Approved 2-6-91
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

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

1:30 a.m./p.m. on February 5, 1991 in room 423-S of the Capitol.

All members were present except:
Representative Theo Cribbs, excused
Representative Tom Bishop, excused

Committee staff present:

Laura Howard, Research
Emalene Correll, Research
Norman Furse, Revisor
Sue Hill, Committee Secretary

Conferees appearing before the committee:

Mr. John Noonan, Member Ks. State Legislative Committee, AARP

Chairperson Sader called meeting to order asking members to read over committee minutes. She allowed several minutes for this review. Rep. Hackler made a motion to approve minutes for January 29, 30, 31st, 1991, as presented, seconded by Rep. Flower, motion carried.

Chair drew attention to agenda schedule.

Mr. John Noonan, AARP representative requested a bill be introduced, and he provided hand-out, (Attachment No. 1). Mr. Noonan explained this particular legislation had been around last year, was covered during Interim study, and it is the wish of AARP Committee to keep the issue alive. The intent of this legislation is to establish a Health Care Data System for the purpose of providing a data base. The primary focus is to compile, analyze, provide information for policy-making groups and eventually for public access. Mr. Noonan noted he had consulted with Norman Furse, Revisor, and it was indicated that the language submitted is sufficient to work on a bill draft.

After thorough explanation, Chair invited motions as to wishes of members of committee. Rep. Neufeld moved to introduce this request from AARP as a committee bill, seconded by Rep. Wiard, motion carried.

Chair drew attention to a glossary prepared by Ms. Correll of Research that was handed out yesterday. Chair asked if there are any questions regarding this glossary. There were none. Ms. Correll informed Chair the next list (Volume II) is in preparation.

Chair drew attention to hand-out (Attachment No. 2), prepared by Dr. Robert Harder, Secretary Department of SRS, Policy Papers of SRS. Chair noted she had been a member of the Task Force and gave background of some of the work done by that Task Force. Chair noted Secretary Harder is present today in committee to answer questions members may have.

Chair recognized Laura Howard, a member of Research Department who presented a report on the Task Force Findings.

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

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S Statehouse, at 1:30 ~~a.m.~~/p.m. on February 5, 1991

Laura Howard, Research Department, noted her comments are taken from findings in the Task Force Report. (Not indicated as an attachment). She stated the Task Force is an ongoing Task Force. The 1991 Interim was charged to study and evaluate the administrative structure and functioning of the SRS, putting emphasis on cost effectiveness of service delivery and effectiveness of program administration, reducing duplication in delivery of services, improving coordination and cooperation between agencies, and maximizing resources. Ms. Howard gave a detailed report on all of the goals studied. Her report concentrated on, i.e., Organizational Structure, Mental Health and Retardation Services, and Childrens' Services.

Ms. Howard answered numerous questions.

Secretary Harder answered questions at this point, i.e., many other states work on a ration of 1 social worker-15, while Kansas has a case load ratio of 1-53. He stated the Department just does not have enough personnel. He stated they are currently having conversations with Michael Petit, of the Child Welfare League of America on a contract for the services of Mr. Petit as consultant whose focus will be on child welfare services, to medical programs, and training packages. The Department is presently looking into ideas to correct the concerns mentioned in the report Ms. Howard has given.

Emalene Correll then offered a comprehensive report on the Task Force Report section on Medical Services. She reported on the findings of the Task Force and detailed its recommendations. In brief, the recommendations were; emphasize prevention and early intervention; health education should receive a high priority; governmental resources should be expended to help the greatest number of people; pilot programs should be introduced to deal with teen pregnancy; responsibility for negotiating rates for direct reimbursement for health care should be placed with a single agency; a board or commission should be established to set reasonabale rates for institutional care services; existing MediKan program should be replaced with a new Kansas Health Benefits program; Proposals No. 31 and No. 32 should be supported; the state's priority in long term care should be continued; a broad based task force should be established to study and make recommendations for a system of medical procedure priorities to be used in allocating Medicaid dollars.

Chair thanked Ms. Correll and Ms. Howard for their fine work.
Chair announced discussion would continue tomorrow on HB 2016.

Chair adjourned meeting at 3:02 p.m.

GUEST REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

Date Feb. 5th, 1991

Name	Organization	Address
David Bateman	Intern	
WAYNE K WIANECKI	KS. AFSCME	TOPEKA
Marilyn Bradt	KINH	Lawrence
Diane Oxford	KCI	Overland Pk, KS
GINA McDONALD	KACIL	Topeka
JAN BUEKER	K-NASW	TOPEKA
Andy Marton	Sen Intern for Ehrlich	Lawrence, KS
Cheryl Shores	KCSL	Topeka
Becci Akin	KCSL	O.P., KS
Halim Barari	KPhA	Topeka
Robert P. Williams	KS. Pharmacists Assoc.	Topeka
Rita L. Wolf	SRS	Topeka.
John Conard	AARP	Lecompton
[illegible]	AARP	Manhattan
Michelle Kinston	John Peterson & Associates	Topeka
Kevin McFarland	Ks. Homes for the Aging	Topeka
Sherri Holliday	Budget Division	"
Betty D Towns	MHAK	✓
[illegible]	Antera	
[illegible]	KDHE	Topeka
[illegible]	KS Foundation for Medical Care	Topeka
RON DAVIS	KU	LAWRENCE
[illegible]	Topeka	Visitor Mary

GUEST REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE Feb. 5, 1991

NAME	ORGANIZATION	ADDRESS
MARY Spinks	Health Benefits Administration	Rm 55-3 LSOB
David M. Klotz	Assoc. of CMHCs Ks, Inc.	Topeka
Eunice Rattan	Shawnee County Mental Health	Topeka
R. Harder	SRS	Topeka
Tom Bell	KHA	Topeka
Nancy Zogleman	BC/BS of Ks	Topeka

John Noonan

PHCW 2-5-91 Attm #1.

Session of 1990

SENATE BILL No. 675

By Committee on Ways and Means

2-16

AN ACT establishing the health data commission; providing for the powers, duties and functions thereof; authorizing the assessing of subscription dues from certain persons; providing for confidentiality of certain information.

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

Section 1. (a) A health data commission is established to ~~act as the state health data clearinghouse~~ develop a system to acquire, compile, correlate, analyze, publish and disseminate data from health care providers, the state medicaid program, third-party payers and other appropriate sources consistent with the intent of this act.

The Kansas health care data system will:

(1) assist public and private health care providers to improve health care policy

(2) enable public and private consumers of health care services to make more efficient decisions and choices.

(b) The commission shall consist of 11 voting members, including the secretary of health and environment, secretary of social and rehabilitation services, secretary of aging, the secretary of human resources and the commissioner of insurance; one member shall be a member of the house of representatives appointed by the speaker of the house of representatives; one member shall be a member of the senate appointed by the president of the senate; and four members shall be appointed by the governor, one of whom shall be a registered nurse, one of whom shall be ~~from business or industry with a record of experience in the administration of an employees health care plan~~ a citizen representing the general public, one of whom shall be a hospital chief executive officer and one of whom shall be a person licensed to practice medicine and surgery. In addition, the executive director of the staff to the commission shall be a nonvoting member of the commission. The governor shall designate the chairperson of the commission.

(c) The commission shall meet at least quarterly during a calendar year. Meeting dates shall be set by commission members or by call of the chairperson upon at least five days' notice to the members of the commission. Action by the commission shall be upon affirmative vote of a majority of all the voting members of the commission.

(d) Members of the commission who are state employees attending meetings of the commission, or attending a subcommittee meeting thereof authorized by the commission, and any member of an ad hoc committee appointed by the commission and attending

PHCW 2-5-91 Attm #1

meetings of the ad hoc committee authorized by the commission shall be paid amounts provided in subsection (e) of K.S.A. 75-3223 and amendments thereto from moneys appropriated to the department or agency of the state which the commission member represents. Members of the commission who are not state employees attending meetings of such commission, or attending a subcommittee meeting thereof authorized by such commission, shall be paid compensation, subsistence allowances, mileage or other expenses as provided in K.S.A. 75-3223 and amendments thereto, except that such members who are not members of the legislature shall receive $75 per diem. Moneys to pay members of the commission who are not state employees or legislators shall be paid equally from moneys appropriated to the state departments or agencies represented on the commission. Moneys to pay members of the commission who are legislators shall be paid from money appropriated for the legislature. Staff members attending commission meetings shall receive no payments of any kind for attending such meetings.

Sec. 2. (a) The health data commission may enter into an agreement or agreements with a firm, corporation or entity it shall establish as qualified and appropriate ~~to provide staff for~~ to assist in the compilation, correlation and development of the data collected by the commission, to conduct or contract for studies on health-related matters which will further the purpose or purposes and intent of the legislature and the commission. ~~Such agreement or agreements may provide for the corporation, association, form or entity to prepare and distribute or make available data to health care providers, subscribers, third party payors and the general public.~~

~~(b) All health care providers licensed or registered by the state shall, as a condition of licensure or registration in this state, be subscribers to the health care data system and be assessed dues applicable to such subscription as periodically established by the commission by rules and regulations. The commission may also prescribe and collect charges for services provided by the commission and made available to others than health care providers when the costs for providing such services are covered by the fees.~~

(c) The commission may require state departments or agencies involved in aspects of health care or social services to obtain for and make available to the commission data related to health care or social services and needed to carry out its purpose, including but not limited to the data specified by this act.

(d) The commission may appoint appropriate subcommittees as deemed necessary to assist the commission in carrying out its duties. In addition the commission may appoint ad hoc committees to deal

(a) The commission will appoint a director and allow for appropriate clerical assistance whose responsibility it will be to administer the policies and responsibilities set by the commission.

(b) After initial start-up funding, continued funding will result from legislative action on recommendation from the commission. In addition to legislative funds, the commission will use monies from charges for information that may be assessed to independent clients.

PH+W 2-5-91 Attm # 1-2

PH+W 2-5-91 Attm # 1-2

with special problems and may appoint members thereto who need not be members of the commission or state employees, except that at least one member of an ad hoc committee shall be a member of the commission.

(e) The data collected by and furnished to the commission pursuant to this act shall not be public records. Compilations developed and approved by the commission for release or dissemination from that data shall be public records provided the confidentiality of patients is protected and the laws of this state with regard to patient confidentiality apply, except to the extent provided in section 5 and amendments thereto.

(f) As used in this section, "health care provider" has the same meaning as is ascribed to such term under K.S.A. 1989 Supp. 65-4921 and amendments thereto.

Sec. 3. The commission shall require that:

(a) ~~The commission members of the departments of health and environment, social and rehabilitation services and the commissioner of insurance shall encourage and assist third-party payers and all medical care facilities to voluntarily implement the use of a uniform hospital billing form, and require that all third-party payers and all medical care facilities use by July 1, 1991, the uniform hospital billing form designated or established by the commission.~~

~~(b) The commission shall establish uniform definitions for the billing forms established by the commission.~~

(a) The commission shall encourage hospitals and third party payers' participation in and refinement of current hospital billing to include content, definitions, and format.

(b)~~(c)~~ The commissioner of insurance is hereby authorized to require that all third-party payers, including but not limited to licensed insurers, medical and hospital service corporations, health maintenance organizations and self-funded employee health plans, provide hospital inpatient and outpatient claims data and corresponding physician claims data to the commission pursuant to this act. ~~This data shall include the patient's age, sex, zip code, third-party coverage, date of admission, procedure and discharge date, principal and other diagnoses, principal and other procedures, total charges and components of those charges, attending physician and hospital identification numbers, disposition of the patient and expected source of payment. Prior to July 1, 1991, the commissioner of insurance may limit the data collection to major third-party payers and a sample of those third-party payers with low market penetration, to more frequent diagnoses and procedures, and to hospital inpatient claims.~~

(c)~~(d)~~ The corporation, association or other entity providing research for the commission shall compile and disseminate comparative information on ~~average~~ charges, total and ancillary charge components, the length of stay on diagnosis-specific and procedure-specific cases

PNeW 2-5-91 Attm. 1-3

PNeW 2-5-91 Attm. 1-3

on a medical care facility-by-facility basis. Prior to the release or dissemination of the compilations and reports, the commission or the corporation, association, firm or other entity under the agreement with the commission pursuant to this act, shall provide for providers an opportunity to verify the accuracy of any information pertaining to the provider. Providers may submit to the commission any corrections or errors in the compilations of the data with any supporting evidence and comments the provider may submit. The commission shall correct data found to be in error.

~~(d) (b) If the data required by the commission or the members of the commission is available on computer or electronic tape, a copy of this tape shall be provided when requested.~~

~~(e) (c) The secretary of health and environment and commissioner of insurance shall establish a system which creates the use of a common identification number between the uniform hospital billing form and the hospital discharge abstract.~~

~~(f) (d) The secretary of health and environment shall establish a system of uniform physician identification numbers for use on hospital discharge abstract forms.~~

~~(g) (e) The secretary of social and rehabilitation services shall make available to the commission data and information on the state medicaid program and medical assistance program similar to that required of other third-party payers.~~

Sec. 4. The commission may require that:

(a) The secretary of health and environment require the uniform discharge abstract form designated or established by the commission be used by all hospitals ~~by July 1, 1991~~.

(b) The commissioner of insurance require corporations regulated by the commissioner which offer health care insurance or service plans to provide health care policyholder or subscriber data by geographic area or other demographics.

(c) The secretary of health and environment require medical facilities to submit annually to the secretary and to post notification in a public area of the medical care facility that there is available for public examination in each facility the established charges for services, including any modification of charges within the year, where applicable; including, but not limited to, routine daily room service, special care daily room service, delivery room service, operating room service, emergency room service and anesthesiology services and as enumerated by the commission for each of the 25 most common laboratory services, radiology services and pharmacy prescriptions and services. In addition to the posting of the notification, the medical care facility shall post in each facility, next to the no-

PHLeg 2-5-91 Attm # 1-4

PHLeg 2-5-91 Attm # 1-4

tification, the established charges for routine daily room service, special care daily room service, delivery room service, operating room service and emergency room service.

(d) Additional or alternative information related to the intent and purpose of sections 1 through 6, and amendments thereto, as outlined in section 1 be submitted to the commission.

Sec. 5. (a) It is the intent of the legislature to protect the confidentiality of patient records.

~~(b) Information provided under this act shall not identify a patient by name, address or patient identification number unless authorized by the patient.~~

(b) ~~(c)~~ The commission shall determine the form in which information will be made available and to whom, when and under what circumstances.

(c) ~~(d)~~ Members of the commission or persons employed by or agents of the commission shall not be civilly liable as a result of their acts or omissions in connection with their duties for the commission.

Sec. 6. Data furnished to the commission under this act shall not constitute a public record. A cause for action in the nature of defamation, invasion of privacy or negligence shall not arise against a person for disclosing information in accordance with this act. However, this act shall not provide immunity for disclosing or furnishing false information with malice or willful intent to injure a person.

Sec. 7. The commission on January 15, 1992, and annually thereafter on or before January 15 shall report to the legislature on the actions taken by the commission.

Sec. 8. The commission shall adopt rules and regulations not inconsistent with the law as necessary to obtain from persons and departments or agencies of the state and from persons licensed or regulated by the state data required by the commission under this act.

Sec. 9. Upon the effective date of regulations which may be adopted by the United States department of health and human services prohibiting combined billing by hospitals and hospital-based physicians under title XVIII of the federal social security act, the charges for all pathology and radiology services in a hospital may upon the mutual agreement of the hospital, physician and third-party payer, be billed separately, the hospital component of the charges being included in the hospital bill and the doctor component being billed by the doctor.

Sec. 10. A commission member of a state department responsible for establishing and enforcing rules and regulations for which such member is responsible for administration and supervision under such

Passed 2-5-91 Attach 1-5

1-5

member's department and as necessary to obtain from persons authorized to do business in the state or regulated by the department and requiring data that department is required to provide under this act shall publish and enforce such rules and regulations consistent with this act.

Sec. 11. This act shall take effect and be in force from and after its publication in the statute book.

PH&W
2-5-91
Attm # 1-6

PH&W
2-5-91
Attm # 1-6

Ins
2-5-91

SRS POLICY PAPERS

Index

PAHCO
2-5-91
Attm # 2

SRS POLICY PAPER

COST-EFFECTIVE AND APPROPRIATE TREATMENT OPTIONS

Problem Statement

A broad range of cost-effective and appropriate treatment options for clients with insurance and/or the ability to pay for services in Kansas should be developed.

Rehabilitation for alcoholism and other drug addiction treatment should occur in the lowest cost setting of appropriate quality. In 1989, there were 34,000 admissions to alcohol and drug treatment programs in Kansas. Half of these admissions were to programs partially funded by SRS/Alcohol and Drug Abuse Services (ADAS). With the major exception of the setting in which clients receive treatment, there is no significant difference in the outcome information reported by public and private programs.

Nearly 50 percent of the clients in non-funded programs are treated in residential facilities at costs of $4,000 to $15,000. In SRS-funded programs, 80 percent of the clients are served in outpatient programs. National studies indicate that 80 percent of all alcohol and drug clients can benefit from treatment in an outpatient program.

ADAS has funded a continuum of cost-effective community-based treatment services for indigent clients in regions across the state. Because of the variety of treatment options, more clients are referred to less costly and appropriate settings such as outpatient and outpatient day treatment. A severity index and standardized admission criteria are being developed so clients can be matched with the most effective treatment option.

Proposed Solutions and Outcomes

There is no comparable treatment system for clients with insurance and/or the ability to pay. Most are treated in residential programs. ADAS recommends that insurance providers develop standardized admission criteria for the various levels of treatment. A greater variety of treatment options such as outpatient and reintegration (halfway houses) programs should be explored and reimbursed by insurance providers. The result will be that more people will seek treatment and overall costs will be reduced.

ADAS recommends consumers and their families who have been through treatment, SRS area offices, and professional alcohol and drug associations be included in providing written and/or verbal input. A special study of this issue could be charged to the Kansas Citizens Committee on Alcohol and Other Drug Abuse by the SRS Secretary.

Possible Consequences

The Kansas Hospital Association and residential alcohol and drug treatment programs may lobby against this proposal. Support should come from the professional alcohol and drug associations.

PHHCU 2-5-91

Attm. # 2-2

01/22/91

SRS POLICY PAPER

YOUTH PREVENTION AND TREATMENT

Problem Statement

The use of alcohol and other drugs by youth can have particularly serious physical, emotional, financial and legal consequences. For the past ten years, SRS/Alcohol and Drug Abuse Services (ADAS) has been a national leader in developing a comprehensive program of alcohol and drug prevention and treatment services for children and youth.

Current ADAS-funded prevention programs include 12 Alcohol and Drug Regional Prevention Centers and teacher training programs such as Kansas School Team Training and Project STAR (Students Taught Awareness and Resistance). These programs work closely with the Kansas Department of Education's Drug-Free Schools Program. The ADAS-funded prevention evaluation system indicates progress is being made in slowing down the rate of drug abuse among Kansas youth.

For youth already having problems, ADAS funds 29 residential treatment beds for indigent youth in Wichita and in the Kansas City area, as well as, counselors in seven group homes, and intensive outpatient day treatment programs.

While SRS is doing a good job in preventing problems among low-risk youth, more intensive prevention work should be done with high-risk youth who are not yet addicted. Once youth are identified, treatment services need to be available. A 1986 SRS study indicated that 7,000 Kansas youth may need alcohol and drug treatment annually. Young people at high risk are generally characterized as abused and/or neglected youth, homeless or runaways, youth with physical and/or mental handicaps, pregnant teenagers, school drop-outs, latchkey children and economically disadvantaged youth. They usually have multiple risk factors and without intervention tend to be among the heaviest users of drugs and alcohol.

Proposed Solutions

Specialized prevention and treatment strategies and services should be developed in cooperation with other SRS programs and state agencies that serve high-risk youth. For example, in response to a need identified by SRS area offices and other groups, alcohol and drug counselors have been placed in seven group homes and in SRS youth institutions across the state.

In addition to identifying and developing strategies with SRS programs, ADAS proposes that outside providers and groups be involved. These include the Regional Prevention Center Directors, School Team representatives, the Project STAR Coordinator, SRS area office representatives, funded treatment program providers and selected consumers. The 24 member Kansas Citizens Committee on Alcohol and Other Drug Abuse should be included in this process as well as youth in the target group.

PH&W
2-5-91
Attm. 2-3

Possible Consequences

These strategies must be systematically planned and represent a balanced approach. If prevention services are developed without consideration of the treatment needs, the treatment system becomes overloaded and unresponsive to these youth. While there is an awareness that alcohol and drug dependency is the root problem of many social issues, we would be asking already overworked program providers to invest resources in long-term solutions.

01/22/91

PHKW
2-5-91
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SRS POLICY PAPER

IMPROVING SERVICES TO BEHAVIOR DISORDERED YOUTH

Problem Statement

Typically behavior disordered youth have repeatedly failed placement in the foster care and/or mental health system. Communities clearly express their desire that these youth be managed and treated in facilities and look to the state for programs which can address these severe behavior problems. Because of the lack of access to community based services, the youth come into state custody. These youth are found in state hospitals, state youth centers, private hospitals, foster care and moving between placements. This takes a major toll on the youth, on agency budgets, and on staff resources. Mental Health Reform adds a new dimension which is likely to develop a separate but parallel and possibly competing system. This lack of organizational focus for the population results in less than comprehensive planning and service delivery.

Proposed Solutions

Placing all state operated Youth Services residential and mental health youth programs in one organizational unit of SRS could provide needed additional flexibility in addressing the needs of families and communities as well as maximizing the use of existing resources. This approach creates no new beds in the system but does create the ability to provide more services through focused management and flexibility directed at serving the needs of families and communities. This program would be carefully coordinated with and enhance the foster care system, medical assistance, family services, and mental health. Overall, this program would operate as a residential treatment program, a case management system, a psychiatric treatment program, and as a broker which maximizes the system potential. Through the provision of a strong focused management structure with flexibility in the delivery of services, more can be done with the existing programs to address the demand for community based and residential services for behavior disordered youth.

Another approach to this growing population would be to contract with private vendors to provide for the needs of these youth. This would predictably be a less flexible system which to date underserves this population because they disrupt the program for other residents and incur liabilities.

Possible Consequences

Failure to recognize the need for some basic system change will continue underserving these youth and hazards further fragmentation and/or gaps. Without careful education about the proposal the providers and advocates are a potential source of resistance. However, with the right approach the providers and advocates would be expected to support as an adjunct to their system.

There are other efforts that need to be undertaken at the same time to improve services for youth. These include reforming service delivery, creating flexible financing strategies, encouraging local solutions, creating coordinating councils, and establishing collaborative legislative and cross-sector structures.

01/22/91

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2-5-91
2-5
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SRS POLICY PAPER

CHILD ABUSE AND NEGLECT CASES: STREAMLINING THE APPEAL PROCESS

Problem Statement

A 1988 amendment to K.S.A. 65-586 mandated that SRS provide an opportunity for an informal review of the agency's intent to identify a person as an abuser or neglecter. This informal due process review is in addition to the normal due process afforded by the formal administrative appeals procedures.

The informal review is redundant and is confusing to the person and often results in the individual incurring the expense of an attorney for what was intended to be an informal process. It consumes a great deal of agency resources without concomitant benefit to the client. It delays final resolution and action through the established formal process. This delay can be costly in time and money to the alleged perpetrator and to the employer when the individual is employed in a child care facility. Most importantly, it adds nothing to the due process protections already afforded by the administrative appeals process.

Proposed Solutions

1 Change the law to eliminate this redundant informal process.

2 Change the law to eliminate the use of the Child Abuse Neglect Central Registry as an employment screen for child care providers.

Possible Consequences

Any discussion of the issue of due process and the Child Abuse Central Registry will raise controversy. However, the political ramifications of eliminating the unproductive informal process are negligible. The change speeds up the resolution of disputed findings and does not infringe on individual due process. The legislature is concerned about unnecessary duplication which the current process fosters.

Total elimination of the Child Abuse Neglect Central Registry will create considerable concern among those who are concerned about the well being and protection of children. It would also result in the loss of eligibility for federal grants funds.

Support for the elimination of the informal process will come from those who are interested in a speedy and impartial resolution of disputed findings. This includes SRS staff, KDHE, many in the legal community and child care providers.

Support for the elimination of the Child Abuse/Neglect Central Registry would come from members of V.O.C.A.L. and individuals who question state intervention into family life.

01/22/91

PH&CJ
2-5-91

Attm 2-6

SRS POLICY PAPER

CHILD CARE

Provision of adequate child care resources to meet all the needs of a diverse population has been an on-going issue for several years. With the additional funding available from the federal government in FY 91 and FY 92, unresolved issues about use of child care funds and who should receive services first will undoubtedly resurface.

Problem Statement

Funding for child care in Kansas diminished considerably in the early 1980's then rose through State general funds appropriated in FY 88 and federal JOBS funding in FY 90. Funds will increase dramatically in FY 91 and FY 92 when the Child Care and Development Block Grant (CCDBG) of $6.5m in FY92 and the Title IV-A (Potential AFDC) of $3m become available. Issues related to SRS administration of these funds such as equity of services (by type of client and by area allocations), timely payment, priority setting and community input will no doubt be topics of public debate during the upcoming Legislative session. In the past certain child care provider groups and Legislators have questioned the authority of SRS to transfer funds within child care accounts with allegations that income eligible funds have been used to fund Kanwork child care services. State general funds available in the income eligible accounts have been used to draw down the AFDC match in some instances, but these funds were already serving AFDC clients and only allowed the agency to increase the overall amount of funding available for child care. With plans to utilize income eligible state general funds to draw down Title IV-A funds for potential AFDC clients during FY 91, the agency may again be open to such criticism.

Another frequently heard complaint is that the current system of area allocations is unfair. While some areas have frozen intake, other areas may still be taking new clients. If excess funds from one area are redistributed to another which is over-projected, the agency essentially penalizes good management and rewards poor management. The use of increasing amounts of child care funds to keep children in their homes in protective service cases (top priority) has become an internal issue with the Kansas City office expending more than $.5m in FY 90 for this service. Although this is an essential service, it is an unpredictable expense that continues to stress other SRS areas' allocations.

SRS rates for providers are also an issue. The CCDBG requires that low provider wages be addressed. Title IV-A child care proposes that provider rates be set at the 75th percentile of local market rates in order for low income clients to compete for available child care. The proposed SRS budget for FY 92 sets rates at $2600 per child year which is approximately the 75th percentile. This is a major increase over FY 91 ($2110) and would address provider wage issues .

PH+CU
2-5-91

Attm #.
2-7

The last issue is community input into agency priority setting for child care services. The agency currently receives substantial input from some providers into policy issues through a self-appointed volunteer child care advisory board. The agency has not had an official advisory board appointed by the Secretary or the Governor for many years nor does the volunteer board include consumers of child care services.

Proposed Solutions

1 Maintain status quo.

2 Increase child care staff in the areas and streamline/computerize the payment system to improve response time. Contract out eligibility determination for income eligible clients to large child care centers willing to do this. Appoint an official advisory group including consumers to advise the agency on child care matters. Encourage local coalitions of child care providers, consumers, supporters and employers to undertake local needs assessment and to develop local plans to deliver child care services and provide adequate funding. These local plans should be the basis for establishing the statewide plan required by CCDBG.

Possible Consequences

Failure to address the issues identified above will result in the continued criticism of the program. Undertaking the strategies identified in the second option would widen the circle of input into agency administration as well as reduce valid criticisms. Potential support will come from those interested in providing adequate and equitable services statewide. Resistance may continue to arise from those who see SRS administration rather than lack of resources as the problem. Any efforts by the agency to streamline payment systems, improve rates and service delivery should meet with public support.

01/22/91

PH&W
2-5-91
Attm #
2-8

SRS POLICY PAPER

DOWNSIZING STATE INSTITUTIONS FOR THE MENTALLY RETARDED
LARGE-BED INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

Problem Statement

The State of Kansas can improve the quality of life for hundreds of individuals who are mentally retarded by expanding community-based residential and training programs. These persons presently reside in large-bed state-operated and private for-profit intermediate care facilities for the mentally retarded (ICFs/MR). There are approximately 630 persons residing in ten private large-bed institutions. While these facilities are less expensive in terms of per diem costs, the quality of life for residents is significantly less than that available in small-bed facilities or in other settings. In recent years, with the federal emphasis on active treatment and client rights, these facilities have faced continual threat of decertification causing costs to increase significantly. At present, the state has little choice but to increase support for these facilities because few, if any, alternatives are available.

Proposed Solutions

This paper proposes that the State of Kansas cease all financial support for ICFs/MR over 16 beds by the year 1995. This provides the management and investors of these facilities time to close their operations and find alternative placements for the clients they now serve. This paper also proposes that, if necessary, state-operated ICFs/MR take management control of facilities if the management decides to abandon them and the clients. This will allow SRS to continue operation of the facilities until placements can be found for clients. Individuals currently served in these facilities can be placed in community integrated settings funded by the home and community based services (HCBS) waiver. They can also be placed in six to eight-bed ICFs/MR, but this is a less desirable, more expensive option. If this solution is pursued, it would be critical to place the responsibility for the facility closing, HCBS waiver administration, and community mental retardation/developmental disability (MR/DD) programs in the same administrative unit. This will allow for optimum coordination of transition, funding and placement. Fragmentation of these responsibilities may result in wasted time and effort.

Possible Consequences

Legislators may question the closing of beds that are the least expensive. Seven of the ten private institutions are owned and operated by Kansans. Communities that benefit from the financial operation of these facilities will not support their closing because jobs will be lost and local businesses will lose a valued customer. Supporters will be advocates and community providers, although some providers find it easier to depend on the large facilities rather than provide the needed services.

State institutions will continue to be downsized during this period. The closing of a state institution should not be considered until the 630 beds in private institutions are closed first.

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Attm # 2-9

SRS POLICY PAPER

STRENGTHENING KANSAS FAMILIES

Problem Statement

In November, 1990 the number of children in SRS custody hit an all time high of 6,646. Foster care remains the single solution to child and family problems not only in Kansas but also nationwide. The number of children in substitute care in the U.S. rose from 280,000 in 1986 to 360,000 in 1989, a net increase of 29.6%. Foster care budgets skyrocketed in the same period, growing 113% in California and 85% in Illinois. The Kansas budget grew 95.9% in the five years from 1987 ($22.8 million) to 1991 ($44.7 million).

Some children are brought to the juvenile court voluntarily by their parents, who are searching for help. Community assistance has not been readily available to these parents. Early intervention strategies at the community level to support and improve family life could maintain these children in their own homes.

The Family Preservation projects in the Salina management area, Reno County and Miami County, authorized by the 1989 legislature, have flattened the rate of growth in children entering the juvenile court system. From October, 1989 to October, 1990 while the state as a whole experienced an 8% growth rate, Salina area experienced only a 3.5% growth.

The cost of community based family services such as the Parents as Teachers program or Family Preservation is minimal compared to the cost of maintaining a child out of his own home.

Proposed Solutions

Expand community resources to include: 1) Crisis intervention services readily available in the community. 2) In-home family based therapy for families with intensive mental health needs. 3) Family preservation teams available in all SRS management areas, especially in the urban areas. 4) Flexible dollars available to families to meet immediate short term financial crises. 5) Services available through school systems that encourage and support families in dealing with troubled youth and maintain them in the community. 6) Parent education and Parents as Teachers programs. The potential outcome will be stronger, more capable families who cannot only parent their children more appropriately but also model self-sufficiency and confidence for the future generations of Kansas parents.

Possible Consequences

Strong capable families rearing capable children benefits the employers of Kansas and results in less drain on the taxpayers for foster care, mental health treatment and ultimately prisons.

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Community advocates, families at risk and youth will certainly support this solution.

People who are concerned that children will be left in unsafe or inappropriate homes will express initial concern, which can be overcome by education and demonstrated success.

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SRS POLICY PAPER

GENERAL ASSISTANCE/MEDIKAN PROGRAM

Problem Statement

The state funded General Assistance Program (GA) has undergone significant reductions in recent years due to fiscal constraints and competing funding priorities of state government. Currently GA serves persons not eligible for a federal program who are unable to meet their basic food, shelter, clothing, and medical need. This population includes intact families and individuals over 55, disabled, and individuals being released from state institutions. MediKan, state funded medical coverage, meets the medical costs of most GA recipients. In December 1989, in response to budgetary concerns, the department began a process to scale back and eventually eliminate GA/MediKan. This action was met with legislative and public resistance and ultimately a court injunction preventing elimination of MediKan. As a result, the program continued with no changes or cutbacks.

In May 1990, as part of the Department's appropriations bill for FY 90 and 91, authority was given to establish a new pared down GA/MediKan program. The new program was never implemented, however, because the existing injunction was expanded to prevent any program cutbacks. Due to the court injunction which is still in effect, the Department is operating a more costly GA/MediKan program than originally budgeted or appropriated.

Again this year, we are faced with the dilemma of maintaining the state funded GA/Medikan services in light of competing agency needs and federally mandated services and expenditures.

Proposed Solutions

Several options are available for the GA/MediKan program. The current program which provides a limited population with minimal cash and medical benefits could be continued. A further scaled back program could be implemented which maintains cash assistance but narrows the eligible population to families and persons disabled for at least six months. Limited physician, drug and community mental health services could be allowed but hospitalization would be eliminated.

Another modification could be to maintain cash assistance and establish medical programs for those whose income falls below a specified percentage of the poverty level. Implementation of this option would require additional reductions of medical services but would offer these reduced services to an expanded population.

The final option would be the elimination of the entire GA/MediKan program.

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Possible Consequences

Continuation of GA/MediKan, as it currently exists, would result in a need for supplemental appropriations for FY 91 and 92. Even immediate implementation of a scaled back program will not eliminate the need for a supplemental request for FY 91. As always, any request for additional funding will meet with legislative resistance. If a scaled back program is implemented, it can be expected that advocates and provider organizations will be deeply distressed and politically active, especially the hospital and mental health sectors. It is possible that the Commission on Access to Services for the Medically Indigent and Homeless would support modifications which maintain cash assistance and offer very limited medical coverage to a larger population. Based on the events of 1990, it can be anticipated that action to eliminate the GA/MediKan program will result in legal action being taken against the Department.

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SRS POLICY PAPER

HOME AND COMMUNITY BASED ALTERNATIVES

Problem Statement

SRS has taken advantage of a federal option to provide home and community based services, for a number of years, as an alternative to institutional long term care. The program has been successful in containing nursing facility costs and has allowed the elderly and disabled to remain in their own homes. Despite this effort, however, many persons who could remain at home or in supervised care are placed in nursing facilities. Kansas has a disproportionately high level of institutional care compared to other states in the nation.

Proposed Solutions

Considering this and the necessary steps which must be taken to contain rising health care costs, home and community based alternatives could be expanded. Such expansion will be critical if options to reduce eligibility for nursing facility placement are implemented.

The following are components of an expansion plan:

1 Creation of an interagency planning group with private sector participation to review available resources, coordinate services across agencies and develop long range plans;

2 Mandatory pre-admission screening of all persons arranging nursing facility placement to allow opportunity for other options;

3 Expansion of case management and in-home services provided directly by SRS staff through our Area offices; and,

4 Expansion of services to include a wider range of options for both private pay and public use. Residential services are a particular need and include programs such as adult foster homes and assisted living facilities.

Possible Consequences

Community support for traditional nursing facility programs is strong, particularly in rural areas. Further, any diversion of consequence is likely to be opposed by the nursing home industry. The benefits are an improved cost picture for the State over the long range and opportunity for the elderly and disabled to remain in their own homes or to remain a part of their local community in a more home like setting. An interagency planning group with private sector participation will reduce duplication of effort and maximize use of available resources. Mandatory pre-admission screening may be viewed by some as an interference with private choice. However, the strategies identified should curb the current demand and excess cost associated with nursing facility placement.

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KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Policy Paper
Implementation of a Statewide Service Delivery System for Long Term Care

Problem Statement

Despite the fact that numerous comprehensive plans for long term care for the elderly and disabled have been developed, the state still lacks a defined statewide service delivery system, and major issues identified by previous studies still exist. Program and funding decisions continue to be made in isolation and in a segmented manner with little or no understanding of the inter-relationship between institutional and community, elderly and disabled, medical and nonmedical, and Medicaid and non-Medicaid services. In addition, while many services and programs are in operation, a coordinating mechanism is still needed to interrelate the various service elements, which continue to be basically independent organizational structures, into a comprehensive, coordinated system of long-term care.

The most recent study, completed December 31, 1986, was built on previous works including the 1978 Home Care Study; the 1981 interim legislative study of alternatives to nursing home services; the State Health Plan for Kansas on long term care; and the 1984 Joint Position Statement on Long Term Care by the Kansas Medical Society, Ks. Dept. of Health and Environment, Ks. Dept. on Aging, Ks. Dept. of SRS. The plan, which was directed by HCR 5052, included an analysis of the need for community alternative long-term care services; the goals and objectives for community long-term care services; recommendations for implementation; analysis of gaps in programs and service; and methods to coordinate efforts among and between appropriate state and community agencies.

In 1985, a Resource Coordination Network was formed with personnel from each of the three agencies involved in long term care and a director from an Area Agency on Aging. With the adoption of HCR 5052, an Advisory Committee was formed within this Network for the purpose of advising the Secretaries on the development of the comprehensive long term care plan. Representation from various community organizations were included. With all of these efforts, an identified and planned statewide service delivery system has yet to evolve.

Proposed Solutions

Creation of a Governor's Commission (staff with a paid staff person) or the formation of a task group, consisting of representatives from the three major state agencies, appropriate organizations in the private sector and consumers, with identification of SRS as the lead agency whose responsibility is to develop the State's philosophy and priorities on long term care and a structure for implementation. A single budget for long term care that crosses the three major agencies involved should be considered.

Possible Consequences

The general feeling among advocates, consumers and providers of long term care services is one of frustration over lack of results with past efforts, and skepticism towards the value of another planning group. The level of involvement and commitment will be minimal unless there is some assurance that concrete results will occur from efforts expended. Area Agencies on Aging, in general, are opposed to efforts to statewide planning efforts as they want local control. **However, only a statewide system can systematically address the service gaps, control costs, reverse the current institutional bias, and ensure equal access and quality care.**

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SRS POLICY PAPER

SOCIAL SERVICES ACCOUNTABILITY

Problem Statement

The SRS Task Force and Legislative Post Audit have recently criticized the scope and accuracy of information the agency is able to provide about social service programs. This criticism is justified. At this time there is no consolidated comprehensive social services information system. Individual systems have been established in response to unique federal mandates and programmatic considerations without system-wide integration.

Generation of internal management reports and ad hoc reports require that data be gathered from a variety of information systems. Fiscal data is found within STARS, KAECSES, and KanPay. Client data is found within the Child Tracking System (CTS), Child Abuse Neglect Information System (CANIS), Family Service Information System (FSIS), and the Kansas Medicaid Management Information System (KMMIS). Data elements from these sources are inconsistent. For example, one report may count "person months," another "client days," another "units of services," and still another may record a "point in time" count of client status. Data must be heavily manipulated or reports extensively annotated to compensate for these differences. These examples refer to Youth Services related issues. Similar problems are encountered by other service commissions.

Proposed Solutions

A truly integrated social services information system could be developed through one of several available options:

1 A system could be designed using existing SRS resources;

2 A system could be designed by a private contractor specifically to meet the agency's needs;

3 Existing systems available from several vendors could be used with some modification.

Each option has unique advantages and disadvantages.

The outcome of any of these options would be a social service system more accountable for its actions. Information would be available which would allow the agency staff and the state's policy makers to make better decisions. More importantly, the quality and timeliness of services to the agency's clients would improve.

Possible Consequences

Initial reluctance to invest in another SRS information system can be overcome through education. The advantages of a unified system are many and impact all levels of SRS and beyond.

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SRS POLICY PAPER

EXPANSION OF KANWORK TO MEET FEDERAL JOBS MANDATE

The Family Support Act of 1988 mandates the states to implement a statewide Job Opportunities and Basic Skills (JOBS) Program by October 1, 1992. Kansas began implementation of the JOBS program in October, 1989 in the four Kanwork counties; however, further expansion to meet federal requirements has been delayed due to overall SRS budget difficulties.

Problem Statement

The Family Support Act mandate has two parts, both of which must be met by October 1, 1992. The mandates are as follows:

1 Complete JOBS services must be available to 75 percent of the Aid to Families with Dependent Children (AFDC) adult population. The KanWork Program meets the complete JOBS Program requirements of four mandatory components: education for basic literacy, up to high school or equivalency, job skills vocational training, job readiness activities and job development/placement activities, plus at least two optional components: group and individual job search, on-the-job training, and community work experience. KanWork currently covers 25 percent of the AFDC adults.

2 Minimal JOBS services must be available to 95 percent of the AFDC adults by October 1, 1992. A minimal program includes high school or equivalent education, one optional component and information/referral to non-JOBS employment services.

The legislature appropriated funds for expansion of the KanWork Program in both FY 90 and FY 91; however, due to overall SRS funding shortfalls, this expansion was not accomplished. There were also some concerns that the KanWork/JOBS model needed further testing before expansion.

In order to meet the federal timelines, the last possible date to gear up the program will be during the last quarter of FY 1992 continuing through the first quarter of FY 1993.

Proposed Solutions

1 Maintain status quo with no further expansion. If expansion does not occur to meet the 75% requirement by October 1, 1992, Kansas could be sanctioned and would not receive some or all of the AFDC federal cash grant funding available.

2 Expand KanWork during the last quarter of FY 92 into the remaining seven counties of the original legislative mandate. These are Wyandotte, Leavenworth, Johnson, Douglas, Butler, Ford, and Seward. This allows for staffing and gearing up of the program for implementation and client service effective July 1, 1992. Client service costs would not be budgeted until FY 93. One hundred eleven additional staff would be needed.

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The second phase of reaching the mandated goal is to expand KanWork into an additional eleven counties between July 1 and October 1, 1992. These counties include: Atchison, Cherokee, Cowley, Crawford, Geary, Labette, Lyon, Montgomery, Reno, Riley, and Saline. This provides KanWork coverage to 78 percent of the AFDC adult population. Client service costs would be budgeted for only nine months. Ninety-nine and one-half additional staff would be needed.

The last phase of reaching the mandate is to provide for minimal JOBS services to an additional 30 counties by January 1, 1993. These minimal services would assign at least one JOBS staff to each of the additional 30 counties. Client service costs would be budgeted for only six months.

Possible Consequences

Many counties have looked forward to the implementation of KanWork and are discouraged by the continued postponement. Some counties have geared up/down several times. Further delays will add to the frustration some communities have had with the SRS implementation schedule.

Option 2 would triple the number of AFDC clients who will improve their capacities to become self-supporting and break the cycle of dependency for future generations. Areas of support can be found in county government and local communities who are interested in providing self-sufficiency services to AFDC clients; they will support a more rapid expansion timeline. Likely support will come from the seven counties scheduled earlier and Southeast Kansas.

Resistance may come from persons who do not believe KanWork, as administered by SRS, can meet the "employment" needs of AFDC clients. This includes those who perceive JOBS/KanWork as just another employment and training program, not a redefinition of the AFDC Program to emphasize family self-sufficiency and education as it is intended.

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SRS POLICY PAPER

MEDICAL ASSISTANCE COST CONTAINMENT

Problem Statement

A number of reductions in the scope of medical services have been proposed to reduce the cost of medical assistance. These include reducing prescription drug coverage, tightening criteria for psychiatric admission to inpatient hospitals, eliminating coverage of substance abuse treatment in inpatient hospitals, restricting mental health services to Community Mental Health Centers, limiting psychotherapy services, reducing coverage of home health services and discontinuing coverage of organ transplants and other medical procedures. These proposals were originally made at the request of the House sub-committee reviewing the SRS budget. While certain restrictions were implemented, those just noted were not, because of awareness of medical need, perceived public opposition and questionable effectiveness in terms of real cost savings.

Proposed Solutions

Certain reductions are planned beginning early in calendar year 1991. These include limiting psychiatric and substance abuse admissions to general hospitals and further tightening of criteria for certain diagnostic and surgical procedures. These steps seem appropriate if coupled with a planned investment in community based services. Discussion is currently underway with representatives of Community Mental Health Centers for review and diversion of intended hospital psychiatric admissions. Community substance abuse services have been expanded. The scope of other medical services could be further reduced.

Possible Consequences

Reduction in the scope of medical services beyond that proposed will have a positive fiscal affect, but will deprive indigent, disabled and elderly Kansans of necessary preventative and acute medical care. Children would be uneffected because of recent federal requirements that all medically necessary services be provided. Prescription drug coverage cannot be reduced and will be expanded, also due to new federal requirements. Reduction in fee for service provider rates, currently well below the market rate, may impact access to care. Reduction in reimbursement to hospitals and nursing facilities may aggravate current legal challenges. Reduction in home health services may cause or prolong institutional care and result in more serious and debilitating conditions. Certain medical procedures not covered, such as organ transplants, will result in death. The legislature has not been supportive of these reductions, but has realized the dilemma of inadequate revenue to support funding at projected levels.

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SRS POLICY PAPER

MEDICALLY NEEDY PROGRAM

Problem Statement

The medically needy program is part of the federally funded Medicaid program and provides assistance to the aged, disabled, and families in meeting the costs of medical care. The program serves individuals and families who have income, but income insufficient to pay all of their medical costs. Medical benefits include coverage of hospital, physician, prescription drug, home health, mental health, and long term care services. Those eligible include persons living at home and persons in nursing facilities. Although the medically needy program is optional under federal regulations, Kansas has historically provided such coverage since the inception of the Medicaid program. However, a large percentage of the State's total Medical Assistance budget is a result of expenditures arising from this program, especially nursing home costs. Because of shortfalls in the agency's budget, the question has been raised as to whether to retain the program in its current form or downsize it in some manner.

Proposed Solutions

There are basically three courses of action which could be taken. One is to simply retain the program as is and find the necessary budget savings through other measures or obtain additional funding. The second course would be to retain a more limited program through reduction in eligible groups. If the program is retained in some form, federal regulations require that the State minimally cover pregnant women and children up to age 7. We then have the choice of covering some, all, or none of the remaining groups including children age 7 and above, the elderly, the disabled, and caretaker relatives. We could, for example, choose to cover the elderly and not the disabled. The third course would be to eliminate the program entirely as it is an optional one. This could be combined with adopting another eligibility option through which coverage of long term care could still be provided to persons whose income was less than a certain percentage of the SSI benefit level (from 100% to no more than 300% of this level).

Possible Consequences

Downsizing or eliminating the program could have dire consequences as there are few, if any, resources to fill the gap. Children and adult caretakers likely reside in families who are uninsured or underinsured. They may be unable to afford routine health care leading to the potential for more disabling conditions. Although the elderly and disabled may have Medicare coverage, it does not provide complete coverage of medical care such as hospitalization and physician services and provides no coverage for long term care. As a high percentage of the current elderly group is in long term care, loss of coverage would force a number to return to the community which may not be able to adequately care for them or move to less costly and inadequate nursing facilities. It is expected that a good deal of resistance will occur with any action to reduce the program. Both advocate groups and provider organizations will be politically active. Additional resistance would likely come from the legislature. The greatest loss of dollars would primarily fall on the hospital and nursing home industries. There would also be the potential for legal action and injunctions as what happened with the plans to eliminate the MediKan program early last year.

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SRS POLICY PAPER

COVERAGE OF ORGAN TRANSPLANTS

Problem Statement

Organ transplants, except kidney, bone marrow and cornea, were non-covered until 1988 when pressure was applied by clients, client advocacy groups, speciality providers and the media. In May, 1988 liver transplants were covered for children, and October, 1988 covered for adults. Legal action was also threatened and it was the determination of executive legal staff that such a case would be lost. Budgetary issues were the primary concern. Liver transplants could no longer be considered experimental. Heart transplants were covered for both adults and children in August, 1989 as a result of a legislative compromise during consideration of HB 2191. KUMC wanted coverage and SRS did not, again due to budgetary considerations. Coverage was included when KUMC agreed to certify availability of necessary state matching dollars. KUMC is reluctant to continue the current agreement. Coverage of liver transplants has represented a cost to the state in state general funds of $746,810 since 1988. The central question is whether limited state dollars should be used to cover organ transplants, so long as other more basic medical services or basic subsistence needs of clients cannot be met.

Proposed Solutions

Choices are more limited than in the past because of federal requirements that all medically necessary services for children be covered. There is no requirement for coverage of adult organ transplants. Since coverage began, nine adults have received organ transplants and nine are currently living who would not be living had the transplants not been done. The current average cost of a liver transplant is $150,000 and a heart transplant is $113,000. This includes the $15,000 annualized cost of life long need for immunosupressent drugs. Dollars saved by non-coverage could be directed toward needed budgetary savings or directed toward preventative and primary health care services or to the subsistence needs of the state's indigent population.

Possible Consequences

It is clear that persons not receiving organ transplants, with the exception of cornea, will die. On the other hand, dollars invested in preventative and primary care services will help prevent acute and chronic health conditions and the accompanying cost of dealing with worsening conditions. It is estimated that some 400,000 Kansans have no means or very limited means of securing basic health care. It is clear that dollars invested in prenatal risk reduction for pregnant women will help avoid premature and high risk births. It is clear that investment in home and community based services for both children and the elderly will help avoid expensive institutionalization. However, if organ transplants are not covered, it can be expected that pressures similar to those in the past will be brought to bear. It will be argued that persons receiving transplants should have the opportunity for an independent and self supporting life.

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SRS POLICY PAPER

VOCATIONAL REHABILITATION FUNDS

Appropriation of state general funds adequate to fully match available federal Vocational Rehabilitation (VR) funds.

Problem Statement

The intent of funding under the Rehabilitation Act of 1973 is to enable people with disabilities to achieve and sustain independence through employment. Vocational guidance and development are provided by VR counselors who provide and contract for services based upon the individual needs of each client. Congressional support of Vocational Rehabilitation services has increased significantly with federal VR funds increasing over 80% since 1982. Division of Budget recommendations for state match for FY 92 are $1,059,379 below the $4,302,147 total state funds needed to fully match $16,555,829 in federal funds available to Kansas. In addition to the increased federal funds available, the match rate began increasing in FFY 89 by one percent per year for five years. Hence, the 20% match rate for state funds will increase to 25% by FFY 93.

Proposed Solutions

1 Maintain the status quo, forfeiting the federal dollars and potential tax revenues.

2 Fully fund the state match with the increased funding to be used in a variety of strategies:
- o Increase case service funds for purchase of services.
- o Fund establishment grants for new and expanded services for groups of persons.
- o Tie match funds to other Kansas program initiatives:
  - mental health reform
  - MR/DD waiting list (supported employment services)
  - special education graduates

Possible Consequences

Potential outcomes include improvement in the agency's ability to meet the demand for more costly services; increase in the number of persons achieving employment, independence and tax payment; and reduced expenditures for public assistance. The emphasis on grants to develop new types of services when existing service programs are underfunded would likely be a matter of concern, eveb though the outcome would be increased grant funds to community programs. The State would realize a return on the investment of public funds for special education and could increase the effectiveness of programs to maintain persons in community settings if done in conjunction with other initiatives. These strategies would assist the shift to community services rather than institutional programs (including ICFs). Potential areas of support include

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SRS POLICY PAPER

REHABILITATION SERVICES STAFFING ISSUES

The major loss of trained experienced counseling staff during the past three years is making a significant impact on the delivery of services to Kansans with disabilities.

Problem Statement

SRS is no longer able to compete with the private sector to hire and retain Vocational Rehabilitation Counselors. The demand from private employers has increased dramatically, and they are willing to pay competitive labor market wages. Salary issues for counseling staff have not been effectively addressed while other groups within SRS and State government have had range adjustments and career ladder development. One example is the Corrections Counselors I & II at ranges 22 and 24 while VR Counselors remain at ranges 19 and 21.

Competition for experienced staff has produced counselor turnover rates: FY 88, 28.9%; FY 89, 39.6%; FY 90, 25.4%; and the projection for FY 91 is 41.8%. Counselor vacancies and inexperienced counseling staff impact the manner in which case service dollars are expended. Fewer cases plan are made resulting in case service dollars being left at the end of the year. Hence state and federal expenditures are reduced. When federal dollars are not used, they are given to other states, and we lose the availability of those dollars for future years.

The Supported Employment initiatives are making employment opportunities for severely handicapped individuals available who in the past have been denied Vocational Rehabilitation services because their disabilities were too severe. President Bush signed the Americans With Disability Act on July 26, 1990 which will increase employment and independence opportunities for individuals with disabilities. We have to have trained counseling staff to work with disabled Kansans who need and will demand rehabilitation services.

Proposed Solutions

1 Maintain the status quo by waiting for the classification study to impact these positions.

2 Establish Vocational Rehabilitation Counselor salary levels which are competitive in the Kansas labor market.

Possible Consequences

Competitive salaries will reduce the loss of counseling staff, and the agency can again attract, hire, and retain qualified staff to deliver timely and effective rehabilitation services. Support will come from citizens who must now wait for services that they have requested, rehabilitation providers, and parent and disability groups. Potential areas of resistance include providers if increased salaries mean less dollars for case services and the general public who may not understand the need to increase State salaries.

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parent and disability groups and KSDE. Potential areas of resistance include community providers who want multiyear grants for groups of clients; MR/DD facilities, some of which are reluctant to divert existing resources to supported employment rather than sheltered workshop; mental health providers who are reluctant to add vocational services without annual funding assured; and special ed programs which want to fund their own staff rather than SRS staff.

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SRS POLICY PAPER

SALARY ISSUES

Funds have not been available to fully fund salaries and wages for the State Department of Social and Rehabilitation Services.

Problem Statement

For the past several years, salary budgets have not been adequate to fully fund existing staff. For example, total funds available increase by two to three percent; at the same time employees are granted a two or three percent cost of living increase, plus merit increases of 2.5 percent, and bonus payments. Thus, these increases are funded by keeping position vacant for extended periods of time or by deleting positions. It is not possible to take either of these actions without affecting the services delivered to clients.

During FY 1991, we had to hold up to 250 positions vacant in order to live within available salary money, and eliminated 57 central office positions in FY 1991. Even then, the agency still did not have enough money to fill the KanWork positions authorized the legislature. KanWork could not be expanded unless the agency reduced staff in other existing social service programs. The agency chose not to layoff social workers, income maintenance worker, or clerical staff.

The agency received abnormally high shrinkage rates. In addition to funding shortages, this created an inbalance of resources since those programs without significant turnover can remain reasonably untouched, while those with high actual turnover rates can never fill the vacancies. The agency cannot transfer staff to other locations; therefore, one office may be forced to live with an 80 percent staffing level, while another location without turnover will be fully staffed.

Proposed Solutions

The agency should be given salary money to fully fund positions. All PTI positions approved in the budget should also be fully funded. Position limitations should be dropped. The budget would still control the dollars expended. This would give the agency the ability to increase or decrease staff as caseloads dictate, as long as dollar restrictions are met. The outcome would be a better service delivery system to all clients.

Possible Consequences

Legislators may feel adequate salary money has been available because the agency has not advocated strongly for the increased monies. Advocates will support increased staff funding since it will result in better service delivery for their clients. It will definitely result in better services for needy Kansans.

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SRS POLICY PAPER

SETTING PRIORITIES

SRS has neither the staff nor the other resources needed to meet the expectations placed on the agency by the state legislature, federal government, and the public.

Problem Statement

The mission of SRS is very broad and is aimed at ameliorating problems which prevent disadvantaged Kansans from living safely and independently in the community. The level of expectation directed to individual staff carrying out the mission have changed over time. Resources have not always accompanied new expectations, and resources which have been provided have often been removed as a result of budgetary considerations. Restrictions have been placed on the use of existing resources due to budgetary or control issues. Increased public knowledge of SRS programs has also increased demands on existing resources. When combined, these circumstances create a large gap between expectations and resources. In this environment, clients do not receive either the quality or quantity of services they need to be successful; the public has an increasingly negative view of the agency and its ability to carry out its mission; and SRS staff are frustrated with their inability to accomplish what needs to be done. Those staff willing to work extra hours to carry out their responsibilities are not able to do so due to changes in interpretation of the Fair Labor Standards Act.

Expanded coverage for the pregnant women and children program illustrates the situation well. The number of clients served increased from 677 to 10,688 while the 34 positions approved for the expansion of the program were eliminated. Without a defined process for setting priorities, individual offices and workers decide what work to forego in order to serve these clients.

Proposed Solutions

1 Maintain the status quo without any recognition of the informal process of priority setting.

2 Maintain legislative control over SRS salaries, but grant the agency the authority to implement and publicize priorities after a process of public discussion and input.

3 Recognize that the state cannot do everything it is presently committed to do, and eliminated programs.

4 Give SRS the authority to manage salaries and other operating expenses as in the past. Appropriate $110 million for salaries with no headcount limitation, allowing the agency the flexibility to employ more support staff at lower salaries if clients can be better served.

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Possible Consequences

Failure to act will reinforce the public's perception that SRS is not doing what it is supposed to do. Any reduction in services will meet with resistance from clients, advocates, and providers. The federal government may question whether the agency is carrying out its mandates. Legislators may view priority setting as their responsibility rather than the agency's responsibility. Clients, staff, and the public will support SRS doing a better job of managing its programs. If concentrating more resources on a few programs will improve client success, more people may be served in the long run.

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P Hall 2-5-91
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