Approved: 1/25/93
Date

MINUTES OF THE HOUSE COMMITTEE ON APPROPRIATIONS.

The meeting was called to order by Chairman Rochelle Chronister at 1:30 p.m. on January 19, 1993 in Room 514-S of the Capitol.

All members were present except: Rep. JoAnn Potorff (excused absence)

Committee staff present: Alan Conroy, Legislative Research Department
Timothy Colton, Legislative Research Department
Laura Howard, Legislative Research Department
Diane Duffy, Legislative Research Department
Jim Wilson, Revisor of Statutes
Jerry Cole, Committee Secretary
Sharon Schwartz, Administrative Assistant
Mike Leitch, Intern

Conferees appearing before the committee:

Secretary Donna Whiteman, Department of Social and Rehabilitative Services
Rep. Carol Sader, Joint Committee on Health Care Decisions for the 90's
Mr. Bob Wunsch, University of Kansas Medical Center
Mr. Harold Riehm, Kansas Association of Osteopathic Medicine
Ms. Joyce Volmut, Kansas Department of Health and Environment
Mr. Harold Perkins, University of Kansas medical student

Others attending: See attached list

Chairman Rochelle Chronister called the meeting to order at 1:32 p.m. The first conferee to appear before the committee was Secretary Donna Whiteman who offered testimony on behalf of the Department of Social and Rehabilitative Services. Secretary Whiteman provided written testimony as well. (See Attachment 1).

Chairman Chronister questioned the closing of a certain Mental Retardation Hospital in the state. Secretary Whiteman stated that information was currently being compiled regarding that very question. Chairman Chronister then informed Secretary Whiteman that the closures were an executive decision and that the Governor should not abdicate the decision. She also said she was requesting the Governor inform Rep. Lowther's sub-committee in consultation with Secretary Whiteman as to which MR hospital should be closed by their February 15 sub-committee meeting.

Secretary Whiteman began her presentation by saying that approximately 522,000 Kansans benefit from the myriad of programs run by SRS. She did raise a concern on how to match money from Medicaid which has doubled in the last four years. Kansas Medicaid has risen from $272 million in FY 1988 to $542 million in FY 1992. She stated that Medicaid and MediKan were two programs which were funded in full by SGF.

Some of the largest increases within the SRS Budget have been in the past five years. Eight programs including Income Support, Medical Services, Cash Assistance, Medical Assistance, Workforce Development, MHRS, and Youth & Adult Services were among those named. Expansions in mandates governing pregnant women and children began in 1989, rising from 1,401 persons to 23,958 in 1993. Secretary Whiteman then stated that in order to insure the quality of services they were providing, they must work to become more efficient given these increases.

There was brief discussion on the KanWork program. Secretary Whiteman said that 70% of monies appropriated for this program goes into day care programs. Secretary Whiteman did voice a concern with regard to this program ; she would like to see an improvement in communications between SRS and the employers. In particular, she cited more defined roles and responsibilities for this group.

Secretary Whiteman concluded her presentation by discussing the FY94 SRS Budget. She showed that the FY 1994 Budget recommended an increase by the Governor for $58.7 million. Also included in that budget was a $700,000 reduction in FY94's youth care projects, as well as some decreases in department administration.

Chairman Chronister then opened the hearings scheduled for **HB 2025, 2029, 2030.** Rep. Carol Sader offered a brief explanation of the aforementioned. (See Attachment 2). Those bills were referred to Appropriations from Rep. Sader's Joint Committee on Health Care Decisions for the 90's.

Mr. Bob Wunsch, University of Kansas Medical Center, offered testimony in support of HB 2025. (See Attachment 3). He said that enactment of said bill would broaden the participation in the program. Mr. Wunsch did state that there was a balloon amendment written to the bill by Mr. Jim Wilson of the Revisor of Statutes. (See Attachment 4).

Mr. Harold Riehm, Kansas Association of Osteopathic Medicine, then testified in support of this bill. (See Attachment 5).

The next proponent of HB 2025 was Joyce Volmut of the Kansas Dept. of Health and Environment. (See Attachments 6). Ms. Volmut also offered testimony to the committee in support of HB 2029. (See Attachment 7).

Mr. Bob Wunsch was again called upon to complete his testimony in further support of HB 2029 and HB 2030. (See Attachments 8 & 10). He referred the committee to a balloon to HB 2029 which was written by Mr. Wilson with the Revisor of Statutes. (See Attachment 9). The balloon called for the fund not only to be retroactive, but also called for an increase from $300,000 to $460,000. This increase would allow the current 30 award rate to increase to approximately 50.

Mr. Harold Perkins, a 2nd year medical student at the University of Kansas School of Medicine, was the final proponent of these bills. He spoke in support of HB 2030. Mr. Perkins said that he was currently $52K in debt and that this bill would eventually decrease said burden. He also said that the bill would permit him to finish school and yet, increase the number of primary care physicians in the state. He further stated that the bill was particularly beneficial to the rural areas, that being the location where many of these physicians are needed.

There being no further business before the committee, Chairman Chronister adjourned the meeting at 3:23 p.m. The next meeting is scheduled for Wednesday, January 20, 1993 at 1:30 p.m.

GUEST LIST

COMMITTEE: HOUSE APPROPRIATIONS DATE: JAN. 19, 1993

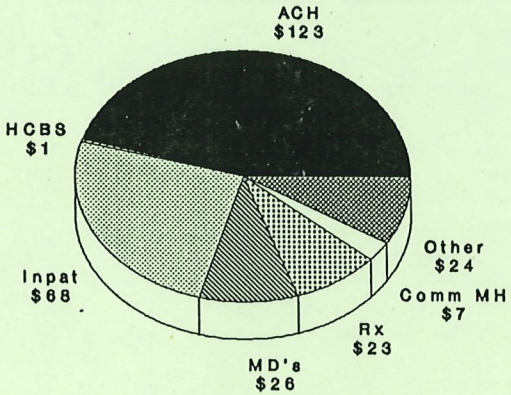
NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Jean Taylor	Topeka	Shawnee County Ad. Counsel agency
Dick Hummel	TOPEKA	Support Systems INT.
Mike Kaufmann	Newton	Friendly Acres
Annette Sibert	Topeka	KAHA
Marie Coones	Olathe	KHCA
Loretta Duitsman	Olathe	KHCA
Kerry Jorgensen	Topeka	Kansas Hospital Assoc
Lisa McDonald	Topeka	KACIL
Michelle Lieber	Topeka	Ks. Gov. Consulting
Roger Fauzke	"	"
Phil Anderson	"	DeptSRS
Greg Tugman	Topeka	DOB
Lisa Unruh	Topeka	DOB
Kristal Turner	Emporia	Intern for Barbara Ballard
Martha Hodgesmith	Topeka	KARF
TK Shuel	Topeka	KS LEGAL SERVICES
Karen Richter	Topeka	KAOM
Gary A. Dugan	"	KS Dept on Aging
Linda Kaminski Clarke	Topeka	KDHR
Bruce Linhos	Lawrence	KALPCCA
Jan Valmut	Topeka	KDHE
Kathy Sexton	DOB	
Amy Abbuhl	Lawrence	Intern for Rep. Minor
Michael Byington	Topeka	Ks. Assn. for Blind + V. I. Inc.
Josie Torrez	Topeka	Families Together, Inc.

GUEST LIST

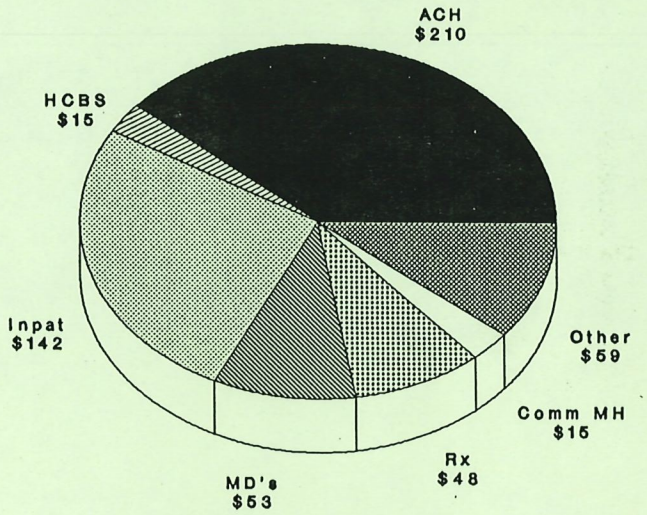
COMMITTEE: HOUSE APPROPRIATIONS DATE:

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATIO:
Kristen Head	Lawerence	Intern for Rep. Edlund
Paul M. Klotz	Topeka	CMHCs Ks, Inc.
Sterly Sanders	Topeka	KS mental Health Coalition
Paul Johnson	TOPEKA	PACK
Donald Hobson	McPherson	Intern. Hon. Rep Heinemann
Bob Wunsch	Lawrence	KDHE

Kansas Medicaid Doubles in 4 Years
Comparision by Type of Service



FY 1988 ($272)



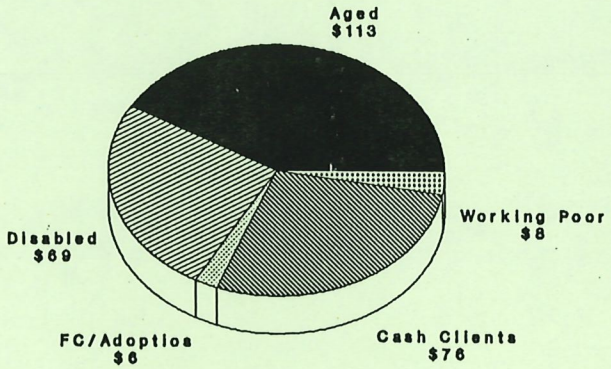
FY 1992 ($542)

JAS 7/12/92 (All $'s In Millions)

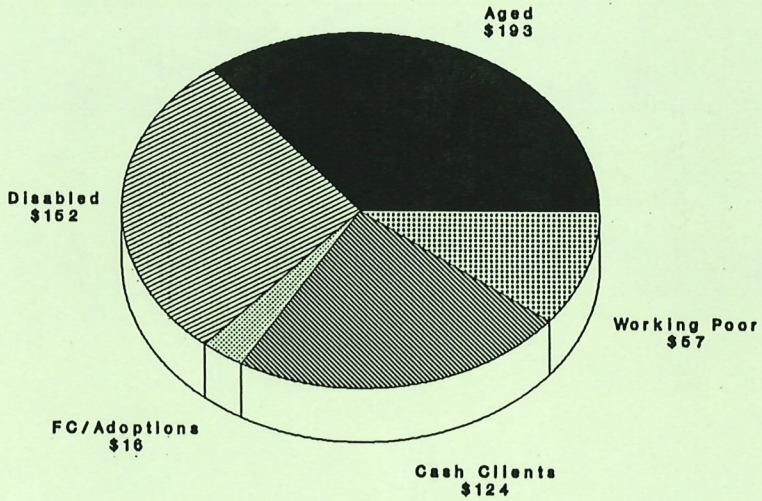
ATTACHMENT 1

ATTACHMENT 1

Kansas Medicaid Doubles in 4 Years
Comparision by Populations Served



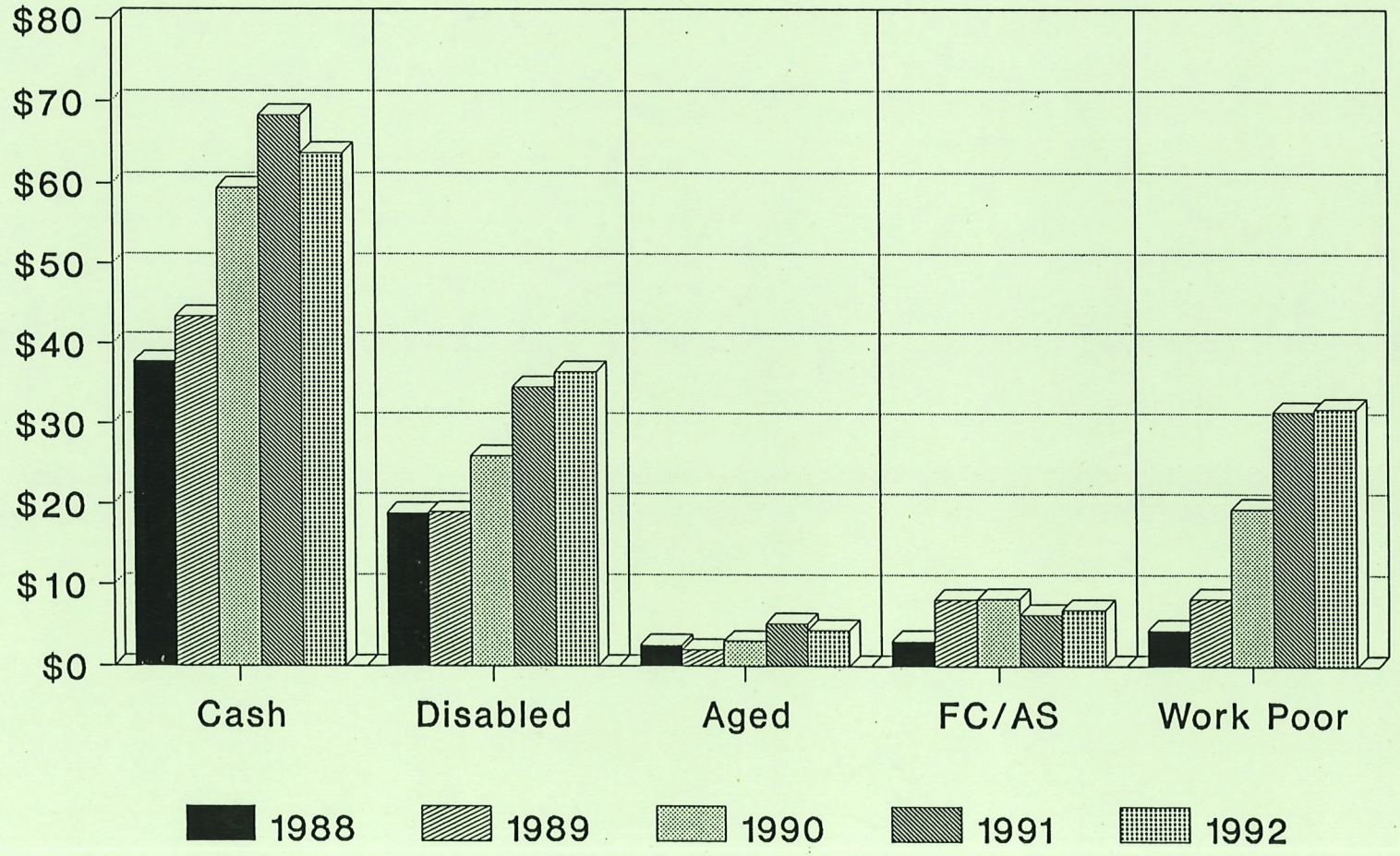
FY 1988 ($272)



FY 1992 ($542)

JAS 7/12/92 (All $'s In Millions)

Use of Inpatient Hospital FY88-FY92
By Population Served



JAS 7/12/92 (All $'s Im Millions)

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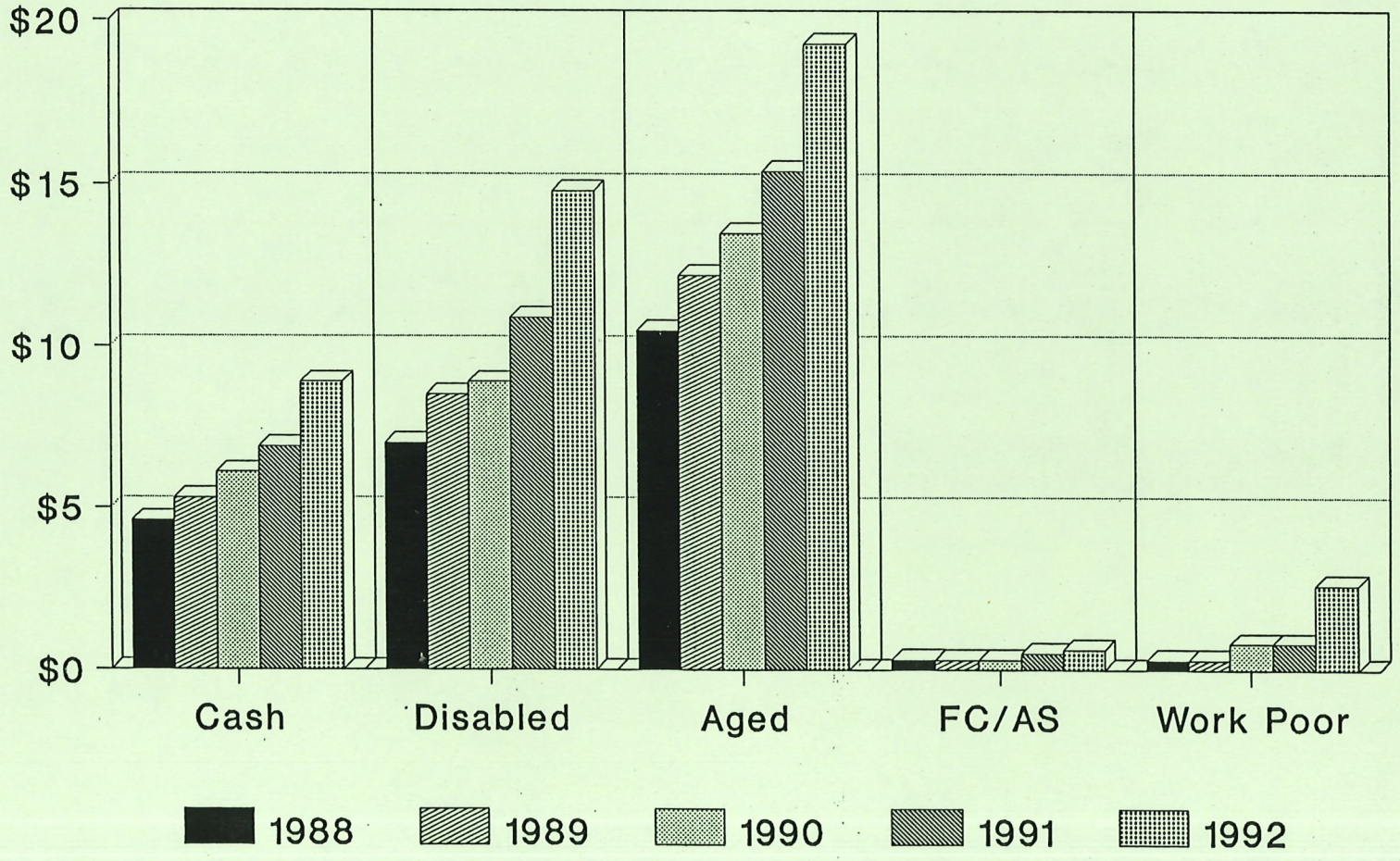
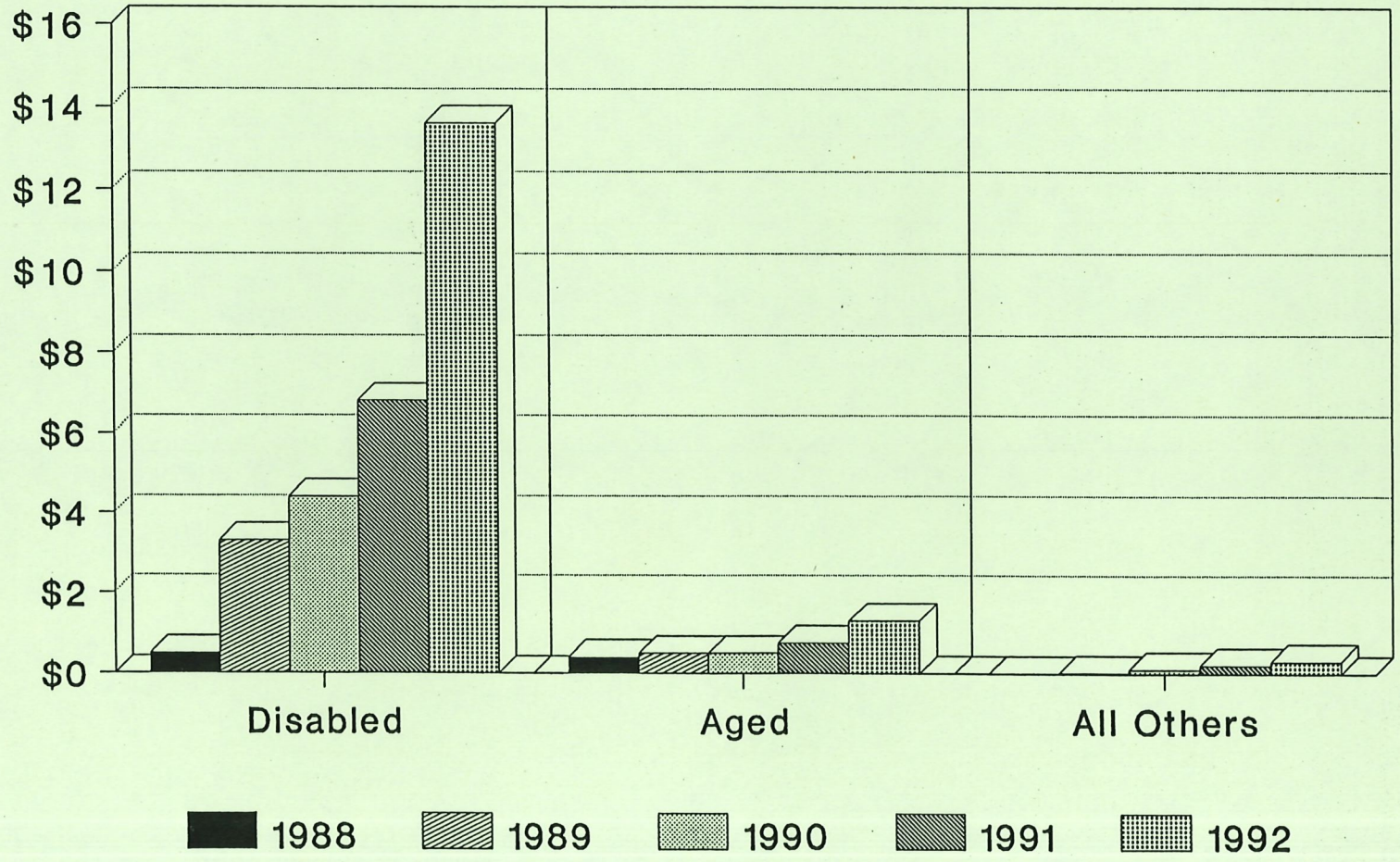
Use of Pharmacy FY 88-FY92
By Population Served



JAS 7/12/92 (All $'s Im Millions)

4-1

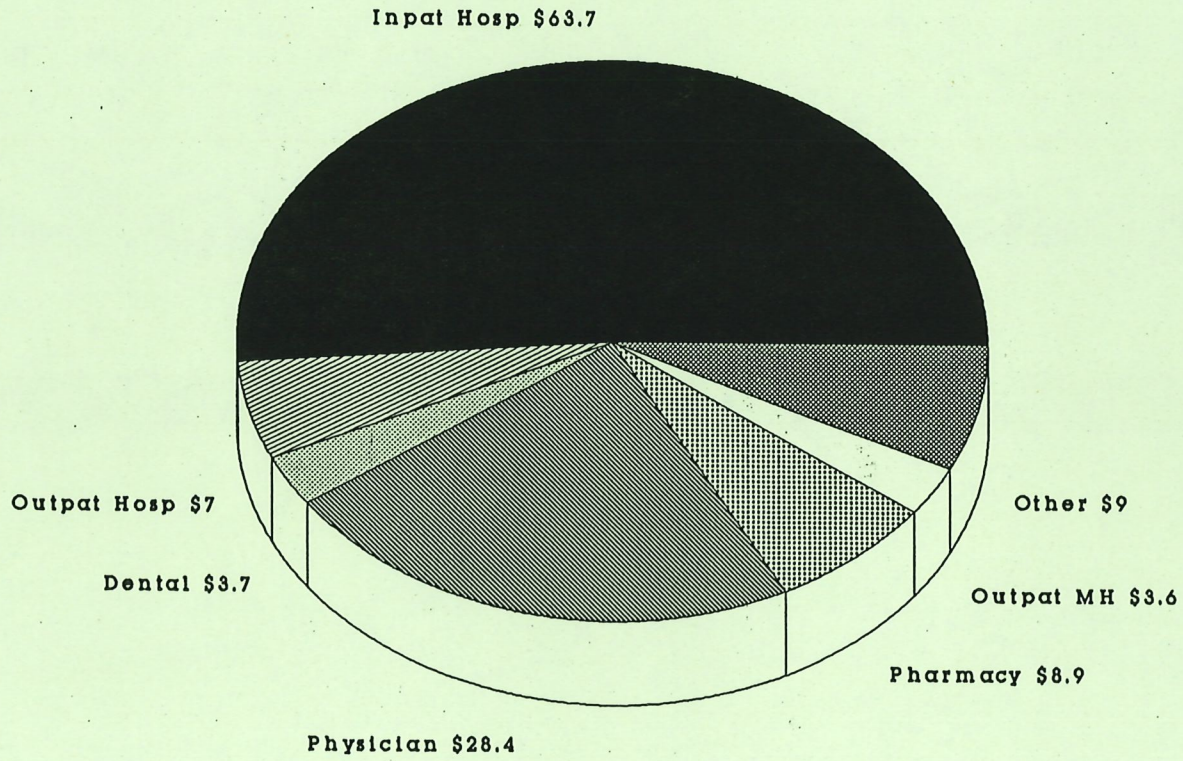
Use of Home/Comm Based Care FY88-FY92
By Population Served



JAS 7/12/92 (Excludes SRS Staff Care)

Medical Svs Used by Cash Clients in FY92

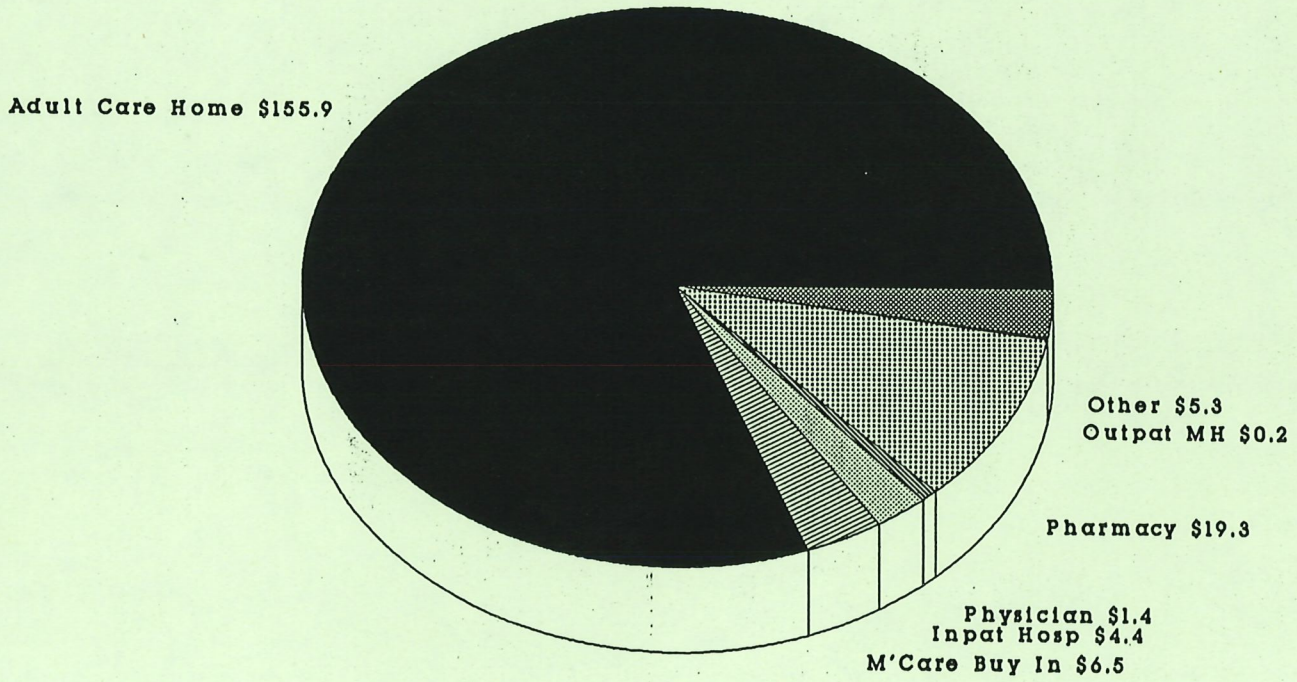
Cash = AFDC, GA, and Refugee Clients



JAS 7/12/92 (All $'s in Millions)

9-1

Medical Svs Used by the Aged in FY92
Aged = SSI Aged and M Needy Aged (No QMB



JAS 7/12/92 (All $'s in Millions)

MAJOR ELIGIBILITY CATEGORIES OF THE KANSAS MEDICAL ASSISTANCE PROGRAM

Kansas Department of Social and Rehabilitation Services
Division of Management Services Budget Office
Based on FY 92 Appropriation as of 3/12/92

AID TO FAMILIES W/DEPENDENT CHILDREN — 1

Anyone receiving AFDC is automatically given a Medical card. Families average well under 12 months on AFDC, particularly two parent ones. The maximum grant in most cases is only $396 per month. This amount is reduced nearly dollar for dollar for earnings, unemployment comp, or other income. Nearly half of all medical expenses involve childbirth/newborn care.

FY 92 Average monthly caseload:	83,000
Number of different persons served:	142,000
FY 92 Average monthly medical cost:	$100
FY 92 Total cost per GBR:	$100,000,000

Top Five Services

Inpatient Hospital	$50,000,000
Physician Services	23,000,000
Prescription Drugs	8,000,000
Outpatient Hospital	5,600,000
Dental Services	3,000,000

SUPPLEMENTAL SECURITY INCOME — 2

Anyone receiving SSI is automatically eligible to receive a Medical card as well. They must apply for the card at an SRS Office for us to be aware aware of their SSI status. A large percent are on Medicare. These individuals seek M'Caid for Nursing Home and Rx expenses.

	Aged	Disabled
FY 92 Average monthly caseload:	7,100	17,300
Number of different persons served:	8,100	21,000
FY 92 Average monthly service cost:	$354	$465
FY 92 Total cost per GBR:	$30,200,000	$96,500,000

Top Five Combined Services

Adult Care Home/HCBS	$17,000,000	$34,000,000
Inpatient Hospital	3,000,000	28,000,000
Prescription Drugs	6,000,000	11,000,000
Physician Services	500,000	7,500,000
CMHC/Psychologists	50,000	6,400,000

FOSTER CHILDREN/ADOPTEES — 3

These are children in the custody of the SRS for a variety of reasons. This also includes approximately 500 children who have been adopted and because of special needs are still being supported medically by the Medicaid program. NOTE: Over 3/4ths of all expenses involve psychiatric care.

FY 92 Average monthly caseload:	5,700
Number of different persons served:	9,600
FY 92 Average monthly service cost:	$205
FY 92 Total cost per GBR:	$14,000,000

Top Five Combined Services

Inpatient Hospital	$5,500,0
CMHC/Psychologists	2,400,0
Rehabilitation (Level 6 Homes)	2,150,000
Physicians Services	1,600,000
Prescribed Drugs	650,000

MEDICALLY NEEDY–AFDC FAMILY — 1a

If a family meets all the criteria for being on AFDC but their income is too great, they may still receive a Medical card. They will need to devote all income above $470 (family of three) toward medical expenses. If they has expenses beyond this, Medicaid will pay them–if they are a covered service. If their monthly income is below $470 their is no requirement that they pay toward a covered service. The $470 figure is known as the Protected Income Level (PIL). The income in excess of this that they must first devote to medical expenses is known as the "spend–down" amount.

FY 92 Average monthly caseload:	3,900
Number of different persons served:	17,000
FY 92 Average monthly service cost:	$128
FY 92 Total cost per GBR:	$6,000,000

Top Five Services

Inpatient Hospital	$3,000,000
Physician Services	1,000,000
Outpatient Hospital	500,000
Dental Services	400,000
Prescription Drugs	300,000

MEDICALLY NEEDY–AGED/DISABLED (SSI) — 2a

If a person meets all the criteria for being on SSI but his income is too great, he may still receive a Medical card. He will need to devote all income above $442 ($30 for ACH client) toward medical expenses. If he has expenses beyond this, Medicaid will pay them–if they are for a covered service.
The vast majority of these people were well covered by Medicare and perhaps a MediGap policy. That is until they entered an ACH.

	Aged	Disabled
FY 92 Average monthly caseload:	14,300	3,900
Number of different persons served:	21,500	8,000
FY 92 Average monthly service cost:	$995	$1,165
FY 92 Total cost per GBR:	$170,700,000	$54,500,000

Top Five Combined Services

Adult Care Home/HCBS	$145,000,000	$37,000,000
Prescription Drugs	15,000,000	4,000,000
Inpatient Hospital	3,000,000	6,000,000
Medicare Premiums	5,900,000	1,500,000
CMHC/Psychologists	100,000	2,200,000

LOW INCOME PREGNANT WOMEN AND CHILDREN — 4

Any of the following persons are eligible, regardless of the families marital situation, upon applying. This population is a product of several progressively more liberal federal OBRA's intended to address this nations poor infant mortality/low birth weight performance.

	If Family Income:	Monthly For Fm
Pregnant Women	< 150% FPL	$1,446
Infants under 1 yr old	< 150% FPL	$1,446
Children ages 1 thru 5	< 133% FPL	$1,285
Children ages 6 and up if born after 9/30/8	< 100% FPL	$964

	Women	Children
FY 92 Average monthly caseload:	3,400	13,000
Number of different persons served:	11,000	31,000
FY 92 Average monthly service cost:	$686	$115
FY 92 Total cost per GBR:	$28,000,000	$18,000,000

Top Five Services

Inpatient Hospital	$29,500,000
Physician Services	11,000,000
Outpatient Hospital	1,400,0
Prescription Drugs	1,200,0
Lab and X–Ray	500,000

AFDC EXTENDED MEDICAL — 1b

The majority of AFDC families who, by obtainting employment are no longer need AFDC assistance, are eligible for a 12 months of transitional Meldicaid coverage. This gives the family time to establish themselves financially. This was a mandated coverage group on the Family Support Act which created the JOBS program. A family does not have to participate in that program in order to receive this transitional coverage.

FY 92 Average monthly caseload:	10,000
Number of different persons served:	25,000
FY 92 Average monthly service cost:	$58
FY 92 Total cost per GBR:	$7,000,000

Top Five Services

Inpatient Hospital	$3,000,000
Physician	1,700,000
Prescription Drugs	700,000
Outpatient Hospital	600,000
Dental Services	400,000

QUALIFIED MEDICARE BENEFICIARY (QMB) — 2b

When Congress created the ill–fated Medicare Catastrophic Care Act it's financing was to come from greatly increased Medicare premiums. To protect the lower income Medicare beneficiary Congress ordered the states Medicaid program to pay these higher premiums for poverty–level persons. While the MCCA was repealed, this provision was not. We now pay the Medicare premiums, deductibles, and co–payments for anyone below 110% of the federal poverty level. This is a monthly income of $624.

FY 92 Average monthly caseload:	2,400
Number of different persons served:	5,000
FY 92 Average monthly service cost:	$52
FY 92 Total cost per GBR:	$1,500,000

Breakdown of ald:

Medicare Premiums	$1,100,000
Inpatient Copay/Deductible (Part A)	130,000
Outpatient Copay/Deductibles (Part B)	270,000

MEDICAID AND MEDIKAN FOR GEN ASST CLIENTS — 5

There are two populations on the GA Cash Assistance program. First are families who, while poor, cannot qualify for AFDC due usually to the presence of two parents in the home. All children in these families, as well as all pregnant women, are MEDICAID clients.
The larger group are individuals who are disabled for 30 days or more who do not yet have a decision regarding permanent federal disability status. These are MEDIKAN clients.

	Disabled	Family
FY 92 Average monthly caseload:	4,400	2,400
Number of different persons served:	10,000	6,600
FY 92 Average monthly service cost:	$436	$153
FY 92 Total cost per GBR:	$23,000,000	$4,400,000

Top Five Services

Inpatient Hospital	$14,000,000	$1,500,000
Physician	3,000,000	1,000,000
CMHC/Psychologists	2,000,000	200
Prescribed Drugs	1,500,000	3
Outpatient Hospital	700,000	5

8-1

JAS 3/12/92 123R3/RSCH9293/MED/ELGGRID3

Department of Social & Rehabilitation Services
Medicaid Pregnant Women & Children
FY 1989 – FY 1994

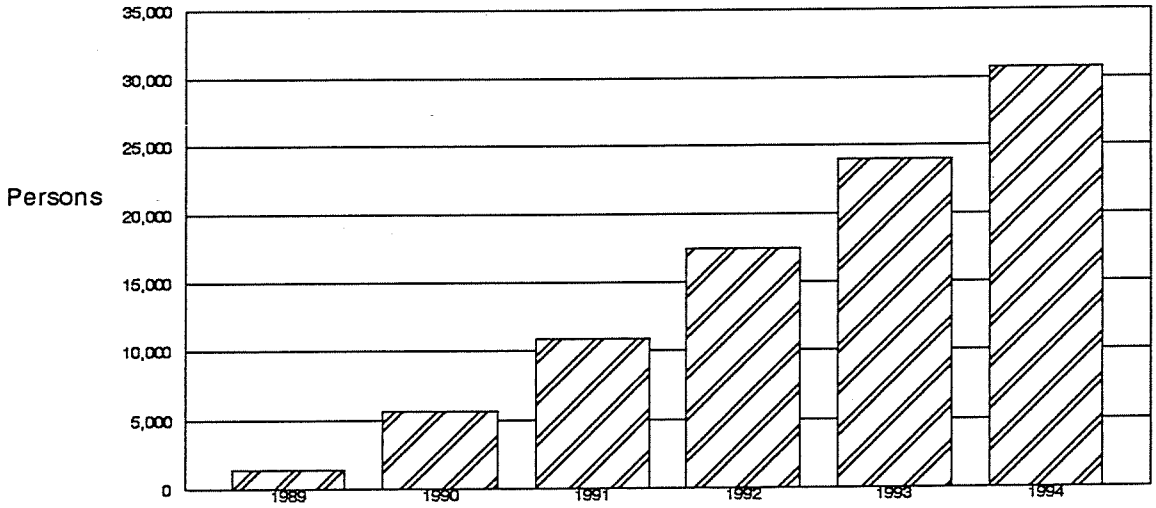
History of Participation and Expenditures

	Children		Pregnant Women & Infants		Total	
FY	Persons	Expenditures	Persons	Expenditures	Persons	Expenditures
1989	na	na	na	na	1,401	3,244,385
1990	na	na	na	na	5,657	18,204,302
1991	na	na	na	na	10,924	32,208,557
1992	10,099	5,454,100	7,377	35,907,909	17,477	41,362,009
1993	14,813	8,176,776	9,145	43,364,414	23,958	51,462,500
1994	20,014	11,287,896	10,669	53,529,622	30,683	71,500,000

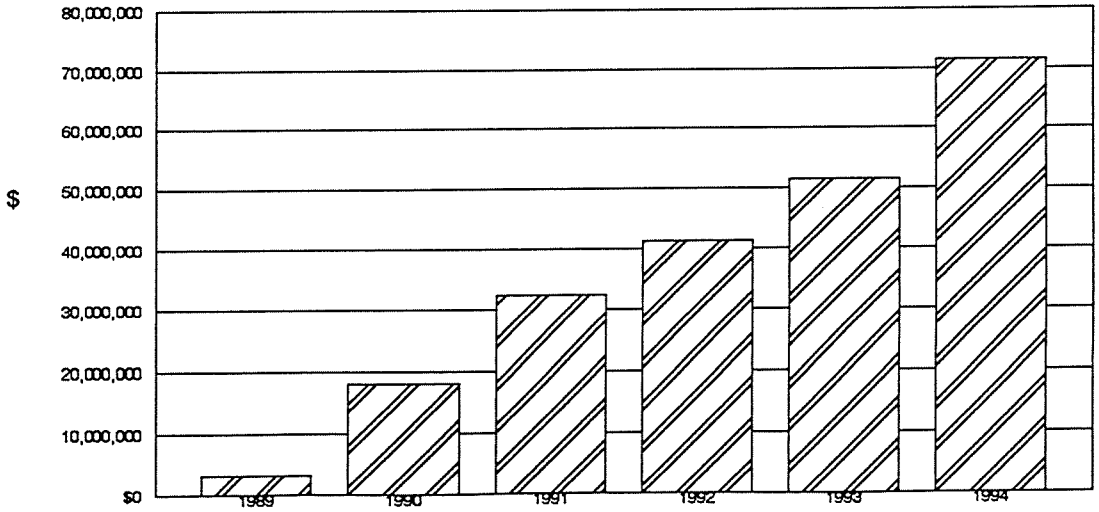
Federally Required Coverage

	Family Income
Pregnant Women & Infants	< 150% FPL
Children ages 1–5	< 133% FPL
Children 6 and over if born after September 30, 1983	<100% FPL

Participation



Expenditures



Department of Social & Rehabilitation Services
Medicaid Pregnant Women & Children
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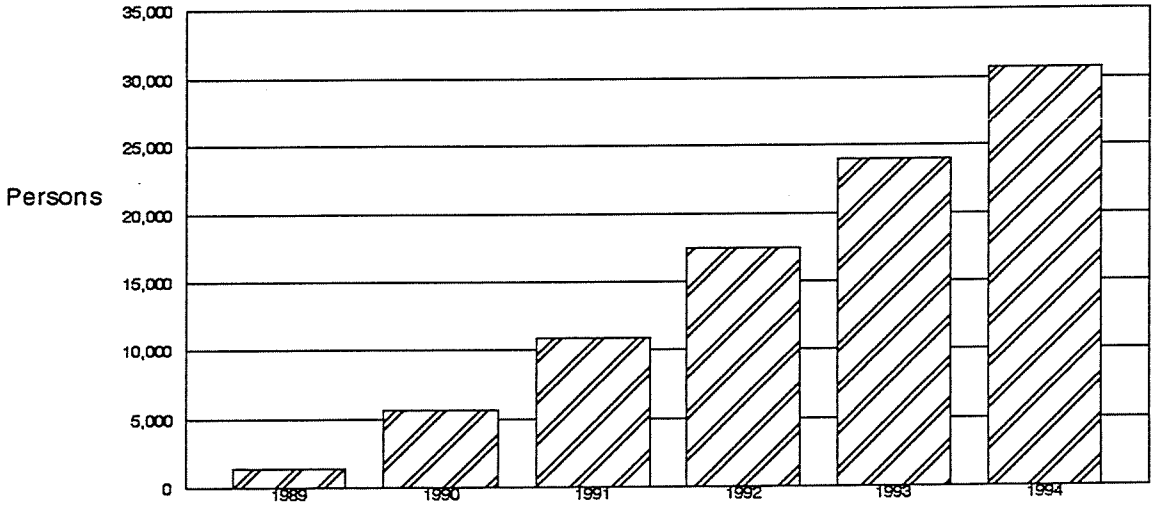
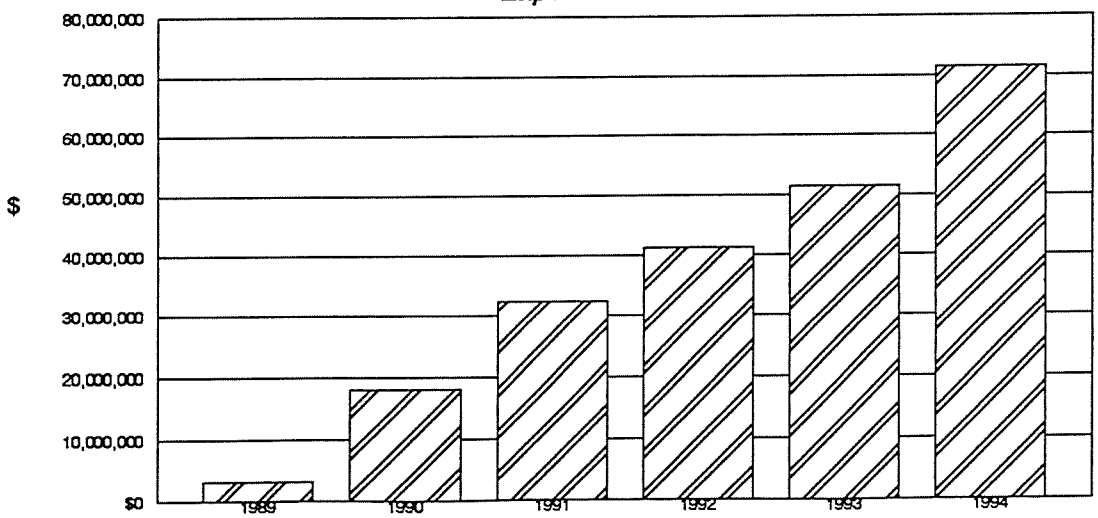


Expenditures



JOAN FINNEY, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

DONNA WHITEMAN, SECRETARY

LEGISLATIVE TESTIMONY ON AGENCY PROGRAMS AND ISSUES
January 19, 1993

Prepared for the House Appropriations Committee

I. LARGE INCREASES IN SRS' BUDGET IN THE PAST 5 YEARS

Major Changes in SRS Expenditures
FY 1989 - FY 1993
(in millions)

Program	FY 1989	FY 1990	FY 1991	FY 1992	GBR FY 1993
Department					
Income Support	30.8	33.0	36.1	34.7	38.8
Medical Services	21.8	25.7	25.7	29.6	35.6
Cash Assistance	127.9	135.3	134.7	144.6	159.0
Medical Assistance	325.0	409.7	485.7	542.8	637.3
Workforce Development	19.4	22.2	22.6	31.5	51.3
MHRS	28.1	33.1	49.4	54.3	63.1
Youth & Adult Services	70.9	83.0	79.3	92.0	94.2

1989 to FY 1993 Summary

Increased Medical Assistance Expenditures
The major expenditure increase during the period under review lies in the Medical Assistance program. Increases in Medical Assistance costs have been dominated by four factors which, taken together, account for 2/3 of the Medical Assistance increase from FY 1989 to FY 1993:

- Federally mandated coverage of pregnant women & children
- Growth in the number of the disabled served
- Aid to Families with Dependent Children growth (AFDC)
- Nursing Facility Rates

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
LEGISLATIVE TESTIMONY ON AGENCY PROGRAMS AND ISSUES
Prepared for the House Appropriations Committee
January 19, 1993

Expansions in mandates governing pregnant women and children (PW&C) began in 1989. The purpose of the Medicaid mandates was to relieve working families from high medical deductibles and to further prevention. The cost of this population since its inception is estimated to exceed $210 million at the conclusion of FY 1994.

FY	PW&C Persons	Expenditures	% Change	% Increase from FY 1989 to FY 1993
1989	1,401	$ 3,244,385		
1990	5,657	18,204,302	461.1%	
1991	10,924	32,208,557	76.9%	
1992	17,477	41,362,011	28.4%	
1993	23,958	51,462,500	24.4%	1486.2%

In contrast to the stabilizing growth in the Pregnant Women and Children population, the growth in the SSI Disabled population is accelerating. The reasons for the rapid growth in this federally mandated population center on four factors:

- a more lenient acceptance policy on the part of the Social Security Administration
- outreach efforts by the Social Security Administration
- the recent Zebley court decision, which established special conditions for determining a child's disability
- increased applications during economic downturns

The number of participants is expected to increase by 52% from FY 1989 to FY 1993.

FY	SSI Disabled Persons	Expenditures	% Change	% Increase from FY 1989 to FY 1993
1989	13,623	$35,626,018		
1990	14,430	45,438,819	27.5%	
1991	15,800	53,579,860	17.9%	
1992	17,635	60,422,646	12.8%	
1993	20,667	73,656,000	21.9%	106.7%

The recent growth in AFDC medical population mirrors the growth exhibited in the Cash Assistance program, as AFDC recipients are automatically eligible for Medicaid. The AFDC caseload is determined by three general factors: the economy, demographic changes, and policy changes. Of these factors, the economy has been the most prominent factor in the increasing AFDC caseload. From FY 1989 to FY 1993, the caseload is expected to increase by 21%.

FY	Persons	Expenditures	AFDC % Change	% Increase from FY 1989 to FY 1993
1989	70,931	$ 65,902,618		
1990	76,586	83,555,046	26.8%	
1991	76,627	93,019,779	11.3%	
1992	81,623	94,643,803	1.7%	
1993	85,768	101,593,397	7.3%	54.2%

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
LEGISLATIVE TESTIMONY ON AGENCY PROGRAMS AND ISSUES
Prepared for the House Appropriations Committee
January 19, 1993

The fourth major area of increase lies in the nursing facility budget. A vivid contrast between participation and rates emerges when the period FY 1989 to FY 1993 is considered. Nursing facility residents increased by 16.4%; in comparison total expenditures increased 58.4%.

FY	Monthly Persons	Monthly Cost	Expenditures	Percent Increase	% Increase from FY 1989 to FY 1993
1989	11,632	$ 847	$118,200,451	11.4%	
1990	12,348	924	136,955,269	15.9%	
1991	13,093	978	153,679,258	12.2%	
1992	13,460	1,073	173,329,702	12.8%	
1993	13,544	1,143	187,259,585	7.0%	58.4%

Foster Care Growth
Foster care costs increased by $21.7 million from FY 1989 to FY 1993. During this period, an increasing proportion of placements have occurred in emergency and high care level settings. The actions of the 1992 Legislative Session to shift the emphasis to community and in-home treatment are reflected in the FY 1993 expenditure reduction.

FY	Foster Care Children	Expenditures	% Change	% Increase from FY 1989 to FY 1993
1989	3,192	$26,128,615		
1990	3,842	33,061,222	26.5%	
1991	4,287	39,241,654	18.7%	
1992	4,785	45,317,975	15.5%	
1993	5,170	47,840,633	5.6%	83.1%

Institutional Costs
The department continues to move toward deinstitutionalization to allow adults and children to live in their own communities. Progress in Mental Health Reform and community mental retardation services has contributed to recent reductions in the state hospital budgets. Despite this progress, the cost of institutionalization still accounts for 12.6% of the total agency budget in FY 1993. The following table presents the combined cost of the state hospitals and youth centers.

FY	Institutional Expenditures	% Change	% Increase from FY 1989 to FY 1993
1989	$155,094,371		
1990	167,124,081	7.8%	
1991	174,439,382	4.4%	
1992	173,384,654	-0.6%	
1993	171,860,590	-0.9%	10.8%

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II. PROBLEM AREAS IN THE CURRENT YEAR BUDGET AND THE FY 1994 BUDGET

Rehabilitation Services

Issue 1:
Increased demand for services

There is a shortage of funds for individualized case services, coupled with an expected increase in costs for these services. The expected increase in costs is due to the increasing federal emphasis on serving persons with severe disabilities, who often require more lengthy and expensive services, and increasing demands from persons in previously unserved or underserved disability groups. These groups include persons who are deaf or hard of hearing, persons with severe and persistent mental illness, persons with traumatic brain injury and persons with autism. In SFY 1992, Rehabilitation Services provided services for 9,820 people with disabilities, only about nine percent of the estimated 108,000 adult Kansans with disabilities that impact employment.

In accordance with the federal Rehabilitation Act, if the agency determines that all eligible persons who apply cannot be served, the agency must prioritize service delivery through an Order of Selection procedure. Generally, clients would be assigned to one of several priority categories, with the highest priority reserved for those with the most severe disabilities. Purchased services, such as training and physical/mental restoration, generally would not be available for clients in the lowest priority categories. Categories could be opened or closed for services, depending on the level of available resources.

Issue 2:
Kansas Industries for the Blind becoming self-sufficient

Making its production component self-supporting is a major goal for Kansas Industries for the Blind. Effective December 1, 1992, KIB became the sole source provider of new and recycled EPS laser printer cartridges used by state government. This contract, and its consistent use by state purchasing authorities, will be a major step toward self-sufficiency for KIB.

Income Support and Medical Services

Issue 1:
Rapid Caseload Growth

The national caseloads for the AFDC and Food Stamp programs hit a new all time high in March 1992 and have continued to increase. In Kansas the cash, medical and food stamp caseloads have also followed this national trend. This growth is due in part to the recession, including the loss of skilled and unskilled jobs forcing those with less education or training to become dependent on assistance programs (see attached on caseload growth.)

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Issue 2:
Assistance Payment Levels

Because of assistance levels which have failed to keep pace with inflation, the purchasing power of Kansas' poor has steadily declined. In 1975 Kansas AFDC benefits for a family of three comprised 75% of the federal poverty level; since then AFDC benefits have declined to 41%. The poor are being faced with choices such as feeding their children or heating their homes. (See attached Comparison of Kansas AFDC Benefits vs. the Poverty Level.)

Issue 3:
Shifting from Institutional to Community Services

Community based services versus institutional services are a goal of the Department and the funding must shift from the institutional services to community services.

Issue 4:
Inadequate Primary and Preventive Care for Children

Services for the elderly and disabled consume most of the expenditures, when preventive and primary care will be most effective for the younger population. There should be a shift in funding to the younger population for preventive and primary care.

Issue 5:
Lack of Resources to Implement Money-Saving Initiatives and Federal Mandates

Medical Services is unable to expand initiatives which will save the Department money in the Medicaid program, such as third party liability, contract oversight and managed care, because of the inability to secure additional staff for these initiatives.

The Child Support Enforcement Program is currently unable to meet federal performance mandates in the areas of paternity establishment, modification of support orders, and the establishment and enforcement of medical support. A federal audit finding and proposed sanction of 1-5% of federal AFDC funding are anticipated in the coming year. Meeting these mandates will require additional staffing resources and enhanced computer support. Resources to implement corrective action have been proposed.

Issue 6:
Lack of Data to Manage Medical Assistance

The current claims processing system which is the data base for decision making is outdated and should be updated to provide timely and detailed information needed to closely manage the medical program. Initiatives such as managed care cannot be designed and implemented without such monitoring tools.

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Youth and Adult Services

Issue 1:
Number of Children in SRS Custody.

The SRS Family Agenda was designed to ultimately reduce the number of children in custody. Major portions of it are in the process of being implemented. In addition, staff have been added to the Central Office on a temporary (one year) basis to assist the Area Offices and Youth Centers in implementing the Agenda and reducing the number of children in custody. Other strategies include training or guardians ad litem, county attorneys, judges, and other key players in the system.

Issue 2:
Scope of the Kansas Code for the Care of Children

Kansas had one of the broadest Codes in the country in bringing children into SRS custody. S.B. 689 proposed changes which would have limited access. There was significant response from the Judiciary which was not resolved in joint meetings since the last session. The Department is now working jointly with the Office of Judicial Administration to identify judicial districts with the most significant problems of children entering custody without reasonable efforts being made. When this is completed, decisions about revisions in the proposed statute and movement forward will be made.

Alcohol and Drug Abuse Services

Issue 1:
Earlier intervention strategies

ADAS' emphasis is on providing alcohol and drug treatment and recovery services to women, children and families. In Fiscal Year 91, the criminal justice system was the referral source for 53.1 percent of all admissions to Kansas treatment programs. This is an increase of 5.3 percent over 1990. About half of these admissions were to ADAS-funded treatment facilities. Of that total, 55 percent were referrals from criminal justice. Referrals from this system mean there has been a late intervention in a person's addiction. The earlier the intervention into a person's addiction, the better the chances for successful recovery. ADAS has developed several strategies to encourage earlier interventions and referrals from the SRS system, health professionals and schools systems.

Issue 2:
Additional treatment resources for women and children

Six specially-designed women and children's treatment centers have been developed and two additional ones will open in 1993 in Pittsburg and Hoisington. Additional services for women and children are being requested through new Federal Alcohol and Drug Block Grant funds in Fiscal Year 94.

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An alcohol and drug counselor, with linkages to a SRS-funded treatment center, has been placed in the Wyandotte, Topeka and Wichita Health Departments.

A pilot project is underway with the Wichita SRS Office, the Northeast Drug and Alcohol Referral Treatment Program and community-based treatment facilities. A counselor will be placed in the area office to assess and refer individuals and families to treatment. The goal is to replicate this project in most SRS Area Offices.

A Secretary's Conference on HIV, Primary Health Care and Substance Abuse is being planned for 1993 in cooperation with the Kansas Department of Health and Environment.

Workforce Devlopment Division, Employment Preparation Services

The Employment Preparations Services' problem areas that have been identified by central office, field and audit staff and independent evaluators are not uncommon to new governmental programs. Other JOBS programs across the nation are similarly challenged. Identified problems and solutions are as follows:

Issue 1:
Roles and responsibilities of all participating agencies and organizations must be clearly defined and understood by all.

SRS, in conjunction with agencies participating in KanWork, will more clearly define the roles and responsibilities of all.

Issue 2:
Lack of agreed upon mission, vision and goals, with defined outcomes.

SRS, in collaboration with DHR, is in the process of developing a clear mission and vision of KanWork, with defined outcomes, and agreed upon by the Governor, Legislature, and participating agencies.

Issue 3:
A management information system is needed.

A management information system that will accurately evaluate the programs, provide information requested by State and Federal agencies, and provide clear evidence of desired outcomes will be implemented in 1993.

Issue 4:
A valid job readiness indicator is needed.

Job readiness indicators that more accurately determine a participant's employability status are currently being developed.

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Issue 5:

Strengthen the link between education, training, and employment.

The means for enhancing private-sector involvement in providing training and other opportunities is being developed. The model created in Wichita (CESSNA Corporation) to move participants from on-the-job training to assured employment provides a good basis for further initiatives of a similar nature.

Issue 6:

Strengthen the monitoring and oversight capabilities of the KanWork Interagency Coordinating Committee.

The monitoring and oversight capabilities of the KanWork Interagency Coordinating Committee are being strengthened by increased involvement in the development of the KanWork program through the use of sub-committees.

Issue 7:

Educational deprivation is more prevalent among KanWork participants than was originally anticipated.

In order to meet the challenge of providing adult education to more participants than was originally anticipated, there needs to be enhancement of interagency coordination for the provision of relevant educational services to meet the needs of participants and their families, and increased funding for these additional services must be secured.

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Mental Health and Retardation Services

CHILDREN'S MENTAL HEALTH NEEDS

Issue 1:
Lack of child/family centered and community based system of care providing an alternative to out of home placements.

Revise policy and funding practices to change reliance on institutions and establish regional or local systems of care where resources can be developed and coordinated among those responsible for children's services.

Issue 2:
Lack of collaboration in providing child and family services.

Support for and collaboration among regional interagency councils established by HB 3113, the Corporation For Change, and the Blueprint For Investing In The Future of Kansas Children and Families. Establish wraparound service capability in Kansas communities as needed.

Issue 3:
Incentives for institutionalization of children, such as local school districts not being responsible for costs of education when a child is placed in a state institution.

Revise statutory policy to keep school districts financially responsible for children placed in state institutions.

Issue 4:
Lack of resources in rural communities.

Amend Mental Health Reform Act to include funding for services to children in the Larned State Hospital catchment area.

SERVICES TO PERSONS WITH DUAL DIAGNOSES (SERIOUS MENTAL ILLNESS AND CONCURRENT SUBSTANCE ABUSE)

Issue:
Lack of specialized services for individuals who have both mental illness and substance abuse.

Develop a mechanism to identify treatment needs of individuals with mental illness/substance abuse.

Develop specialized training for staff working with clients in state-funded programs.

Continue developing plan for community-based programs to supplant the Larned State Hospital and Osawatomie State Hospital substance abuse programs.

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Identify a "target population" with SRS Commission on Alcohol and Drug Abuse Services to consistently project service and resource needs.

VOCATIONAL SERVICES

Issue 1:

We need to help people get and keep real jobs.

Establish vocational services as a central office priority. This is in progress through office reassignments.

Issue 2:

Barriers to work activity include the potential loss of Medicaid coverage, especially for medication, the lack of transportation, the lack of funding, and the disincentives to work activity for people on SSI and SSDI disability benefits.

Collaborate with Rehabilitation Services to match federal funds for vocational services including transportation and medication. Work with other agencies to reduce disincentives to work.

QUALITY ASSURANCE

Issue:

The quality assurance process for state-funded mental health services does not involve consumer or local community agency review to any significant degree.

Include participation of consumers, families, and peer reviewers in program quality review. Increase scope of surveys to increase input from consumer/advocacy groups and others such as law enforcement, schools, public agencies.

DATA & REPORTING

Issue:

The lack of an adequate information system in client data reporting prevents an accurate count, tracking, and coordination for persons receiving services in the mental health system and another system such as mental retardation, substance abuse, or special education. An unduplicated count of clients is necessary to appropriately plan coordinated services and allocate funding.

Continue development of the federally funded Mental Health Statistical Improvement Program as the data reporting system to be consistent with special education and mental retardation systems. Integrated reporting will allow us to tie client services to costs and identify persons with multiple needs or high utilization.

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COMMUNITY BASED CRISIS CARE

Issue 1:

Substantial numbers of persons (adults and children) with mental retardation and substance abuse disorders are inappropriately hospitalized because there are few community-based crisis services in the substance abuse system and none in community mental retardation system.

Increase availability of attendant care, home based crisis services, and respite care.

Issue 2:

Children and adults are often placed in overly restrictive settings (such as hospitals) during periods of crisis.

Increase flexible funding for intensive community-based crisis services such as attendant care.

Assess whether Medicaid reimbursement for attendant care should extend to agencies or individuals other than community mental health centers.

HOUSING

Issue:

The lack of affordable, decent housing in integrated settings is a major barrier to including individuals with serious mental illness in the normal fabric of society.

Continuation of mental health reform to increase local development of supports necessary to help individuals live in natural settings.

Reassign central office staff to allow greater focus on the development of supported housing.

Increase contact with federal (HUD), state and local housing authorities to increase the development of non-congregate, integrated and supported housing.

NURSING FACILITIES/MENTAL HEALTH (NFs/MH)

Issue:

Kansas has approximately 1,200 beds in NFs/MH supported primarily by SGF, yet most individuals with serious mental illness do not need nursing homes unless they have an overriding medical condition requiring this level of care.

Continuation of mental health reform to increase local development of supports necessary to help individuals live in natural, non-congregate settings.

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Develop a plan to describe the policy decisions necessary to move individuals residing in these facilities into community settings with sufficient supports.

Reassign Central Office staff to allow greater concentration in this area.

HUMAN RESOURCE DEVELOPMENT

Issue:

The goal of meeting client needs in community settings is largely dependent upon the availability, composition, competency, utilization, and stability of the workforce.

Continue development of a strategic plan by the Human Resource Development Committee of the Governor's Planning Council for Mental Health to assure critical manpower issues are identified and addressed.

HIGH RATE OF HOSPITALIZATION

Issue 1:

Historically, Kansas has had one of the highest rates of hospitalization for children and adults with mental or emotional illness. The high cost of this restrictive level of care has limited the resources necessary to develop community-based services.

Screening admissions to state hospitals and Medicaid psychiatric admissions to general hospitals have eliminated inappropriate admissions. Screening for alcohol and drug treatment programs at Larned State Hospital and Osawatomie State Hospital currently is being developed.

Issue 2:

Medications are cost effective compared to hospitalization, but the high cost, especially for clozapine, restricts access for some patients who could potentially benefit from its use and be subsequently discharged.

Increase access to state of the art medications such as clozapine.

HIGH COST OF MEDICATION

Issue:

The working poor often have insufficient resources to pay for medication while trying to meet a spenddown to become Medicaid-eligible.

Earmark funds for clozapine for clients in the community otherwise unable to afford the medication.

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EROSION OF FEDERAL FUNDS

Issue:

The Alcohol, Drug Abuse and Mental Health Services block grant (the second largest single Federal funding stream for community mental health services) has been revised for Federal FY 93. Kansas will be receiving significantly less Federal funds:

The table below illustrates the erosion in Federal funds.

FFY 1991	$2,136,057
FFY 1992	$2,359,124
FFY 1993	$1,824,722

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III. PUBLIC EPXECTATIONS AND PROPOSALS TO IMPROVE SERVICE

Rehabilitation Services

Rehabilitation Services policy has been modified recently to reflect the intention to provide services in the most cost-effective manner in order to prepare the client for suitable employment that is consistent with his or her capacities and abilities. This focus on jobs with a career track, instead of entry-level employment, responds to consumer input and should help reduce client recidivism.

Income Support and Medical Services

Income Maintenance

The public expects the agency to provide quality services to the citizens of Kansas while conserving state resources. Clients expect timely service of acceptable quality and quantity. To that end the agency has taken steps to develop efficient support systems and to maximize federal funding. Several examples include:

As discussed above, development of computer systems which allow caseworkers to determine eligibility more rapidly and to share information electronically between programs.

Utilized new optional provisions within the AFDC program which allowed the state to claim federal match for some costs which had previously been covered totally by state funds.

Refocused the emergency assistance program to provide services to help prevent children from being removed from their home. This will allow the state to receive federal match for many of the preventive services the state provides.

Medical Assistance

The public in general expects that SRS will control the expenditures for medical services without any reductions that affect them individually such as reductions in eligibility, services, freedom of choice or reimbursement rates.

Providers expect equitable and timely reimbursement for services provided. Many also expect that SRS should secure the resources necessary to meet their expectations for reimbursement.

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Child Support Enforcement

The more effective the Child Support Enforcement Program becomes, the greater expectations become. The public expects the program to enforce parental responsibility and reduce the tax burden. Custodial parents expect support to be collected and processed quickly, and support orders to be reviewed regularly and modified as appropriate. Non-custodial parents expect fairness and responsiveness to their individual situations. With an ever increasing caseload and rising expectations from the public and federal government, an ever greater commitment of resources is required.

Not all of these expectations can be achieved. The provision of assistance and reimbursement for services is a partnership between the clients, providers and governmental agencies. Each should understand the other's problems and not expect that government will be the solution to all problems. Only if all of the interested parties work together will the problems be resolved.

Youth and Adult Services

Youth and Adult Services has goal is to be more responsive to children, families, foster parents, and other in the children and family service delivery system. However, it is our expectation that the increased resources available to us will enable us to be more "family friendly." A more thorough assessment process based on family strengths should improve the impressions we leave with families and other key players in the system and should enable us to be more supportive of families.

In the adult programs, it is our hope that our continued work with other Commissions and KDHE and Aging will result in elimination of fragmentation and duplication in services to adults.

Alcohol and Drug Abuse Services

ADAS' goal is to set a course for the State's alcohol and drug program. Leadership includes providing research-based information, data and program models; and statewide planning and evaluation.

Workforce Development, Employment Preparation Services

To assure the public that EPS is using state and federal dollars wisely:

* There must be coordination between participating agencies for the provision of quality, cost-effective services to participants.

* SRS must effect the reduction in the growth rate of the number of cash assistance recipients and lower the aggregate cost of cash assistance through the provision of services leading to employment and avoidance of long-term dependency.

* EPS must have data systems that evidence desired outcomes.

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* EPS must have improved assessment tools in order to ensure that barriers such as chemical dependency and learning disabilities are identified and time and resources are spent on participants who are appropriate for the programs.

* Participants must have timely, individualized services and the training and support of their choice to enable them to support their families without cash assistance.

* SRS must make available to employers a pool of qualified workers and qualification for monetary incentives such as targeted job tax credits and on-the-job training subsidies.

Mental Health and Retardation Services

Adults with severe and persistent mental illness and children/adolescents with severe emotional disturbances and their families are the targeted populations for the State mental health authority. These constituent groups expect:

- to have meaningful participation in all areas of policy and program development, implementation, and evaluation.

MH&RS has developed mechanisms to include consumer and family representation on the Governor's Mental Health Services Planning Council, grant review committees, and other policy groups.

- to have the opportunity to implement consumer-run/self-help programs.

Six new consumer-run programs have been implemented with the funding provided in 1992.

- to receive the support and assistance necessary to live in decent, affordable housing; to be engaged in competitive employment; and to develop friendships.

Community-based support services have been expanded through Mental Health Reform, revised community mental health center licensing regulations, and grants to local mental health providers.

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Mental Retardation and Developmental Disability Services

Support and funding for services to persons who are MR/DD currently being served should be maintained.

The number of persons who are MR/DD waiting for community services should be reduced.

A people first value system which encourages generic or integrated, inclusionary nonfacility based services should be used in program service development and funding rather than supporting segregated specialized services. For example:

1. Families and individuals should be empowered by paying nuclear families or individuals directly when possible. If a natural family can not support their child a surrogate family should be secured. All children should be served in families not in group homes or institutions.

2. Funds should be available to wrap services around individuals. Service development and funding allocations should support individuals not fund facilities and agencies.

3. Reliance on State MR/DD hospitals and large ICFs/MR should be reduced.

4. Universal service coordination should be provided independent of direct service providers.

5. All persons with developmental disabilities should be served and not just those with mental retardation.

6. Quality services should be provided.

7. Direct service staff should be sufficiently trained and adequately paid.

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IV. AGENCY EMPHASIS AND GOALS

Rehabilitation Services

The major focus of Rehabilitation Services is to provide employment and independent living services for Kansans with disabilities. Programs emphasize consumer choice and involvement, community-based services and integration. Individualized services are paid for through case service funds (SGF match of federal vocational rehabilitation dollars).

Income Support and Medical Services

The agency has placed priority on prevention including those programs which encourage self-sufficiency. To that end an agency task force has been established to look at public assistance and child support programs with the goal of identifying areas of change in order to decrease long term dependency. The work of this group will not be complete in time for this session but is part of our strategic plan for the next several years.

Goals for the Medical Assistance program include the expansion of preventive and primary care, the transition to community based services, expansion of cost effective administrative initiatives and managed care.

Youth and Adult Services

Pursuit of the Family Agenda remains the highest priority of Youth and Adult Services, training and information system capacity and staff coverage at the Youth Centers. The next priority for the Commission is increased attention to the Commission's responsibility for adults, both the specific programs assigned to the Commission and overall leadership for adult issues.

Alcohol and Drug Abuse Services

Developing innovate, quality program strategies to better serve women, children and families.

Besides the women and children treatment facilities, ADAS is working with existing community-based treatment programs to develop new strategies to serve the family and not just the addicted person. This includes continuing care services for at least a year once an individual has received primary treatment. Recovery involves improvement in all aspects of a person's life: employment, legal, psychological, medical and social. SRS is requesting spending authority for $900,000 in new Federal Block Grant funds for two women and children's treatment programs and related services.

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Providing community-based prevention approaches.

A 1991 Legislative Committee on SRS and Prevention strongly recommended that SRS put more resources into prevention and that the Regional Prevention Centers become the focal point for all community-based prevention services. This includes substance abuse, teenage pregnancy, violence, and truancy.

SRS, in cooperation with the Centers, has conducted State, regional and county risk assessments which allows the Department and other agencies the ability to target high-risk areas for programming. SRS' plan is for the Regional Prevention Centers to work with communities and grassroots groups in developing a local plan of action to reduce the risks. SRS plans to strengthen the Regional Prevention Centers in Fiscal Year 94 through new Federal Block Grant funds.

Communication, Coordination, Collaboration

Approximately 21 State agencies receive Federal and State alcohol and drug funds. Extensive communication, coordination and collaboration is required to avoid duplication and maximize the dollars. A working agreement has been developed with the Kansas Department of Health and Environment and others are in the process with the Kansas State Board of Education and the Kansas National Guard. SRS is also part of the Governor's Inter-Agency Coordinating Committee on Alcohol and other Drug Abuse.

Workforce Development, Employment Preparation Services

Our foremost priority is to continue to make long-term investments in the human capital of the State of Kansas. At the recent economic summit in Little Rock, President-elect Bill Clinton's opening remarks included the following comment, "What you earn depends on what you can learn...there must be a lifetime investment in education." If one considers the education, skills training, and postsecondary components together as the "human capital investment components" of JOBS programs, then the majority of the participants are in this human investment component. To meet the challenges we face in EPS, we have established the following priorities:

1. To meet new federal mandates which include developing EPS outcome measures that are in line with the federal outcome measures which will be published this fall and to meet the participation rates for AFDC-UP's in CWEP and OJT type activities.

2. Provide quality assessment, education, training, employment and support services to participants as they move toward self-sufficiency. This will include new opportunities for present and future generations to escape dependence on public assistance as a way of life.

3. Develop a shared vision for the future of KanWork among participating agencies.

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4. Effectively manage resources by reviewing staffing patterns and expenditures, find new resources, target participants and meet quotas for enhanced federal participation, and pilot innovative, cost-effective projects.

5. With the JOBS program fully implemented, EPS Central office will be restructured to provide effective program management through enhanced technical assistance in light of the issues identified by audit staff and independent evaluators.

6. Increase responsiveness to participating agencies, the legislature, and the public by developing data collection systems that provide evidence of desired outcomes accurately and efficiently.

7. More closely define the participant base through enhanced assessment and screening of inappropriate referrals thereby freeing up resources to be targeted to individuals who can reach self-sufficiency,

8. Resources will be more effectively managed by reviewing staffing patterns and expenditures, finding new resources, targeting participants and meeting quotas for enhanced federal participation, and piloting innovative, cost-effective projects.

Mental Health Agencies

1. Mental Health Reform.

2. Vocational Services--provide skills-building, on-the-job experience, and supports for individuals with severe and persistent mental illnesses.

3. Consumer-operated Programs--are support or self-help programs or services run and controlled by consumers as an alternative or adjunct to traditional mental health services.

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V. OVERVIEW OF FY 1994 SRS' BUDGET

SRS Budget Overview
FY 1994 GBR

Program	FY 1992	FY 1993	FY 1994	Increase
Department				
Administration	$ 46.9	$ 55.0	$ 53.8	($1.2)
Income Support	34.7	38.8	40.9	2.0
Medical Services - Adm.	29.6	35.6	36.1	0.5
Cash Assistance	144.6	159.0	158.8	(0.2)
Medical Assistance	542.8	637.3	697.4	60.1
Workforce Development	31.5	51.3	58.9	7.6
MHRS	54.3	63.1	69.1	5.9
Alcohol & Drug Abuse Svcs	13.9	16.6	17.7	1.0
Youth & Adult Svcs	92.0	94.2	98.4	4.1
Vocational Rehabilitation	30.1	34.0	34.1	0.1
Capital Imprvmnts/Debt Svc	0.6	7.0	4.1	(2.9)
Total Department	$1,021.0	$1,192.0	$1,269.3	$77.2
State General Funds	399.9	376.4	418.6	42.2
FTE	3,378.2	3,917.0	3,903.5	(13.5)
Institutions				
MH&MR Hospitals	$156.2	$153.4	$153.3	($0.1)
Youth Centers	17.2	18.5	17.8	(0.7)
Total Institutions	$173.4	$171.9	$171.2	($0.7)
State General Funds	90.8	89.3	81.1	(8.2)
FTE	5,196.8	5,021.6	4,908.6	(113.0)
Total Expenditures	$1,194.3	$1,363.9	$1,440.4	$ 58.7
State General Funds	490.7	465.7	499.7	34.0
FTE	8,575.0	8,938.6	8,812.1	(126.5)

Department

Income Support
The increase in the FY 1993 Income Support budget reflects the FY 1993 child support expansion. The FY 1994 budget continues funding for this expansion.

Medical Services (Administration)
Funding is provided for the annualization of pre-assessment and screening administrative costs in FY 1994. The contract cost for assessment and screening increases from $871,278 in FY 1993 to $1,494,414 in FY 1994. FY 1993 funding reflects the January 1, 1993 effective date for this initiative.

Continued funding is provided for the FY 1993 expansion in Homecare. The 1993 Homecare increase was for expanded services and to divert entry to nursing facilities by providing an alternative to private institutional care. The Homecare budget is maintained in FY 1994.

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Cash Assistance

The Aid to Families with Dependent Children budget increases by $8.0 million in FY 1993 and $7.1 million in FY 1994. For FY 1993, the cost of the 4.7% caseload increase is $5.5 million; the remaining $2.5 million funds the $2.25 approved grant increase. For FY 1994, the expected 5.7% caseload increase is funded with $7.1 million.

The General Assistance budget reflects the 1992 Legislature's action to restrict services to adults having a disability sufficiently severe to meet the federal Social Security Administration guidelines. The savings resulting from the January 1, 1993 modification of the cash component is estimated to be $2.6 million in FY 1993 and $5.7 million in FY 1994.

Medical Assistance

The Medical Assistance budget increases by $95.0 million (17.5%) in FY 1993 and $60.1 million (9.4%) in FY 1994. The three principle divisions of Medical Assistance are discussed below.

Regular Medical Assistance

The Regular Medical Assistance budget contains funding for caseload increases of $48.0 million in FY 1993 and $52.4 million in FY 1994. The full effect of the MediKan program modification is felt in FY 1994. Total estimated savings from the MediKan modification is $17.1 million. In general, reimbursements to providers remain at FY 1993 levels. Also included in the FY 1994 budget are funds to continue FY 1993 changes, including federal matching funds for school health programs ($10.3 million), local health departments ($3.5 million), and youth rehabilitative services ($1.6 million).

Adult Care Homes

The FY 1994 Adult Care Home budget increases by $4.0 million (1.8%) over the FY 1993 level. Included in the FY 1994 budget is a $1.3 million reduction attributable to annualized prescreening savings.

Community-Based Care

The major increase in the Community-Based Care budget occurs in the waiver serving the mentally retarded and developmentally disabled (HCBS MR waiver). For fiscal years 1993 and 1994, the respective increases are $11.3 and $7.7 million. In FY 1993, an additional 192 persons will be served. Of these, 108 placements would occur from the community waiting list and 84 from state MR institutions. For FY 1993, an additional 84 placements from the state MR institutions is funded.

Employment Preparation/Workforce Development

The FY 1993 funding of $49.1 million for Employment Preparation contains a 20 percent shrinkage rate for the KanWork field staff based on the belief that all the authorized positions will not be filled and trained prior to the end of the fiscal year. This higher shrinkage rate for FY 1993 should not severely affect the current expansion efforts and program implementation. The shrinkage rate for FY 1994 returns to the 6.0% global agency rate to continue the FY 1994 expansion.

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Funding is continued in FY 1993 for JOBS Services for transportation, education and training, special services, and contracted employment services. It is estimated that 8,920 individuals will be served. For the same services in FY 1994, an estimated 12,242 persons would be served.

Child Care Services are fully funded in FY 1993 at $33.6 million. Approximately 19,590 children would be served. For FY 1994, $36.1 million is budgeted for 19,590 children.

Mental Health & Retardation Services
The Mental Health and Retardation Services budget contains an increase of $4.3 million for the expansion of Mental Health Reform in the Larned catchment area.

The budget for this program also contains $1.4 million to annualize the FY 1993 cost of placing 108 mentally retarded and developmentally disabled persons in community programs.

Alcohol & Drug Abuse Services
The budget for Alcohol and Drug Abuse Services increases by $2.7 million in FY 1993 and $1 million in FY 1994. Major increases in federal block grants explain the increases. Funding for regional prevention centers is increased by $500,000 for both fiscal years 1993 and 1994. In addition, funding for local treatment centers is increased by $700,000 in FY 1993 and $660,000 in FY 1994.

Youth Services
A total of $3.4 million in FY 1993 will allow the phase-in of new field positions related to the department's Family Agenda. In FY 1994, $3.9 is budgeted for full-year funding of the new positions.

New federal grants result in an increase of $2.3 million in FY 1993. The majority of the increase is designated for staff training. The grants fall by $1.6 million in FY 1994.

Increases in foster care caseload contribute to a $2.5 million increase in FY 1993. For FY 1994, caseloads and expenditures are held level due to the implementation of the Family Services expansion.

The Family Services expansion increases expenditures by $2.8 million in FY 1993 and $2.0 million in FY 1994. The FY 1994 increase provides for the annualization of 49 new Family Preservation positions phased in during FY 1993.

The Topeka Screening Unit is reduced in FY 1994, as capacity is decreased from 30 to 15 beds. The $457,000 reduction reflects a shift in focus to community-based assessments.

Note: during FY 1992, the Economic Opportunity programs were transferred from SRS to the Department of Commerce. The transfer explains an $8.7 million reduction from the Youth and Adult Services budget.

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Rehabilitation Services
Administrative increases in FY 1993 include $600,000 for the reclassification of Rehabilitation Services staff, $300,000 for 5.0 new Vocational Rehabilitation transition counselors and 5.0 special project positions for disability determinations. These costs are annualized in FY 1994.

The continuous increase in the disabled caseload contributes to a $200,000 increase in both fiscal years for outside medical examinations.

A total of $300,000 for three new independent living centers approved in FY 1993 are continued in FY 1994. In addition, the FY 1993 decrease in client services is restored in FY 1994. Due to available federal funds, establishment grants (which provide initial funding for new rehabilitation services) increase by $1.6 million. These grants typically decrease over a four-year period. As a result of grant timing, establishment grants decline by approximately $800,000 in FY 1994.

Administration
Area office administrative expenditures associated with the major expansions in Youth Services, KanWork, and Child Support Enforcement increased by $3.1 million (11%) in FY 1993. Continued funding is provided for the expansions during FY 1994. Overall, the Area Office Administration budget declines by $890,816 chiefly due to a $1.1 million reduction in capital outlay costs.

Funding is included for the continued development of two federally required automation systems including the "KS Cares" system supporting the KanWork program, and the child support enforcement system. Because of project development timing, the costs for the new systems fluctuate. In FY 1994, the combined cost for the new systems declines by $2.5 million.

State Hospitals & Youth Centers

Youth Centers
The $700,000 reduction in the FY 1994 youth center budgets reflects shifts toward community treatment. A net of 5.0 positions are removed from the Youth Center at Beloit, and the facility's bed capacity is reduced by 18. Similarly, the number of positions is reduced by 3.0 and bed capacity is reduced by 18 at the Youth Center at Atchison. In addition, $730,000 is contained in the Youth Services budget for juvenile offender day treatment. These contracts would be used to treat targeted youths in the community.

State Hospitals
Improvements in community placements and the continuation of Mental Health Reform contribute to a 105 reduction in the average daily census of the state hospitals. The absence of an increase in the FY 1994 hospital budgets for FY 1994 represents the continued priority of community care. The census reductions include a reduction of 85 beds from the state mental retardation hospitals and 20 beds at Topeka State Hospital.

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VI. COST EFFECTIVE PROGRAMS

Rehabilitation Services

Employment Placement -- Kansans with disabilities who complete their rehabilitation programs and become employed earn an average of more than four times more than they did before receiving services. Dependency on government assistance is reduced; tax consumers become tax payers. National statistics also indicate that vocational rehabilitation is a cost effective program. According to the Council of State Administrators of Vocational Rehabilitation, Washington D.C., the most conservative benefit/cost analysis indicates that the estimated lifetime earnings for persons rehabilitated improve by $5.55 for every dollar spent on services.

Transition Planning Services -- Through transition planning services, young adults with disabilities are empowered to achieve community employment and living, reducing their need for institutional types of services. Therefore the transition planning program helps assure that Kansas receives a return on its annual $170 million investment (federal, state and local funds) in special education. Recognizing the value of a strong system of transition planning services, the U. S. Department of Education recently awarded a systems improvement grant to Rehabilitation Services and the Kansas State Board of Education. This a five-year, $2.5 million grant to improve staff training, to increase technical assistance to local transition councils, to develop model programs, and to evaluate outcomes related to transition services.

Income Support and Medical Services

Medical Services for Low Income Women and Children -- In keeping with our priority on prevention, the agency has provided programs to make needed medical service accessible to low income pregnant women and children. Preventive and primary care are cost effective and prevent medical problems and further complications.

Third Party Resources for Medical Care -- We have developed initiatives to expand third party resources for medical services, including the payment of health insurance premiums when cost effective.

Third party liability plays an increasing role in stretching medical assistance funds as far as possible and insuring that children, whether receiving public assistance or not, have access to health insurance coverage. Title IV-D requires Child Support Enforcement to seek a medical support order (group health insurance coverage) whenever cash support is established or modified, or when group insurance coverage becomes available.

Once coverage is ordered, CSE must see that insurance coverage is obtained, children are enrolled, and coverage is maintained. Studies indicate that only 13% of obligors voluntarily enroll children as ordered.

It is estimated there are 124,895 children currently enrolled for IV-D services. Of these, 60,374 are covered by support obligations, with medical coverage ordered for an estimated 20%, 12,075. If only 13% of these

children are actually enrolled, 112,820 children currently need establishment or enforcement services. It is estimated that 40% of these children's non-custodial parents can be located and would have group insurance available.

Child Support Enforcement -- The Child Support Enforcement Program has always provided a cost effective, revenue generating service to both the public and the state. In FY 1992 child support collection efforts contributed over 11 million dollars to the SRS fee fund at a cost to the state of only 4.8 million. The program also assisted 2,600 families to become self-sufficient, no longer relying on public assistance.

Other Cost-Effective Measures in Medical Assistance --

Utilization review of the major services is an ongoing cost effective initiative for cost avoidance and recoupment.

Community based services versus institutional services are generally cost effective and avoid the high cost of institutions.

Diagnosis Related Groupings (DRGs) and other reimbursement systems that maintain equitable rates but are not inflationary are cost effective.

Prior approval or precertification of medical procedures avoids unnecessary costs.

Surveillance for abuse of the program by providers and recipients is an ongoing cost effective initiative.

Enhanced Computerization

We have developed computer systems which allow caseworkers to determine eligibility more rapidly and to share information electronically between programs. Also, the Child Support Enforcement program is about to complete the initial phase of a computerized interface with the clerks of court which provide up to date support payment information on a daily basis. This interface is part of the process to enhance the Kansas Automated Eligibility and Child Support Enforcement System (KAECSES) to meet federal requirements and improve the efficiency and effectiveness of program efforts. Design work to develop a federally certifiable system which supports effective and efficient casework is underway.

Youth and Adult Services

Family Preservation -- Where SRS staff or contracted providers provide intensive services on a short-term basis to families to prevent the removal of the children from the home or to return the children home to a safe environment more quickly. Dramatic differences in cost exist when children leave the home for foster care rather then being served in their own home.

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Day Reporting -- The Department is experimenting with a group of services in the community to maintain juvenile offenders offense-free either within their own homes or within the community, preventing costly residential or youth center place outside the community. These services include intensive supervision with frequent contact between the youth and program staff, electronic monitoring, coordination and frequent contact with other organizations such as the schools, etc. Long-term cost savings are significant if youth can be maintained at home without further offending behavior. Since a percentage of juvenile offenders go on to the adult corrective system, success with these services has significant long-term savings for the state.

Wraparound Services -- A process whereby children and families are involved in identifying what they need to successfully remain together. It involves the family being an equal partner with the organizations who collaborate to meet the special needs of the child and family. This process can also benefit any adult at risk of removal from home. Wraparound services are considered to be more cost-effective in the long run and to be a more humane way of assisting families. This is particularly true when these services are used to prevent institutionalization or to return people to the communities from the institutions.

Flexible Funding for Independent Living -- The Department has a small amount of money available to purchase items which will assist vulnerable adults in remaining in their own homes when other resources are not available. These are typically one-time expenses which can make a significant difference, such as making a residence accessible for a person with a disability. Use of these flexible funds typically is part of a home care plan or a plan to reduce abuse, neglect, or exploitation of a vulnerable adult. Since nursing home placement can result, cost savings are significant. The Home Care Program is included in the Medical Services budget.

Alcohol and Drug Abuse Services

Women's and Children's Treatment Programs -- These programs provide a cost-effective solution to breaking the cycle of addiction. Alcohol and other drug exposed babies can result in a range of physical, emotional and financial problems. About 80 percent of the women seeking treatment in Fiscal Year 1991 were of child-bearing age and more than four percent were already pregnant. Left untreated, the children of these women become a high-risk for addiction themselves and other health related problems.

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Workforce Development, Employment Preparation Services

Education and Training -- In order to increase the likelihood of job retention and decrease dependence on public assistance, EPS participants must have the education and skills needed to enter and remain in the workforce at a wage that ensures self-sufficiency. Studies show there is a strong correlation between eduation and earnings. The likelihood that those with limited education will have low earnings has increased over the past fifteen years. It is now clear that JOBS has resulted in a new emphasis on basic education in state work/welfare programs. EPS Programs cannot be viewed as a "quick-fix" to welfare dependency. Placing AFDC recipients in jobs without improving their basic skills is bound to fail because there are few jobs for welfare recipients with low skills and the jobs that are available do not pay a living wage.

EPS will develop methods of assessing participants that will permit appropriate tailoring of services to meet individual needs. A recent U.S. Department of Labor study shows that 25 to 40 percent of adults on AFDC and in the JOBS programs may be learning disabled. Enhanced assessment procedures would help to identify those individuals for referral to appropriate programs.

Mental Health and Retardation Services

Mental Health Reform --
FY 92 originally projected cost avoidance -- 0;
Actual cost avoidance -- $672,006

FY 93 originally projected cost avoidance -- $797,932:
Currently projected cost avoidance -- $2,114,725

COST EFFECTIVE COMPONENTS OF MENTAL HEALTH REFORM

SCREENING - the process of identifying individual needs to determine the level of services necessary and diversion to the least restrictive level of care.

CASE MANAGEMENT - helps clients get and keep resources for living; reduces reliance on out-of-home placements; and helps parents cope with children who have serious emotional disturbances.

IN-HOME THERAPY - intensive family therapy service, generally in the client's home. 2 to 10 hours weekly is typical. Goal is to enhance client/family functioning and reduce risk of out of home placement.

OTHER COST-EFFECT SERVICES:

REGIONAL INTERAGENCY COUNCILS (HB 3113) - these newly established councils offer the potential to coordinate services among agencies, reduce costs of

duplicated or unnecessary services, and find alternatives to high cost services.

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COLLABORATION ON VOCATIONAL SERVICES - Collaboration with Rehabilitation Services to draw federal funds for supported employment is cost effective in the MR system--we hope to duplicate this outcome in the MH central office.

CONSUMER-OPERATED PROGRAMS - provide skills building, entry level employment opportunities, and peer support to reduce acute episodes of illness; help integrate people into their home communities.

Mental Retardation and Developmental Disability Services

Targeted Case Management -- uses funds already provided to community MR/DD agencies to match federal medicaid funds to reimburse service coordination activities. This approach does compromise the principle that service coordination should be separate from direct service provision.

The HCBS/MR waiver -- allows SRS to obtain federal medicaid matching funds to serve people leaving institutions and people being served from the waiting list. As a result Kansas has stopped the establishment of new costly ICFs/MR and the historical practice of using 100% state general funds for these services.

Family support services and services to children -- recognizes the families' role as the primary service provider thus utilizing natural support systems as appropriate, often provides funds directly to families thus avoiding agency over-head and administrative expenses and empowers families to coordinate their own services thus targeting funding to the area of greatest need for their family. Services in this area include: Family Subsidy, Family Support and Supported Family Living

Vocational Rehabilitation Services -- is providing initial first year federal funds to match with approximately 22% state funds to award grants to serve the equivalent of 75 people in support employment and supported living.

Coordinators of Quality Assurance -- SRS/MH&RS has assigned Coordinators of Quality Assurance to the field to assist with and monitor quality assurance processes in community MR/DD agencies. The duties of these staff involve over-seeing HCBS/MR and Targeted Case Management services and therefore half of their salary is matched by medicaid as an administrative cost.

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HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
CHAIRPERSON: PUBLIC HEALTH AND WELFARE
CHAIRPERSON: JOINT COMMITTEE ON HEALTH CARE DECISIONS FOR THE 1990'S
VICE-CHAIRPERSON: ECONOMIC DEVELOPMENT
MEMBER: PENSIONS, INVESTMENTS AND BENEFITS
JOINT COMMITTEE ON ECONOMIC DEVELOPMENT

TESTIMONY BEFORE HOUSE APPROPRIATIONS COMMITTEE

Representative Carol Sader

January 19, 1993

H.B. 2025 concerns the Kansas Medical Residency Bridging program. The bill was drafted and recommended for passage by the Joint Committee on Health Care Decisions for the 1990s as a result of comments made by the representative of the Kansas Association of Osteopathic Medicine, who pointed out that the bridging program created by the Legislature in 1992 applied only to persons in residency programs "operated by or affiliated with the university of Kansas school of medicine. . . ." He reminded the Committee that there are residency slots in osteopathy in Kansas and that it would be of benefit to Kansas to have those residents in primary care training eligible for the new bridging program.

H.B. 2029 concerns the University of Kansas School of Medicine Medical Student Loan program created by the Legislature in 1992 (converted the scholarship program to a loan program). The bill was drafted and recommended for passage by the Joint Committee as an expression of the strong Committee belief that qualified Kansas residents should have priority in the receipt of loans. On at least two occasions in the 1992 interim, representatives of the University appeared before the Joint Committee to discuss the attempts being made to increase the number of students interested in primary care training and the types of persons most likely to be attracted to the practice of primary care medicine in rural Kansas. The Committee was made aware of various programs being reviewed by the University, some in conjunction with other regents' institutions to begin to bring prime candidates for such practice into contact with rural practitioners early in their medical training, and also those efforts at curriculum reform that would bring students into contact with patients early in their medical education.

H.B. 2030 concerns increasing the expenditure limitation on the Medical Scholarship and Loan Repayment Fund, thereby increasing the number of loans to students from 30 to 44. Again, representatives of the University of Kansas School of Medicine told the Committee during the interim that the number of applicants for loans exceeded the number authorized by the 1992 Legislature and supported a 1993 legislative directive to increase the number of loans. Funds for the new scholarships would be taken from the Repayment Fund which the Joint Committee believes has sufficient resources to cover the additional 14 loans.

ATTACHMENT 2

House Appropriations Committee
January 19, 1993

House Bill 2025

My name is Bob Wunsch and I am here today representing the University of Kansas Medical Center to testify in support of House Bill 2025. This bill would amend the legislation enacted by the 1992 Legislature which established a state-funded medical residency bridging program.

The legislation enacted a year ago was patterned after a program initially piloted with funding from a grant from the Wesley Foundation. The experience during that pilot program was a positive one, and the 1992 Legislature saw fit to establish a similar program with funding from the state. The residency bridging program provides financial incentives to residents in their second and third years of residency training in primary care to commit eventually to establish a medical practice in a rural Kansas community upon completion of training. The financial incentives provided by the state are additional payments of $5000 per year in each of the second and third year of residency training and a $6000 bonus upon completion of training. There are requirements that the resident must have entered into a contract with a community which contract provides that the community will provide financial incentives at least equal to those provided by the state. Residents participating in the program incur a three-year obligation in that community. They may select practice locations in any county in Kansas other than Douglas, Johnson, Sedgwick, Shawnee, or Wyandotte.

As the legislation was enacted a year ago, eligibility for participation is limited to primary care residency training programs in pediatrics, medicine, or family practice which are operated by or affiliated with the University of Kansas School of Medicine. House Bill 2025 would broaden that eligibility to include all other primary care residency training programs in Kansas which were approved by the State Board of Healing Arts. It appears that the intent of the legislation is to extend eligibility for participation to osteopathic residency programs. It could also conceivably extend to any other primary care programs that might be initiated in the state not affiliated with or operated by the University of Kansas School of Medicine. We are totally supportive of any initiative that hold promise of increasing the number of primary care health providers that will establish practice locations in rural Kansas communities. While we have only had limited experience with the program to date, we continue to be excited about the potential impact this program can have on encouraging primary care residents to select Kansas practice locations. At this point, we have one resident who has been qualified and certified for payment of the stipend and we have three other residents that are in various stages of gaining approval.

ATTACHMENT 3

If I might, Madam Chairwoman, and other members of the committee, I would like to address another concern we have with the legislation that was enacted a year ago. In fact, we have secured Regents approval to seek legislation to modify this program and would offer that amendment for your consideration as a modification to House Bill 2025. Under the law as it was enacted a year ago, the resident is required first to have entered into a practice commitment agreement with a community before they can enter into an agreement with the University. The reality is that most residents have little opportunity in their first year of training to pursue sufficiently what practice locations are available in order to make a decision. As a consequence, we have several second year residents who are seriously interested in the program but have not as yet made a commitment to a specific community. We would like to see the legislation amended to permit residents to sign up for the residency bridging program prior to the time they have entered into a practice commitment agreement with a community. We think this would greatly increase participation in the program and would offer that for the committee's consideration.

Again, in closing, we are pleased to support House Bill 2025. We think it is a progressive piece of legislation in that it will broaden eligibility for participation in this program which we believe will aid the recruitment of primary care physicians to rural Kansas. I would be pleased to attempt to answer any questions members of the committee might have regarding this program.

# # #

MLR:rdm
1-15-93

Session of 1993

HOUSE BILL No. 2025

By Joint Committee on Health Care Decisions for the 1990's

1-11

AN ACT concerning the Kansas medical residency bridging program; amending K.S.A. 1992 Supp. 76-387 and repealing the existing section.

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

Section 1. K.S.A. 1992 Supp. 76-387 is hereby amended to read as follows: 76-387. (a) There is hereby established the Kansas medical residency bridging program at the university of Kansas school of medicine which shall be developed and implemented in order to provide encouragement, opportunities and incentives for persons in primary care residency training programs in general pediatrics, general internal medicine, family medicine or family practice, which are operated by or affiliated with the university of Kansas school of medicine, to locate their medical practice in rural Kansas communities upon completion of such residency training. The Kansas medical residency bridging program shall be administered by the institute for rural health care of the university of Kansas school of medicine.

(b) Subject to the provisions of appropriation acts, the university of Kansas school of medicine may enter into residency bridging loan agreements, in accordance with the provisions of this section, with any person who has completed the first year of a primary care residency training program in general pediatrics, general internal medicine, family medicine or family practice, which is operated by or affiliated with the university of Kansas school of medicine *or other such primary care residency training program which is operated in Kansas and approved by the state board of healing arts* [~~, and who has entered into a practice commitment agreement~~].

(c) Subject to the provisions of appropriation acts, each person entering into a residency bridging loan agreement under this section shall receive a payment of $5,000 each year of primary care residency training, or any part of a year of such training, after the date that the residency bridging loan agreement is entered into by the resident and the university of Kansas school of medicine and, upon completion of the primary care residency training program, a payment of $6,000.

(d) Each residency bridging loan agreement shall require that the person receiving the loan:

Proposed Amendments for Consideration by Committee on Appropriations

1-19-93

ATTACHMENT 4

ATTACHMENT 4

(1) Complete the primary care residency training program;

(2) engage in the full-time practice of medicine and surgery in any county in Kansas other than Douglas, Johnson, Sedgwick, Shawnee or Wyandotte for three years under a practice committment agreement;

(3) commence such full-time practice of medicine and surgery within 90 days after completing the primary care residency training program; and

(4) upon failure to satisfy the obligation to engage in the full-time practice of medicine and surgery in accordance with the provisions of the residency bridging loan agreement and this section, the person receiving the loan under this section shall repay to the university of Kansas school of medicine, within 90 days of such failure, the amount equal to the amount of money received by such person from the university of Kansas school of medicine, less credits earned, under such agreement plus interest at the annual rate of 15% from the date such money was received.

(e) An obligation to engage in the practice of medicine and surgery in accordance with the provisions of a residency bridging loan agreement and this section shall be postponed during (1) any period of temporary medical disability during which the person obligated is unable to practice medicine and surgery because of such medical disability, or (2) any other period of postponement agreed to or determined in accordance with criteria agreed to in the practice commitment agreement.

(f) An obligation to engage in the practice of medicine and surgery in accordance with the provisions of a residency bridging loan agreement and this section shall be satisfied: (1) If the obligation to engage in the practice of medicine and surgery in accordance with such agreement has been completed, (2) if the person obligated dies, or (3) if, because of permanent physical disability, the person obligated is unable to practice medicine and surgery.

(g) The university of Kansas school of medicine may adopt additional provisions, requirements or conditions for participation in the Kansas medical residency bridging program as are practicable and appropriate to accomplish the purposes of the program or as may be required for the implementation or administration of the program and, in any case, as are not inconsistent with the provisions of this section or the provisions of appropriation acts.

(h) As used in this section, "practice commitment agreement" means an agreement to commence the full-time practice of medicine and surgery in a city located in any county in Kansas other than Douglas, Johnson, Sedgwick, Shawnee or Wyandotte county, which (1) was entered into by a person in a primary care residency training

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program in general pediatrics, general internal medicine, family medicine or family practice, that is operated by or affiliated with the university of Kansas school of medicine *or other such primary care residency training program which is operated in Kansas and approved by the state board of healing arts*, with the city where such practice is to commence or another contracting entity other than the university of Kansas school of medicine that is representative of the interests of such city, and (2) provides benefits to such person that have an aggregate monetary value equal to or greater than the aggregate amount of payments to such person from the university of Kansas school of medicine under a residency bridging loan agreement under this section.

Sec. 2. K.S.A. 1992 Supp. 76-387 is hereby repealed.

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

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Kansas Association of Osteopathic Medicine

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January 19, 1993

To: Chairperson Chronister and Members, House Appropriations Committee

Subject: Testimony of The Kansas Association of Osteopathic Medicine on H.B. 2025

Thank you for this opportunity to explain H.B. 2025, a Bill introduced by The Health Care Decisions for the 1990's Committee, at the request of KAOM.

H.B. 2025 would extend the provisions of the Kansas Medical Residency Bridging Program as passed by the 1992 Legislature, to osteopathic primary care residents. The law now provides that only persons in primary care residency training programs operated by or affiliated with the University of Kansas School of Medicine are eligible. This excludes some D.O.s now in residency training.

Currently, there are several osteopathic residents in programs operated by or affiliated with the KU School of Medicine. However there is one program, and potentially more, in which there are D.O.s in primary care residency training that does not fit that description--the residency training program operated by Riverside Hospital in Wichita.

The Riverside Hospital program now has two general practice residents, and in July, 1993, will have three. That program is expected to experience continued growth. In addition, Riverside has been approved for residency training in internal medicine.

Experience indicates that physicians often go into practice in areas in which they conduct their residency training. Thus it is our view that D.O. Residents should be included in this bridging program as part of a continuing effort to resolve the shortage of primary care physicians in parts of Kansas.

Regarding administration of the bridging program as it interacts with D.O. residency training programs, we suggest that these program, too, be administered by the KU Medical Center, as is provided in the Act passed last year.

Thank you, again, for hearing this request for change.

NOTE: One clarifying amendment may be needed for H.B. 2025. The language in italics that appears in Section 1(b) and Section 1(h) (new language), may also need to be added in Section 1(a), to be consistent throughout. The following balloon would make that change.

Be it enacted by the Legislature of the State of Kansas:
Section 1. K.S.A. 1992 Supp. 76-387 is hereby amended to read as follows: 76-387. (a) There is hereby established the Kansas medical residency bridging program at the university of Kansas school of medicine which shall be developed and implemented in order to provide encouragement, opportunities and incentives for persons in primary care residency training programs in general pediatrics, general internal medicine, family medicine or family practice, which are operated by or affiliated with the university of Kansas school of medicine, to locate their medical practice in rural Kansas communities upon completion of such residency training. The Kansas medical residency bridging program shall be administered by the institute for rural health care of the university of Kansas school of medicine.

Amendment to H.B. 2025,
Section 1(a), line 21

or other such primary care residency training program which is operated in Kansas and approved by the state board of healing arts,

ATTACHMENT 5

State of Kansas
Joan Finney, *Governor*

Department of Health and Environment

[redacted]

Robert C. Harder, Secretary

Reply to:

Testimony presented to

House Appropriations Committee

by

The Kansas Department of Health and Environment

House Bill 2025

House Bill 2025 establishes the Kansas medical residency bridging program at the University of Kansas School of Medicine in order to provide encouragement, opportunities and incentives for persons in primary care residency training programs in general pediatrics, general internal medicine, family medicine or family practice which are operated by either the University of Kansas School of Medicine or other Kansas operated primary care residency training programs approved by the Board of Healing Arts.

KDHE supports House Bill 2025 which expands the bridging program to include doctors of osteopathy who have proven to be valuable primary care resources across the state and particularly in rural areas.

Currently there remain 23 federally designated health professional shortage areas in the state, with six more pending approval. This means fewer than 1 physician to 3500 population. In addition there are 82 counties considered underserved by state criteria.

Osteopathic physicians have a long history of rural practice. Of the 300 currently practicing in Kansas fewer than 90 are in metropolitan areas. HB 2025 provides further incentive to select Kansas residency programs as well as return to small town rural areas to establish their practice.

Testimony presented by: Joyce Volmut
Director, Primary Care Services
Office of Local and Rural Health Systems
January 19, 1993

ATTACHMENT 6

State of Kansas
Joan Finney, *Governor*

Department of Health and Environment

[redacted]
Robert C. Harder, Secretary

Reply to:

Testimony presented to

House Appropriations Committee

by

The Kansas Department of Health and Environment

House Bill 2029

In the last few years, we have become painfully aware of the lack of access to primary medical care suffered by the majority of counties in Kansas. The crisis that is upon us promises to get worse before it gets better due to the aging of physicians currently practicing in many of the underserved or borderline counties and the lack of sufficient planning for this situation a decade ago.

As you witnessed in last year's legislative session, we are now faced with rapidly making difficult decisions that will hopefully reverse the trend and, in the meantime, slow the damage. Numerous initiatives have been and will continue to be introduced aimed at trying to solve pieces of the access problem. The legislation before you is such a strategy.

This amendment to the medical student loan act passed last year gives preference to loan applicants who are Kansas residents when they enter the University of Kansas School of Medicine. Loan recipients are expected to practice in an underserved Kansas county for a number of years equal to the number of years they received financial assistance. Thereafter, they are free to go wherever they please.

Our experience with the Kansas Medical Scholarship Program introduced in 1978 has been that identical service obligations have not made an appreciable difference in overall access to medical care in Kansas as measured by the yearly numbers of medically underserved counties. After nearly 15 years of a program intended to improve the retention of KU medical students in Kansas, the doctors still aren't out in the underserved counties. What can be done?

The growing body of research on the diminishing numbers of family practice and rural practitioners has demonstrated that one of the best predictors of a medical students ultimate practice site is the size of town the student grew up in. Doctors coming from rural backgrounds are more likely to set up practice in rural settings than doctors raised in urban settings.

ATTACHMENT 7

By giving a preference to loan applicants from Kansas, the odds are improved that graduates will stay on in Kansas after their service obligations are satisfied.

Additionally, this type of selection preference dovetails nicely with the recent Kansas State University initiative designed to increase the number of rural Kansans preparing for admission to UKSM. The larger the proportion of rural Kansas medical school students, the greater the likelihood of more UKSM graduates practicing in underserved areas of the state.

Testimony presented by: Joyce Volmut
Director, Primary Care Services
Office of Local and Rural Health Systems
January 19, 1993

House Appropriations Committee
January 19, 1993

House Bill 2029

House Bill 2029 amends the current provisions regarding the medical student loan program administered by the University of Kansas School of Medicine. The bill would write into law that in the awarding of student loans, preference or priority shall be given to students who were Kansas residents at the time of first entry into the School of Medicine. Inasmuch as the purpose of the loan program is to encourage medical students to pursue careers in primary care and eventually to locate a medical practice in a rural practice location, we believe that the likelihood of compliance with those requirements is greatest for students who are Kansans and for that reason, we are supportive of House Bill 2029. In fact, we had received approval from the Board of Regents to seek introduction of legislation which would have accomplished the same purposes as House Bill 2029.

As one reviews the history of the former medical scholarship program, the issue of student residency was never a concern. Although the scholarship program had as one of its purposes to encourage students to locate their practice in Kansas, it was originally primarily a form of financial assistance. The first medical scholarship legislation enacted was an outgrowth of a 1977 interim study by the Special Committee on Ways and Means. That committee recommended that resident tuition at the School of Medicine be increased more than three-fold. In conjunction with that recommended increase, the committee also supported enactment of a student scholarship program. In its early years, no limits were placed on the number of students who could participate in the program, nor was there any obligation on the student to select primary care specialties. Looking back, 155 students of the entering freshman class in 1978 enrolled in the program. Over the next several years the number of students that participated ranged from 165 to 177 per class.

In 1983 the Legislature began to limit the number of new awards by appropriation act, first to 100, then in 1985 to 75, and in 1986, the number was limited to 50. In recent years, the Legislature has tended to limit the number of new awards to 30 each year.

Residency was never an issue because as the number of allowable new awards decreased, so did student interest in the program. In many instances, even when only 30 new awards could be granted, there were insufficient numbers of students willing to participate in the program to utilize the full authorization. Several factors contributed to that decline in student interest, including the Legislature's continued efforts to make the service

ATTACHMENT 8

obligations and specialty selections more restrictive, and the fact that the financial incentives, the principal one being the monthly stipend, remained unchanged.

In an effort to rekindle interest in this program, the 1992 Legislature retitled the program as a medical student loan program, and greatly increased the financial incentives to the student. The monthly stipend which had remained at $500 a month was increased to a limit of $1500 per month with the actual amount to be at the discretion of the student. Students would be required to select a residency training program upon graduation among general pediatrics, general internal medicine, family medicine, family practice, or emergency medicine. Upon completion of their residency, the student could satisfy the service obligation by practicing in any community within Kansas other than in Douglas, Johnson, Sedgwick, Shawnee or Wyandotte counties. In making the appropriations for this program for FY 1993, the Legislature again limited the number of new awards to 30. While it was hoped that making the financial incentives more generous would heighten student interest in this program, there was no certainty that such would be the case and as a consequence, the number of new awards was fixed at that level.

Prior to receiving award applications for Fiscal Year 1994, the University established the following policies for choosing students to receive the awards in the event that there was more interest than could be satisfied.

1. The first priority was given to first-year students on the assumption that one of the purposes of the program was to create a significant financial obligation thereby making it likely the student would comply with the service obligation.

2. Kansas residents were given preference over non-residents.

3. Applicants from counties other than Douglas, Johnson, Sedgwick, Shawnee and Wyandotte were given preference.

4. Finally, if needed, a judgment would be based on financial need.

I must confess that the institution was totally unprepared for the response by students for this program. A total of 69 applications were made for 30 awards, 49 of which were from the first year class, 18 second year and 2 third year students. Of the 49 first year applicants, 39 were Kansas residents and 10 were non-residents. Under the criteria that was established, all 30 awards went to first-year students who were residents of Kansas.

The Joint Committee on Health Care Decisions for the 1990s has recommended a companion bill, House Bill 2030, which would authorize an additional expenditure of $300,000 for the current fiscal year in order to provide additional awards. That level of additional funding would provide 14 to 15 additional new awards for the current year. Without the enactment of House Bill 2029, the first preference would be given to the 9 first-year Kansans who were not initially granted awards and secondly, then to those first-year non-resident applicants. Were House Bill 2029 enacted, we would continue to give first preference for any additional awards to those first year Kansans previously not awarded and then, go to the Kansans in the second year class.

In conclusion, I would restate that we are supportive of this legislation and concur that priority should be given to students who were Kansas residents at the time of first entry into the School of Medicine. I would offer for the committee's consideration one technical amendment that might either be to House Bill 2029 or 2030 and would leave to your staff the judgment as to where the amendment should be made. If House Bill 2029 and its companion bill House Bill 2030 were enacted early in this legislative session, we would proceed to grant the additional awards. We believe that the award should be made retroactive to the beginning of the current academic year. As a consequence, some provision should be made for allowing us in this particular fiscal year to make those awards retroactively. If a student is going to assume a full year service obligation as a result of receiving the award, then they should be entitled to a full year's financial benefit.

I would be happy to respond to any questions and we thank the committee for their interest in this program.

# # #

MLR:rdm
1-15-93

Session of 1993

HOUSE BILL No. 2029

By Joint Committee on Health Care Decisions for the 1990's

1-12

AN ACT concerning the university of Kansas school of medicine; relating to medical student loans; amending K.S.A. 1992 Supp. 76-382 and repealing the existing section.

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

Section 1. K.S.A. 1992 Supp. 76-382 is hereby amended to read as follows: 76-382. (a) There is hereby established the medical student loan program at the university of Kansas school of medicine.

(b) Subject to the provisions of appropriation acts, the university of Kansas school of medicine may make medical student loans in accordance with the provisions of this act to undergraduate students enrolled in or admitted to the university of Kansas school of medicine in a course of instruction leading to the degree of doctor of medicine who enter into a written medical student loan agreement with the university of Kansas school of medicine in accordance with K.S.A. 1992 Supp. 76-383, *and amendments thereto*.

(c) Each medical student loan agreement under this act shall provide to the person receiving the loan the payment of all tuition and a stipend for living expenses in an amount of up to $1,500 per month for each month enrolled in such school during a year. Subject to the maximum amount, the amount of the monthly stipend shall be determined on an annual basis by the student receiving the loan.

(d) Subject to the provisions of appropriation acts, medical student loan agreements under this act may be entered into on an annual basis and shall provide the payment of the amounts specified under subsection (c) for one year unless otherwise terminated before such period of time. Subject to the provisions of appropriation acts, an undergraduate student enrolled in or admitted to the university of Kansas school of medicine in a course of instruction leading to the degree of doctor of medicine may receive a separate loan under this act for each separate year the student enters into a written medical student loan agreement with the university of Kansas school of medicine in accordance with K.S.A. 1992 Supp. 76-383, *and amendments thereto*. For each separate year a student receives a loan under this act, the student shall engage in the full-time practice of medicine and surgery in an appropriate service commitment area

Proposed Amendments for Consideration
by Committee on Appropriations

1-19-93

scholarships and

76-376 and

;also repealing
K.S.A. 1992 Supp. 76-376a

Insert attached Section 1.
Technical Amendment

ATTACHMENT 9

for a period of 12 months unless such obligation is otherwise satisfied as provided in K.S.A. 1992 Supp. 76-386, *and amendments thereto.*

(e) Medical student loans shall be awarded on a priority basis to qualified applicants who are Kansas residents at the time of entry into the university of Kansas school of medicine. As used in this subsection, "Kansas residents" means persons who meet the residence requirements established in K.S.A. 76-729, and amendments thereto.

Sec. 2. K.S.A. 1992 Supp. 76-382 is hereby repealed.

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

as follows, first

, and second, to qualified applicants who are not Kansas residents at the time of entry into the university of Kansas school of medicine

are

76-376, 76-376a and

Sec. 1. K.S.A. 1992 Supp. 76-376 is hereby amended to read as follows: 76-376. (a) (1) Except as otherwise provided in paragraphs (2)~~,~~ ~~(3),~~ ~~(4),~~ ~~(5),~~ ~~(6),~~ ~~(7)~~ ~~and~~ ~~(8)~~ through (9) of this subsection (a) or in K.S.A. 76-377 and amendments thereto, upon the failure of any person to satisfy the obligation to engage in the full-time practice of medicine and surgery within the appropriate service commitment area of this state for the required period of time under any agreement entered into pursuant to K.S.A. 76-373 through 76-377a, and amendments thereto, such person shall repay to the university of Kansas school of medicine an amount equal to the total of (A) the amount of money received by such person pursuant to such agreement, or the amount of money determined under rules and regulations of the university of Kansas plus (B) annual interest at a rate of 10%, if the agreement was entered into prior to January 1, 1982, 15%, if the agreement was entered into after December 31, 1981, from the date such money was received.

(2) Any person first awarded a scholarship after December 31, 1985, who fails to apply for and enter an approved three-year primary care postgraduate residency training program shall be required to repay all moneys received pursuant to an agreement entered into for any such scholarship, plus accumulated interest at an annual rate of 15% within 90 days of graduation from the school of medicine, or termination or completion of a residency training program which does not comply with the provisions of this section, whichever occurs later.

(3) If a person fails to satisfy an obligation to engage in the full-time practice of medicine and surgery within a service commitment area I for the required period of time under an agreement entered into pursuant to K.S.A. 76-373 through 76-377a, and amendments thereto, but is engaged in the full-time practice of medicine and surgery within this state in a service commitment area II which would have applied to such person had such person received a type II scholarship under an agreement entered into pursuant to K.S.A. 76-373 through 76-377a, and amendments thereto, and if the chancellor of the university of Kansas, or

the designee of the chancellor, finds that exceptional circumstances caused the failure of such person to engage in such practice in a service commitment area I, such person shall not be required to repay the amount of money received by such person for up to 50% of tuition fees pursuant to such agreement.

(4) If a person fails to satisfy an obligation to engage in the full-time practice of medicine and surgery in Kansas for the required period of time under an agreement entered into pursuant to K.S.A. 76-373 through 76-377a, and amendments thereto, because such person is engaged in the full-time practice of medicine and surgery in a state other than Kansas and if such person is subject to or currently making repayments under this section and if such person subsequently commences the practice of medicine and surgery in this state which complies with the agreements entered into under such statutes, the balance of the repayment amount, including interest thereon, from the time of such commencement of practice until the obligation of such person is satisfied, or until the time such person again becomes subject to repayments, shall be waived. All repayment amounts due prior to such commencement of practice in this state, including interest thereon, shall continue to be payable as provided in this section. If subsequent to such commencement of practice, the person fails to satisfy such obligation, the person again shall be subject to repayments, including interest thereon, as otherwise provided in this section.

(5) Any person awarded a type I scholarship prior to January 1, 1986, who is satisfying the obligation to engage in the full-time practice of medicine and surgery in a service commitment area I by complying with the provisions of subsection (e)(3) of K.S.A. 76-375 and amendments thereto and who except for the provisions of such section (e)(3) would not otherwise be eligible to satisfy such obligation in the area in which such person is engaged in the full-time practice of medicine and surgery shall repay all moneys received by the person pursuant to the type I scholarship for living expenses, including interest thereon as otherwise provided in this section, in accordance with

the repayment schedule established for the purposes of this paragraph by the chancellor of the university of Kansas.

(6) If, during the time a person is satisfying the service requirement of an agreement entered into pursuant to K.S.A. 76-373 through 76-377a, and amendments thereto, such person desires to engage in less than the full-time practice of medicine and surgery within the appropriate service commitment area of the state and remain in satisfaction of such service requirement, such person may make application to the chancellor of the university of Kansas or the designee of the chancellor for permission to engage in less than such full-time practice of medicine and surgery. Upon a finding of exceptional circumstances made by the chancellor of the university of Kansas, or the designee of the chancellor, such person may be authorized to engage in less than the full-time practice of medicine and surgery within the appropriate service commitment area of the state for the remaining required period of time under such agreement and for an additional period of time which shall be equal to the length of the originally required period of time multiplied by the decimal fraction which is equal to the reduction of the full-time practice of medicine and surgery to be authorized hereunder, multiplied by two. In any such determination of the period required to be engaged in the less than full-time practice of medicine and surgery, the decimal fraction utilized shall not exceed .5 and any person granted permission to engage in less than the full-time practice of medicine and surgery in accordance with the provisions of this paragraph (6) shall be required to engage in at least the half-time practice of medicine and surgery.

(7) Any person first awarded a scholarship after December 31, 1985, who enters but fails to complete an approved three-year primary care postgraduate residency training program, or who enters and completes an approved three-year primary care postgraduate residency training program but fails to satisfy the obligation to engage in the full-time practice of medicine and surgery within the appropriate service commitment area of this

state for the required period of time shall be required to repay all money received pursuant to an agreement entered into for any such scholarship, plus accumulated interest at an annual rate of 15% within 90 days of failure to complete an approved residency or 90 days of failure to commence qualifying practice, whichever occurs first. This provision shall apply only to agreements entered into from and after the effective date of this act.

(8) Any person who was satisfying such person's obligation to engage in the full-time practice of medicine and surgery within the appropriate service commitment area of the state for the required period of time under any agreement entered into pursuant to K.S.A. 76-373 through 76-376 and amendments thereto, by practicing in the specialty of emergency medicine at Memorial Hospital in Topeka, Kansas, may satisfy the remainder of such person's obligation to engage in the full-time practice of medicine and surgery by practicing in a critically medically underserved area in the specialty of emergency medicine.

(9) Any person who was first awarded a type I scholarship prior to January 1, 1986, who has completed an approved three-year primary care postgraduate residency training program in pediatrics, who is employed as a clinical assistant professor in the department of pediatrics and as director of the sexual abuse program at the university of Kansas medical center on at least a 55% full-time equivalent basis and who provides on-call services 24 hours per day for sexual abuse evaluations and consultations and administrative decisions, may satisfy the remainder of such person's obligation to engage in the full-time practice of medicine and surgery in a service commitment area I by continuing to provide such services in such capacities on at least a 55% full-time equivalent basis with the university of Kansas medical center, and such person shall be credited for such service against the annual obligation of such person under agreements entered into pursuant to K.S.A. 76-373 through 76-377a, and amendments thereto, at the percentage rate of the full-time equivalent employment of such person as determined by the chancellor of the university of Kansas for each year such

person qualifies under this subsection.

(b) Except as otherwise provided in this section, if the person first entered into an agreement under K.S.A. 76-374 and amendments thereto prior to January 1, 1982, the person shall make 10 equal annual installment payments totaling the entire amount to be repaid under all such agreements for which such obligations are not satisfied, including all amounts of interest at the rate prescribed.

(c) If the person first entered into an agreement under K.S.A. 76-374 and amendments thereto after December 31, 1981, the person shall repay an amount totaling the entire amount to be repaid under all such agreements for which such obligations are not satisfied, including all amounts of interest at the rate prescribed. Except as otherwise provided in this section, such repayment shall be in installment payments and each such installment shall be not less than the amount equal to 1/5 of the total amount which would be required to be paid if repaid in five equal annual installments.

(d) All installment payments under this section shall commence six months after the date of the action or circumstance that causes the failure of the person to satisfy the obligations of such agreements, as determined by the university of Kansas school of medicine based upon the circumstances of each individual case. In all cases where the person first entered into an agreement under K.S.A. 76-374 and amendments thereto after December 31, 1981, if an installment payment becomes 91 days overdue, the entire amount outstanding shall become immediately due and payable, including all amounts of interest at the rate prescribed.

(e) The total repayment obligation imposed under all agreements entered into under K.S.A. 76-374 and amendments thereto may be satisfied at any time by any person who first entered into an agreement under such statute prior to January 1, 1982, and at any time prior to graduation from the university of Kansas school of medicine by any persons who first entered into an agreement under such statute after December 31, 1981, by

making a single lump-sum payment equal to the total of (1) the entire amount to be repaid under all such agreements upon failure to satisfy the obligations under such agreements to practice in Kansas, plus (2) all amounts of interest thereon at the rate prescribed to the date of payment.

(f) There is hereby created in the state treasury the medical scholarship and loan repayment fund. The university of Kansas school of medicine shall remit all moneys received under this section to the state treasurer at least monthly. Upon receipt of each such remittance the state treasurer shall deposit the entire amount thereof in the state treasury, and such amount shall be credited to the medical scholarship and loan repayment fund. All expenditures from the medical scholarship and loan repayment fund shall be for scholarships awarded under K.S.A. 76-373 through 76-377a and amendments thereto, for medical student loans under the medical student loan act, for payment of the salary of the medical scholarship program coordinator and for the expenses of administration of K.S.A. 76-373 through 76-377a and amendments thereto and the medical student loan act and shall be made in accordance with appropriation acts upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the chancellor of the university of Kansas or by a person designated by the chancellor. On the effective date of this act, the director of accounts and reports shall transfer all moneys in the medical scholarship repayment fund to the medical scholarship and loan repayment fund. On the effective date of this act, all liabilities of the medical scholarship repayment fund are hereby imposed on the medical scholarship and loan repayment fund and the medical scholarship repayment fund is hereby abolished. Whenever the medical scholarship repayment fund, or words of like effect, is referred to or designated by any statute, contract or other document, such reference or designation shall be deemed to apply to the medical scholarship and loan repayment fund.

Sec. 2. K.S.A. 1992 Supp. 76-376 is hereby amended to read as follows: 76-376. (a) (1) Except as otherwise provided in

paragraphs (2)~~,~~ ~~3),~~ ~~(4),~~ ~~(5),~~ ~~(6),~~ ~~(7)~~ and ~~(8)~~ through (9) of this subsection (a) or in K.S.A. 76-377 and amendments thereto, upon the failure of any person to satisfy the obligation to engage in the full-time practice of medicine and surgery within the appropriate service commitment area of this state for the required period of time under any agreement entered into pursuant to K.S.A. 76-373 through 76-377a, and amendments thereto, such person shall repay to the university of Kansas school of medicine an amount equal to the total of (A) the amount of money received by such person pursuant to such agreement, or the amount of money determined under rules and regulations of the university of Kansas plus (B) annual interest at a rate of 10%, if the agreement was entered into prior to January 1, 1982, 15%, if the agreement was entered into after December 31, 1981, from the date such money was received.

(2) Any person first awarded a scholarship after December 31, 1985, who fails to apply for and enter an approved three-year primary care postgraduate residency training program shall be required to repay all moneys received pursuant to an agreement entered into for any such scholarship, plus accumulated interest at an annual rate of 15% within 90 days of graduation from the school of medicine, or termination or completion of a residency training program which does not comply with the provisions of this section, whichever occurs later.

(3) If a person fails to satisfy an obligation to engage in the full-time practice of medicine and surgery within a service commitment area I for the required period of time under an agreement entered into pursuant to K.S.A. 76-373 through 76-377a, and amendments thereto, but is engaged in the full-time practice of medicine and surgery within this state in a service commitment area II which would have applied to such person had such person received a type II scholarship under an agreement entered into pursuant to K.S.A. 76-373 through 76-377a, and amendments thereto, and if the chancellor of the university of Kansas, or the designee of the chancellor, finds that exceptional circumstances caused the failure of such person to engage in such

practice in a service commitment area I, such person shall not be required to repay the amount of money received by such person for up to 50% of tuition fees pursuant to such agreement.

(4) If a person fails to satisfy an obligation to engage in the full-time practice of medicine and surgery in Kansas for the required period of time under an agreement entered into pursuant to K.S.A. 76-373 through 76-377a, and amendments thereto, because such person is engaged in the full-time practice of medicine and surgery in a state other than Kansas and if such person is subject to or currently making repayments under this section and if such person subsequently commences the practice of medicine and surgery in this state which complies with the agreements entered into under such statutes, the balance of the repayment amount, including interest thereon, from the time of such commencement of practice until the obligation of such person is satisfied, or until the time such person again becomes subject to repayments, shall be waived. All repayment amounts due prior to such commencement of practice in this state, including interest thereon, shall continue to be payable as provided in this section. If subsequent to such commencement of practice, the person fails to satisfy such obligation, the person again shall be subject to repayments, including interest thereon, as otherwise provided in this section.

(5) Any person awarded a type I scholarship prior to January 1, 1986, who is satisfying the obligation to engage in the full-time practice of medicine and surgery in a service commitment area I by complying with the provisions of subsection (e)(3) of K.S.A. 76-375 and amendments thereto and who except for the provisions of such section (e)(3) would not otherwise be eligible to satisfy such obligation in the area in which such person is engaged in the full-time practice of medicine and surgery shall repay all moneys received by the person pursuant to the type I scholarship for living expenses, including interest thereon as otherwise provided in this section, in accordance with the repayment schedule established for the purposes of this paragraph by the chancellor of the university of Kansas.

(6) If, during the time a person is satisfying the service requirement of an agreement entered into pursuant to K.S.A. 76-373 through 76-377a, and amendments thereto, such person desires to engage in less than the full-time practice of medicine and surgery within the appropriate service commitment area of the state and remain in satisfaction of such service requirement, such person may make application to the chancellor of the university of Kansas or the designee of the chancellor for permission to engage in less than such full-time practice of medicine and surgery. Upon a finding of exceptional circumstances made by the chancellor of the university of Kansas, or the designee of the chancellor, such person may be authorized to engage in less than the full-time practice of medicine and surgery within the appropriate service commitment area of the state for the remaining required period of time under such agreement and for an additional period of time which shall be equal to the length of the originally required period of time multiplied by the decimal fraction which is equal to the reduction of the full-time practice of medicine and surgery to be authorized hereunder, multiplied by two. In any such determination of the period required to be engaged in the less than full-time practice of medicine and surgery, the decimal fraction utilized shall not exceed .5 and any person granted permission to engage in less than the full-time practice of medicine and surgery in accordance with the provisions of this paragraph (6) shall be required to engage in at least the half-time practice of medicine and surgery.

(7) Any person first awarded a scholarship after December 31, 1985, who enters but fails to complete an approved three-year primary care postgraduate residency training program, or who enters and completes an approved three-year primary care postgraduate residency training program but fails to satisfy the obligation to engage in the full-time practice of medicine and surgery within the appropriate service commitment area of this state for the required period of time shall be required to repay all money received pursuant to an agreement entered into for any

such scholarship, plus accumulated interest at an annual rate of 15% within 90 days of failure to complete an approved residency or 90 days of failure to commence qualifying practice, whichever occurs first. This provision shall apply only to agreements entered into from and after the effective date of this act.

(8) Any person who was satisfying such person's obligation to engage in the full-time practice of medicine and surgery within the appropriate service commitment area of the state for the required period of time under any agreement entered into pursuant to K.S.A. 76-373 through 76-376 and amendments thereto, by practicing in the specialty of emergency medicine at Memorial Hospital in Topeka, Kansas, may satisfy the remainder of such person's obligation to engage in the full-time practice of medicine and surgery by practicing in a critically medically underserved area in the specialty of emergency medicine.

(9) Any person who was first awarded a type I scholarship prior to January 1, 1986, who has completed an approved three-year primary care postgraduate residency training program in pediatrics, who is employed as a clinical assistant professor in the department of pediatrics and as director of the sexual abuse program at the university of Kansas medical center on at least a 55% full-time equivalent basis and who provides on-call services 24 hours per day for sexual abuse evaluations and consultations and administrative decisions, may satisfy the remainder of such person's obligation to engage in the full-time practice of medicine and surgery in a service commitment area I by continuing to provide such services in such capacities on at least a 55% full-time equivalent basis with the university of Kansas medical center, and such person shall be credited for such service against the annual obligation of such person under agreements entered into pursuant to K.S.A. 76-373 through 76-377a, and amendments thereto, at the percentage rate of the full-time equivalent employment of such person as determined by the chancellor of the university of Kansas for each year such person qualifies under this subsection.

(b) Except as otherwise provided in this section, if the

person first entered into an agreement under K.S.A. 76-374 and amendments thereto prior to January 1, 1982, the person shall make 10 equal annual installment payments totaling the entire amount to be repaid under all such agreements for which such obligations are not satisfied, including all amounts of interest at the rate prescribed.

(c) If the person first entered into an agreement under K.S.A. 76-374 and amendments thereto after December 31, 1981, the person shall repay an amount totaling the entire amount to be repaid under all such agreements for which such obligations are not satisfied, including all amounts of interest at the rate prescribed. Except as otherwise provided in this section, such repayment shall be in installment payments and each such installment shall be not less than the amount equal to 1/5 of the total amount which would be required to be paid if repaid in five equal annual installments.

(d) All installment payments under this section shall commence six months after the date of the action or circumstance that causes the failure of the person to satisfy the obligations of such agreements, as determined by the university of Kansas school of medicine based upon the circumstances of each individual case. In all cases where the person first entered into an agreement under K.S.A. 76-374 and amendments thereto after December 31, 1981, if an installment payment becomes 91 days overdue, the entire amount outstanding shall become immediately due and payable, including all amounts of interest at the rate prescribed.

(e) The total repayment obligation imposed under all agreements entered into under K.S.A. 76-374 and amendments thereto may be satisfied at any time by any person who first entered into an agreement under such statute prior to January 1, 1982, and at any time prior to graduation from the university of Kansas school of medicine by any persons who first entered into an agreement under such statute after December 31, 1981, by making a single lump-sum payment equal to the total of (1) the entire amount to be repaid under all such agreements upon failure

to satisfy the ligations under such agree nts to practice in Kansas, plus (2) all amounts of interest thereon at the rate prescribed to the date of payment.

(f) There is hereby created in the state treasury the medical scholarship and loan repayment fund. The university of Kansas school of medicine shall remit all moneys received under this section to the state treasurer at least monthly. Upon receipt of each such remittance the state treasurer shall deposit the entire amount thereof in the state treasury, and such amount shall be credited to the medical scholarship and loan repayment fund. All expenditures from the medical scholarship and loan repayment fund shall be for scholarships awarded under K.S.A. 76-373 through 76-377a and amendments thereto, for medical student loans under the medical student loan act, for payment of the salary of the medical scholarship program coordinator and for the expenses of administration of K.S.A. 76-373 through 76-377a and amendments thereto and the medical student loan act and shall be made in accordance with appropriation acts upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the chancellor of the university of Kansas or by a person designated by the chancellor. On the effective date of this act, the director of accounts and reports shall transfer all moneys in the medical scholarship repayment fund to the medical scholarship and loan repayment fund. On the effective date of this act, all liabilities of the medical scholarship repayment fund are hereby imposed on the medical scholarship and loan repayment fund and the medical scholarship repayment fund is hereby abolished. Whenever the medical scholarship repayment fund, or words of like effect, is referred to or designated by any statute, contract or other document, such reference or designation shall be deemed to apply to the medical scholarship and loan repayment fund.

House Appropriations Committee
January 19, 1993

House Bill 2030

House Bill 2030 is a companion piece of legislation recommended by the Joint Committee for Health Care Decisions for the 1990s. It is an appropriations bill increasing the expenditure limitation on the Medical Scholarship and Loan Repayment Fund by $300,000 for Fiscal Year 1993. The purpose of this legislation is to address the issue that I discussed in House Bill 2029 which was the large number of applicants for a medical student loan that could not be satisfied because of the current limit on the number of new awards. We believe that increasing the expenditure authorization by $300,000 will permit an additional 14-15 awards. As I previously mentioned, it is the University's position that provision should be made for these awards being retroactive to the beginning of the current academic year.

In December, the Kansas University Medical Center sought authority from the Board of Regents to amend its budget request for Fiscal Years 1993 and 1994 relative to the medical student loan program. We received approval and have amended our budget to increase expenditures in the current fiscal year by $460,000 which would permit an award of 20 additional loans raising to 50 the number authorized for the current year. We also have proposed in our amended budget that 50 new awards be authorized for Fiscal Year 1994. Whether sufficient funds are available to support this increased number of awards from this funding source is dependent upon income that accrues to the Medical Scholarship and Loan Repayment Fund, and secondly, to what extent that fund source is used for purposes other than financing medical student loans. The Governor's budget recommendation would continue the 30 loans for the current year as well as for Fiscal Year 1994. In all fairness, I suspect that our amended request was not received in sufficient time for the Governor to address that proposal in formulating her budget recommendations.

Estimating income to the Repayment Fund is less than precise. We believe that adequate funds would be available to sustain this level of program (50 per year) through FY 1994 provided that the use of this funding source for general operations is largely curtailed. In our budget proposal originally submitted in September 1992, we utilized $500,000 from this fund for general operations. In the current fiscal year, the Legislature approved $2.4 million from this funding source for general operating support of the institution. In FY 1992, $5.4 million of medical scholarship repayment funds were used for general operations for the purpose of reducing state general fund support for the Medical Center.

ATTACHMENT 10

Attached to my testimony you will note is a projection of income and expenditures for Fiscal Years 93-94 made by the KU Medical Center in our amended budget request. You will also note in the attachment that we have shown the same information based on the Governor's budget recommendation. I confess that the institution is a bit apprehensive about the income estimate made for FY 1994 in the Governor's budget of $4.4 million. What makes income to this fund difficult to estimate is that there is no certainty of the degree to which physicians out of compliance with their service obligations will make advance payments of their contractual obligations. Under current contracts for repayment, actual collections for both years could be in the magnitude of $1.5 to $1.7 million per year. On the basis of experience to date for the current year, we feel that an estimate of $4.4 millon in income is achievable. Whether that trend will continue in FY'94 is of question.

In conclusion, while we are supportive of House Bill 2030, it would be our preference that the increase not be $300,000 but rather $460,000. Legislative committees will continue to review income and expenditures from the Medical Scholarship and Loan Repayment Fund over the course of their budget review. If their judgement is that income estimates of the Governor's staff are too optimistic, then it may become necessary to reduce the recommended expenditure made by the Governor of $1.7 million from this fund for general operations in FY 1994. To the extent that becomes a necessity, increasing the number of awards made in both 1993 and 1994 could ultimately increase the level of State General Fund appropriations that would be necessary as compared to the recommendation made by the Governor.

I would be happy to stand for questions.

# # #

MLR:rdm
1-15-93

MEDICAL SCHOLARSHIP AND LOAN REPAYMENT FUND

	FY 1992	FY 1993	FY 1994
KUMC Amended Request			
Beginning Balance	$ 2,851,803	$ 796,779	$ 242,622
Receipts	4,402,232	4,400,000	3,500,000
Expenditures:			
General Operations	(5,372,220)	(2,403,750)	(500,000)
Scholarships/Loans	(1,085,036)	(2,550,407)	(2,809,038)
Ending Balance	$ 796,779	$ 242,622	$ 433,584
Governor's Budget			
Beginning Balance	$ 2,851,803	$ 796,779	$ 702,622
Receipts	4,402,232	4,400,000	4,400,000
Expenditures:			
General Operations	(5,372,220)	(2,403,750)	(1,700,000)
Scholarships/Loans	(1,085,036)	(2,090,407)	(2,349,038)
Ending Balance	$ 796,779	$ 702,622	$ 1,053,584