansas EACH Project

The Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) Program is designed to help small, rural hospitals (RPCHs) convert their focus from inpatient care to primary care services through a network supporting relationship with a larger (EACH) hospital. The RPCH must limit its inpatient services but becomes eligible for enhanced, cost-based reimbursement for services to Medicare patients. Kansas is one of seven pilot states in the program, with eight networks and seven certified RPCHs. The program is continuing to grow, with two more RPCHs about to become certified.

Community Based Primary Care Clinics

Fifteen community based clinics currently receive grants to provide services to the medically indigent, defined as persons without health insurance and below 200% of

the federal poverty level. These clinics provided 64,500 patient visits during the 1994 calendar year. The FY 1997 Budget maintains this program with $1,480,100 in State General Fund support.

Medical Shortage and Underserved Areas

This program assists communities with achieving designation in one of several federal classifications of underservice that provide eligibility for a variety of supporting services. These efforts have achieved designation of 39 medical shortage and 79 underservice areas which enabled five community health centers, 131 rural health clinics and the placement of 33 National Health Service Corps physicians and mid-level practitioners. This past year, thirteen Dental Health Professional Shortage Areas were designated. The 1996 Primary Care Underserved Areas Report will be available in about 60 days.

EMS/Trauma Planning Project

This objective of this project is to develop a comprehensive EMS/trauma system to respond to injury occurrences in Kansas. The project is sponsored by a partnership composed of KDHE, the Board of Emergency Medical Services and the Kansas Medical Society in cooperation with 13 other statewide agencies and organizations with a stake in EMS/Trauma services. The Project is supported by a three year grant from the Kansas Health Foundation and is guided by a Policy Group composed of representatives of all the participating organizations.

Again, I appreciate this opportunity to highlight some of our rural health activities and would be pleased to respond to any questions you have.

Testimony presented by: Richard J. Morrissey
Director, Bureau of Local and Rural Health Systems
January 17, 1996