Approved Jan. 28, 1992
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 January 21, 1992 in room 423-S of the Capito

All members were present except:

Committee staff present:

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

Conferees appearing before the committee:

Donna Whiteman, Secretary/Department of SRS
Dennis Priest, Medically Eligibility Programs Supervisor
Carla Nakata, Income Maintenance, Department of SRS

Chairperson Sader called meeting to order announcing Committee meetings will commence promptly at 1:30 p.m. hereafter.

Chair welcomed and introduced Representative Bob Grant as newly assigned member of this Committee. Rep. Grant said he is still learning and he represents the Second District.

Chair drew attention to first item on the Agenda, a continuation of the discussion on 300% Supplemental Security Income Cap. She invited staff to review this topic.

Ms. Correll drew attention to a memo that had been distributed to the office of each member on Friday, January 17th. (Attachment No.1) She reviewed the text from that memo. To summarize, she noted the cap set at 300% of the SSI benefit for one person was intended to temper the growth of the adult care home population and thus, the escalating costs of this component of Medicaid. As recommended by several studies, the cap would begin to address the bias toward institutional, rather than in-home and community care, that currently exists in the Kansas Medicaid program. The effect of using the SSI benefitrelated cap on the ability of individuals to deduct an allowance from their income for the noninstitutionalized spouse arises from federal policy and regulations, not from state policy or regulations.

Ms. Correll gave a detailed explanation of the transfer of property and assets; Division of Assets, (The Federal Spousal Impoverishment Provisions); and a detailed explanation of eligibility for Medicaid. It was noted the spousal impoverishment provisions are based on changes made to Medicaid statute in the Medicare Catastrophic Coverage Act of 1988. This Act was repealed by Congress that same year, the spousal impoverishment changes were retained and went into effect October 1, 1989. She cited examples of an applicant and the eligibility status depending on the determination of the resources and income of that individual.

Ms. Correll noted that often when division of assets is being discussed, it is really the resources and income that are being addressed.

Chair invited questions and discussion at this time.

Donna Whiteman, Secretary of Department of SRS answered numerous questions and offered informational hand-outs: (Attachment No.2), a Report on The Federal Spousal Impoverishment Provisions, (Attachment No.3), Summary of area office report on breakdown of Income/Support medical services. She answered questions regarding persons qualified under the grandfather clause; if an estate is left after a patients death there is a tool available for the SRS to try and recapture some state funds spent; there are many creative ways to dispose/divide property or holdings.

It was noted at this time, perhaps Committee members could notify the federal representatives of their concern in regard to the inconsistencies between the federal statutes and state regulations. Secretary Whiteman agreed contacting the Federal Delegation might be helpful.

Further questions addressed, i.e., numbers of cases in the appeal process and number of cases completed; a real policy issue is: Can the state continue to afford cost increases for care of these individuals?

A form was requested for the review of the appeal process. It will be made available for those requesting this form.

It was noted a sliding scale cannot be used when there is a cap in place. A sliding scale with a spend down provision as in effect in other states can be done if the current cap is removed. It was noted, the average cost per day in a nursing facility is $45.00.

If in-put or additional help is needed, Secretary Whiteman urged members to contact their area Directors or her office.

Ms. Carla Nakata, Income Maintenance Director of Medically Eligibility Services, Department of SRS also answered questions.

Secretary Whiteman stated there is expected growth in nursing home numbers, however, policy issues are how Kansas can change the high ranking in percentage of numbers of people receiving institutional care and the low ranking in numbers of persons not being provided community services. It appears we have relied on institutions to deliver these services and have not progressed as we should have in offering community based services.
Ms. Correll noted the cap affects adult care home eligibility, and does not affect other medicaid services.

Chair thanked Secretary Whiteman for her testimony.

Chair drew attention to report on Interim Committee Recommendations.

Ms. Correll gave a comprehensive explanation of the report on Interim Recommendations Relating to Health Issues, which covered Juvenile issues, i.e., relating to establishment of death review teams whenever a "suspicious" death occurs; a proposal on Right to Die; more cost effective alternatives to the delivery of special education services; education reform. The Special Committee on Children's Initiatives propose, i.e., greater support to children and their families; invest in young children ages 0-5; Restructure schools to respond to changing education/developmental needs of children; improve physical and mental health status of children. It was noted the Children's Initiative Committee found that preventive health care, particularly if targeted to prenatal, maternal, and infant care, immunizations, and nutritional programs, is the best investment for Kansans. They recommended development of an integrated system for children's services involving social service, judicial, health, mental health, and educational agencies at all levels of government. They recommended trying to have the business climate become partners relating to insurance coverage; recommended to reduce high risk behavior in children and families.

The Task Force on SRS recommends the SRS study and evaluate the administrative structure to improve cost-effectiveness in delivery of services; improve cooperation among agencies and administrative units, and maximize resources; review rules/regs adopted by the federal government and determine whether or not these regs. assist or hinder in the administration of programs and functions; to evaluate cost increases.

The SRS Task Force was divided into four subcommittees, i.e., Mental Health/Mental Retardation; Medical Services/Long-Term Care; Prevention; and Finance. Ms. Correll then outlined numerous recommendations from each of these subcommittees.

Finance Subcommittee recommends pursuing available provider tax options and to present a proposal to the 1992 Legislature; that legislation be introduced to allow the Department a first class claim against an estate to enable recovery of expenditures made for medical care.

Mental Health/Mental Retardation Subcommittee recommends mandating all Medicaid eligible clients be screened through a mental health center prior to admission to any private facility for mental health treatment; that HB 2530 be enacted in the 1992 Session.

Subcommittee on Prevention recommends that the highest priority for state expenditures for social services be in the areas of prevention and primary care, with state resources redirected to these areas; continued emphasis be placed on substance abuse prevention, targeting state funding directed to children and youth; that the Legislature consider substantive health-related legislation and appropriations action toward the goal of preventive and primary care; that SRS take the initiative in identifying and developing cooperation with other state agencies and local programs; legislation be enacted requiring preadmission screening prior to any adult care home admission; a long-term goal implemented holding the size of adult care home population; review policy changes in determining Medicaid eligibility by the 1991 Legislature.

Subcommittee on Medical Services and Long-Term Care recommended, giving prenatal care to all prospective mothers through cooperative agreements with other state and local agencies; high priority for prevention and early intrvention to health education for Medical Assistance clients in appropriate use of health care services/self care; a state policy that emphasizes in-home care/independent living options; that state/local agencies work coopratively to establish community-based planning processes concerning health care; and that the Joint Committee on Health Care Decisions for the 1990s receive reports from entities studying health care in order to facilitate coordination among them; recommends development of a coordinated health care system. Specific recommendation made by subcommittees on Medical Services and LongTerm care were to explore ways to recruit and retain professional health care providers; better use of mid-level health care providers; Joint Committee on Health Care Decisions for the 1990s to continue to monitor implementation of charitable health care provider program; medical community reevaluate its role in providing health care to Medicaid clients and low income individuals; Commissioner of Insurance compile data from claim forms when Medicaid clients are suing providers; efforts to increase participation in the EPSDT program; increase immunization rates; expansion of Healthy Start/Mothers and Infants program; That the SRS, Ks. Hospital Association, Ks. Medical Society, Blue Cross-Blue Shield of Kansas explore possiblity of expanding the Caring Program for Children; give attention fo AFDC grants; WIC program be expanded; look at alternatives in managed care to increase access to cost-effective care for Medicaid clients; community based projects currently funded to be monitored/evaluated.

Chair thanked all persons that contributed to the agenda this date.

Chair adjourned the meeting at 3:00 p.m.

GUEST REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE Jan. 21, 92

NAME	ORGANIZATION	ADDRESS
Bob Williams	Ks Pharmacists Assoc	
Rep George Dean	LEG.	
John Conard	AARP	Rt. 1, Lecompton
George Goebel	AARP-CCTF-SLC	
Joseph Kroll	KAHF	Topeka
Marilyn Bradt	KINH	Lawrence
Michael Robertson	Intern	
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS	TOPEKA
Carla Nakata	SRS	Topeka
Robert Epps	SRS	Topeka
Cindy Kelly	KASB	Topeka
Alex Hamilton Intern	KDOA	Topeka
Bob Deeds	KARC	TOPEKA
Sheryl Sanders	Ks Mental Health Coalition	Topeka
LISA Getz	WICHITA Hospitals	WICHITA
THERESA Shively	KANSAS LEGAL SERVICES	TOPEKA
Tim Cook	Legis. Intern	
Kirby Harris	Legis Intern	
Scott Wilke	Legis. INTERN.	Lawrence
Marilyn Purhase	Ks Pediatric [illegible]	Topeka
HAROLD RIEHM	KAOM	TOPEKA

MEMORANDUM

Kansas Legislative Research Department

Room 545-N – Statehouse
Topeka, Kansas 66612-1586
(913) 296-3181

January 17, 1992

Re: Eligibility Cap for Adult Care Home Services

During the 1991 Legislative Session, a number of committees struggled with issues relating to the direction and funding of programs operated by the Department of Social and Rehabilitation Services, including the Medicaid program. The Medicaid program in Kansas, and in virtually every other state in the United States, has become a major drain on state resources that limits the ability of the states to deal with other high-priority issues such as education, housing, children's services, and other issues of concern to the citizens of the individual states. Kansas is no exception, and a major amount of legislative time and attention in recent sessions has been directed toward the funding of medical services through Medicaid.

Two major problems with the Medicaid program have been identified over the past several years by committees of the Legislature and study committees, commissions, and task forces considering health care in Kansas. One such issue is the change in the population served by Medicaid. Originally intended to provide access to health care for the poor, Medicaid expenditures increasingly are directed toward middle class, middle income elderly, and, in Kansas and other parts of the United States, fall far short of covering persons whose income is at or below the federal poverty level. The former is the result of expenditures for adult care home services for the elderly and disabled, and the latter, the result of efforts to keep escalating costs at manageable levels by keeping eligibility standard increases for public assistance well below increases in the poverty level. The second problem that has been identified by legislative committees, and by study commissions and task forces, is the bias toward institutional care in the long-term care component of the Kansas Medicaid program. It has been consistently recommended that this bias be addressed by limiting the growth in adult care home use combined with the development of community-based long-term care services.

During the 1991 Session, legislators reviewed various alternatives for dealing with the Medical Assistance budget, including capping eligibility for adult care home services at 150 percent of the federal Supplemental Security Income (SSI) benefit, dropping the medically needy component from the Medicaid program, and extensively reducing or eliminating MediKan. All the alternatives were directed toward capping the eligible population and slowing the growth of Medicaid expenditures. This growth has for some time been most apparent in the long-term care component of the Medicaid budget, which accounts for 42 percent of Medicaid expenditures in the Governor's budget for FY 1993 and 41 percent of the current FY 1992 Medicaid budget.

The 1991 Legislature recommended that adult care home eligibility be capped at 300 percent of the SSI benefit level for one person, one of the options available to the states for creating an eligibility criteria for a specific population that is more generous than eligibility standards applicable to AFDC and SSI cash grant recipients. Currently, the income cap is $1,266 per month.

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Under the federal regulations, 300 percent of the SSI benefit is the maximum income allowed if the state chooses an income cap. In making this decision, the Legislature also agreed to "grandfather" some 480 individuals already Medicaid eligible and in an adult care home whose income was above the cap. Because such persons do not meet the eligibility standard, the Medicaid share of their care must be paid from all state funds with no federal financial participation.

Under federal regulations found at 42 CFR 435.1005, all income before deductions must be considered in determining whether the applicant's income is above or below the income eligibility cap. As noted below, it is the language of the federal regulation that gives rise to the change in the treatment of income under the federal spousal impoverishment provision of Title XIX of the Social Security Act that is popularly referred to as "division of assets," but which relates to both division of income and resources or assets by persons entering long-term care in a nursing facility or home and community-based services component of Medicaid. The relevant provision of the Social Security Act, which became effective less than six months after the effective date of a similar Kansas law, specifically supersedes state laws dealing with the division of income and assets. Thus, the Kansas law is suspended and not in effect until such time as the federal law is repealed.

Under the federal spousal impoverishment provision of the Social Security Act, an individual who is entering a nursing facility (adult care home or long-term care bed) or a Medicaid-approved home or community-based program is allowed to deduct up to a specified amount of such individual's income for the maintenance of the spouse who remains in the community before such income is considered available for the purpose of determining Medicaid eligibility. Under certain circumstances, deductions may also be made for the support of dependent children, dependent siblings, and dependent parents. The federal Act uses the term "deduction" rather than "division" in setting out how income is to be treated for eligibility purposes. Thus, it is the lack of compatibility between the language in the federal law and the federal regulation that results in not allowing a deduction for the support of the community spouse prior to determining eligibility under the 300 percent of SSI benefit cap. No Kansas law is involved, nor is there a state regulation that prevents the division or deduction of income for purposes of determining whether the income of the applicant for Medicaid long-term care is under the cap.

Division of resources (assets) is allowed under the provisions of the Social Security Act relating to spousal impoverishment. Such division is not affected by the federal regulation relating to income caps. Therefore, if a part of the income of a spouse applying for adult care home services under Medicaid arises from interest on investments, CDs, savings accounts, stocks, etc., such resources can still be divided with the spouse remaining in the community up to the maximum allowed by federal law. Such division may result in a change in the individual's income for purposes of the cap on income. There are also provisions relating to transfer of property under federal law that may apply in those circumstances in which an individual seeks Medicaid eligibility. An outline of the latter provisions is attached, as is a table showing Kansas Medicaid expenditures for long-term care.

The income cap instituted pursuant to the recommendation of the 1991 Legislature relates only to eligibility for adult care home services. An individual whose income is above the cap for the purpose of adult care home services may still be eligible for other services offered through the Medicaid program such as drugs, physician services, etc.

In summary, the cap set at 300 percent of the SSI benefit for one person was intended to temper the growth of the adult care home population and thus, the escalating costs of this component of Medicaid. As recommended by several studies, the cap would begin to address the

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bias toward institutional, rather than in-home and community care that currently exists in the Kansas Medicaid program. The effect of using the SSI benefit-related cap on the ability of individuals to deduct an allowance from their income for the noninstitutionalized spouse arises from federal policy and regulations, not from state policy or regulations.

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ADULT CARE HOME EXPENDITURES FY 1981–FY1992

FISCAL YR	*TOTAL $'s*
1981	$81,190,564
1982	83,806,177
1983	85,318,957
1984	91,479,357
1985	95,424,030
1986	101,828,373
1987	107,168,140
1988	123,472,381
1989	140,427,653
1990	167,456,662
1991	189,609,911
Approp 1992	220,548,900

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TRANSFER OF PROPERTY AND ASSETS

A little understood change in eligibility that resulted from enactment of the Medicare Catastrophic Coverage Act is the difference in the manner in which the transfer of property is treated for the purpose of determining eligibility for Medicaid.

In Kansas, prior to the change resulting from the federal legislation, only the transfer of a home in which a spouse or a dependent child, whether a minor or adult, was living at the time of the transfer of the property to the spouse or dependent child was exempt from the prohibition against the transfer of assets without compensation at fair market value. Transfer of assets, other than an exempt transfer as noted above, subjected the individual who had transferred the asset without reasonable compensation to ineligibility for a period of time based on the value of the transfer. Under the provisions of Section 303 of the Medicare Catastrophic Coverage Act, any state laws or regulations are preempted by the federal legislation. The latter requires the state to provide for a period of ineligibility in the case of an institutionalized individual who at any time during the 30 months immediately prior to the individual's application for medical assistance disposed of resources for less than fair market value. The period of ineligibility begins with the month in which the resources were transferred and the number of months of ineligibility shall be either:

1. 30 months, or

2. the total uncompensated value of the transferred resources divided by the average cost to a private pay patient at the time of an individual's application for Medicaid of an adult care home in the state or, at the option of the state, in the community in which the individual is institutionalized.

Under the federal law, certain transfers of property are exempt from the penalty of ineligibility. Transfer of the title of the individual's home is an exempt transfer if the transfer of title is to:

1. a spouse,

2. a child who is under age 21 or blind or permanently and totally disabled,

3. a sibling who has an equity interest in the home and who was residing in the home for at least one year immediately before the admission of the institutionalized individual, or

4. a son or daughter who was residing in the institutionalized individual's home for at least two years immediately prior to the institutionalization and who provided care that permitted the applicant for Medicaid to remain at home.

Other transfers of resources that are exempt are: transfers made under the provisions usually known as division of income and resources to a community spouse or another person for the

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sole benefit of such spouse or the institutionalized individual's child who is blind or permanently and totally disabled; a satisfactory showing that the individual intended to dispose of the resources either at fair market value or for other valuable consideration or that the resources were transferred exclusively for purposes other than becoming eligible for Medical Assistance; or if the state determines that the denial of benefits would result in undue hardship.

Under the provisions of the federal law an individual who is not institutionalized within 30 months of the transfer may transfer any amount of property and other tangible or intangible resources to another without receiving compensation and not be penalized in regard to eligibility for Medicaid. The revised transfer provisions became effective on July 1, 1988, although states that had to revise their state laws to comply were granted a grace period until after the next legislative session had taken place. Thus, the provisions of federal law became effective in Kansas following the 1988 Session.

Both the ability of certain individuals to protect income and resources for the benefit of a community spouse and the changes relating to the transfer of resources have resulted in increased state and federal expenditures for Medicaid in Kansas.

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DIVISION OF ASSETS

(THE FEDERAL SPOUSAL IMPOVERISHMENT PROVISIONS)

The spousal impoverishment provisions of the Medicaid program permit a husband and wife to protect a portion or all of their combined income and resources when one of them requires long-term care in an institutional or home-and community-based services setting. The amount protected is intended for the use of the person who remains at home. At the same time, these provisions help the spouse needing long term medical care to qualify for Medicaid benefits which can help in paying for that care.

In regards to resources, the amount of the couple's total resources which can be protected is the greater of:

- o $13,740, or
- o 1/2 of the value of the couple's nonexempt resources owned at the time the husband or wife first entered long term care, not to exceed $68,700.

Only nonexempt resources are considered. This would include such things as checking and savings accounts and land or buildings other than an exempted home. The protected resources must usually be transferred to the spouse in the community and are not considered in determining the eligibility of the person in long term care.

The $13,740/68,700 allowance limits are subject to change annually due to increases in the federal consumer price index.

In regards to income, if the person in the nursing facility has gross monthly income of less than the special income cap of $1,266, then the amount of the couple's combined income which can be protected is either:

- o up to $984 per month, or
- o up to $1,718 per month if there are excess shelter expenses.

In addition, up to $328 per month can be protected for each dependent family member who lives with the spouse who remains at home. A dependent family member is defined as a minor or adult child, a parent, or a brother or sister of either the husband or wife who has been dependent on the couple because of legal, financial, or medical reasons.

Only nonexempt income is considered. This includes income from such sources as Social Security, Veterans, or Railroad Retirement benefits, wages, income from investments, and other public or private retirement or disability benefits. The protected income must be allocated each month to the spouse in the community and any dependent family members. The amount of this income is then exempted from consideration in determining the liability of the person in long term care for his or her cost of care.

The minimum income allowance standard is currently based on 133% of the federal poverty level. As such, it is subject to annual increases based on increases to

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the poverty level standards. Effective July 1, 1992, the minimum standard will cap out at 150% of poverty. The maximum allowance standard is subject to increases in the federal consumer price index and, therefore, also changes annually. The current $984 minimum level became effective July 1, 1991 and the $1,718 maximum limit became effective January 1, 1992. The dependent family member allowance is 1/3rd of the minimum community spouse allowance.

The spousal impoverishment provisions are based on changes made to Medicaid statute in the Medicare Catastrophic Coverage Act of 1988. Although this Act was, for the most part, repealed by Congress that same year, the spousal impoverishment changes were retained. They went into effect on October 1, 1989. Previous to that time, a state Division of Assets law was in effect which had been developed by the state legislature during the 1988 legislative session and went into effect May 1, 1988. That law was similar to the federal provisions in that it allowed for the same protection of a couple's income and resources although at a lower level. In addition, no provision was made for dependent family members. The legislature later set aside the state law to permit the federal provisions to supersede that law on October 1, 1989. Since implementation of the original state law, almost 1,700 divisions have been approved.

EXAMPLE

Application is taken on a 67 year old man who has just entered a nursing home. He receives $800/month in Social Security benefits and his wife, who remains at home, receives $475/month Social Security. The couple jointly owns a home, car, $30,000 C.D., and a checking account with a $200 balance.

Resource Determination

The home and car are exempt as resources and are not counted. The remaining countable resources equal $30,200 (C.D. and checking account). As one-half of this equals $15,100, that is the amount the wife can protect. The remaining $15,100 must be considered available to the husband and would make him ineligible until this amount is brought down to $2,000 or less. The couple would likely put the wife's protected amount in her name only. This would likely be done once the C.D. matures.

Income Determination

The husband's gross income is less than the special income cap of $1,266 per month; therefore, once he becomes resource eligible, an income allowance would be determined. Of the couple's total income of $1,275, at least $984/month can be protected for the wife. As there are no excess shelter expenses, the husband would allocate sufficient income to bring her income up to $984/month or, in this instance, $509. The remainder of his income, $291, would be budgeted toward his nursing home care.

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KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Income Support/Medical Services

MEMORANDUM

TO: Secretary Donna Whiteman **DATE:** January 21, 1992

FROM: Robert L. Epps **SUBJECT:** 300% Cap Report

All area reports for the months of September, October, and November 1991 have been returned concerning the affects of the 300% income cap. Altogether, 37 total persons have been denied nursing home coverage since September. Most of these denials appeared to have occurred in September with 23 showing for the month and only 14 additional for the months of October and November.

Average income for those exceeding the cap was just over $1,500/month. The primary sources of income included Social Security, VA, private and government pensions, and interest or investment income. It should be noted that 9 individuals had income close to the cap, generally around $1,230-1,250/month.

Of the total number exceeding the cap, 28 have remainded at the facility they were residing in and most all were still getting a medical card. In most of these instances, the individual has either been able to pay the private rate (5), get financial help from a spouse or other relative (4), or negotiate a lower rate (8). There are also 6 instances in which the client is paying what he or she can while incurring a debt to the facility on the difference between the private rate and what they're able to pay. In addition, 3 have appealed the cap decision and Medicaid payment continues while the case is under appeal.

Of the remaining 9, 5 persons didn't end up following through with their application and it is not known what has happened to these individuals. For the other four, one moved to a less expensive home, one left the home and went to live with an adult child, one died, and one did not end up being put in a facility.

It should be noted that a community spouse was involved in only five of the cases. It appears that in all of the instances, the spouse's income was low enough to have been allocated to under the spousal improverishment provisions. It also appears likely that had an income division been allowed, the spouse in the nursing facility would have ended up with income below the cap.

One final note. Several of the areas claimed that the low figures they had were misleading. They reported receiving numerous phone contacts and inquiries where a formal application was never filed once the family learned the individual was over the cap. One worker in Kansas City reports getting 4 to 5 calls a week from people who exceed the cap. Another worker in Olathe reported at least 30 such calls over the 3 month period. We did not measure these numbers as staff do not have an accurate means of keeping tally on these inquiries. I would guess that the impact of the cap is more dramatic than the figures in this report indicate.

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All in all, the greatest hardship at this juncture seems to be on married couples who are unable to divide their income to meet the cap and on those single individuals who are running up a debt at the nursing facility or being forced to rely on any family or friends for financial help. This picture may change as we get further down the road.

A table summarizing the results described in this memo is attached for handy reference. We will continue to update this table for you on a monthly basis as reports are filed for the coming months.

Please let know if you have any questions or need further data.

RLE:DP:jmm

Attachment

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NUMBER OF APPLICANT/RECIPIENTS DENIED NURSING HOME FACILITY COVERAGE EACH MONTH

AREA	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JUL.	AUG.
Chanute	3	0	0									
Emporia	0	4	2									
Garden City	4	0	0									
Hays	0	0	0									
Hutchinson	4	0	0									
Kansas City	1	0	1									
Lawrence	3	1	0									
Manhattan	1	3	1									
Olathe	2	0	0									
Salina	1	1	0									
Topeka	0	0	0									
Wichita	4	0	1									
TOTAL	23	9	5									

TOTAL FOR SEPT. - NOV. 37

1. AVERAGE INCOME: $1,500/month

2. PRIMARY TYPES OF INCOME: SSA, VA, Private & Government pensions, interest and investment income.

* 3. NUMBER RECEIVING MEDICAL CARD: 29

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* 4. NUMBER WHO REMAIN IN FACILITY:	28
A. NUMBER PAYING PRIVATE RATE:	5
B. NUMBER GETTING HELP FROM SPOUSE OR FAMILY:	4
C. NUMBER WHO NEGOTIATED LOWER PAYMENT:	8
D. NUMBER WHO ARE PAYING WHAT THEY CAN AND RUNNING UP DEBT:	6
E. NUMBER UNDER APPEAL AND MEDICAID PAYMENT STILL BEING MADE:	3
* 5. NUMBER WHO ARE NOT IN ORIGINAL FACILITY:	3
A. MOVED TO A CHEAPER FACILITY:	1
B. RETURNED TO COMMUNITY:	1
C. WENT INTO HCBS:	0
D. DIED:	1
* 6. NUMBER WHO DIDN'T FOLLOW THROUGH WITH APPLICATION:	5
* 7. NUMBER W/COMMUNITY SPOUSE:	5

* NOTE: Because of summarization as well as cross-categorization of data, figures in these items will not add up to total number or to subtotal within item.

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MEMORANDUM

Kansas Legislative Research Department

Room 545-N -- Statehouse
Topeka, Kansas 66612-1586
(913) 296-3181

January 14, 1992

To: Joint Committee on Health Care Decisions for the 1990s

Re: Interim Committee Recommendations Relating to Health Issues

Special Committee on Judiciary

Two of the proposals assigned to the interim Special Committee on Judiciary appear to relate to health care decisions that have been discussed by the Joint Committee.

Proposal No. 12 -- Juvenile Issues directed the Judiciary Committee to review the following juvenile issues: the enactment of a model bill which would provide for the creation of a child death review team when a "suspicious" death occurs; court ordered placement of juvenile offenders in state youth detention facilities; confidentiality under the Juvenile Code; screening procedures for children admitted to state hospitals; and safety of children who are placed in child protective services.

Under the portion of the proposal relating to suspicious child deaths, the interim Committee reviewed a bill introduced in 1991 (H.B. 2582) that would require the establishment of child death review teams whenever a suspicious or unexplained death of an individual under age 18 occurs and set out the procedure to be followed in such instances. The Special Committee on Judiciary concluded that the issue is whether such teams are needed or whether current laws should be better implemented. Rather than recommending enactment of 1991 H.B. 2582, the interim Committee recommends new legislation (S.B. 477) that extends the responsibility of the Department of Health and Environment to review suspicious and unknown child deaths and gives the agency the power to access necessary evidence for investigative purposes. The interim Committee also expressed the belief that additional training should be offered for health care providers and others responsible for the reporting of child deaths.

The Joint Committee may want to hear from the Department of Health and Environment at some time in the future on the type of data that has been collected as a result of previously enacted legislation that prevents a finding that SIDS was the cause of death of an infant unless an autopsy is conducted if the child's death is unexpected.

Proposal No. 14 -- Right to Die directed the Special Committee on Judiciary to review the Kansas Natural Death Act and changes proposed to it contained in the Uniform Rights of the Terminally Ill Act to see if changes are needed and to review the responsibilities of emergency medical services personnel in the prehospital setting in regard to this issue. The request emanated from two 1991 bills, S.B. 272, which would amend the Kansas Natural Death Act to provide for

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prehospital "do not resuscitate" orders in the event of acute cardiac or respiratory arrest, and S.B. 350, which would enact the Uniform Act.

The interim Committee has made recommendations in the form of two bills drafted for consideration by the 1992 Legislature -- H.B. 2672 and H.B. 2671.

H.B. 2672 amends the act governing emergency medical services to include a provision that, in the event of an acute cardiac or respiratory arrest, no health care provider or emergency medical service personnel who in good faith causes or participates in the withholding or withdrawal of CPR pursuant to a valid do not resuscitate order may be subject to criminal or civil liability or be found to have committed an act constituting unprofessional conduct. A health care provider whose decision concerning the validity of a do not resuscitate order is made in good faith is not to be subject to civil or criminal liability or disciplinary action.

H.B. 2671 would create the Medical Treatment Decision Act that would allow any competent individual over age 18 to make and fully participate in decisions regarding such individual's medical care and treatment through either written or oral communication with an attending physician, through an agent designated pursuant to the Durable Power of Attorney for Health Care Decisions Act, or by means of a declaration signed by the declarant and two witnesses in a form substantially as provided in the bill. The bill also sets out the procedure to be followed by surrogate decision makers for individuals who are incompetent, comatose, or unconscious and in a terminal condition. The interim Committee also recommends that the Legislature consider the merits of S.B. 350 in conjunction with consideration of H.B. 2671.

Special Committee on Education

Proposal No. 6 – Special Education directed the interim Committee to consider more cost effective alternatives to delivery of special education services while still complying with service requirements imposed by federal and state law; including specifically, a focus on procedures and techniques for identifying and serving gifted children.

While the interim Committee made a number of recommendations under the heading of Proposal No. 6, the one that appears to be pertinent to the interests of the Joint Committee is the recommendation that the State Board of Education assume a leadership role in urging school districts to draw more effectively on the resources of other agencies in order to provide the full range of services that individual pupils may require. *While there is no specific recommendation relating to health, certainly health needs of special education pupils could be served through increased linkages with local health agencies and increased linkage at the state level between special education and the state health agency.*

Proposal No. 8 – Education Reform directed the interim study of elementary and secondary education reform issues such as, but not restricted to, governance of public education, student assessment, accountability for educational outcomes, access to technology, choice of schools attended, promotion of parental involvement in the school system, role of the State Department of Education in the regulation of public education, alternative means of organizing school programs, promotion of teaching excellence, and expansion of services provided at the school site to preschool as well as school age children.

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Again the interim Committee made a number of recommendations in regard to Proposal No. 8, but only a few are particularly relevant to the concerns of the Joint Committee. One such recommendation is that the Legislature should promote increased funding for the Parent Education Program so that full funding will be achieved within the next two fiscal years (FYs 1993 and 1994). *It is not clear to staff whether the Parent Education Program has a significant health related component at this time. However, it appears that such a program is an excellent vehicle for involving local health authorities who can emphasize the importance of health in adequate school functioning and the importance of immunizations and routine wellness monitoring.*

A second recommendation arising from Proposal No. 8 urges school districts that do not presently provide school breakfast programs to do so.

Yet a third recommendation is that the State Board of Education should incorporate in the Quality Performance Accreditation program the objective of effectively networking school and various social service agency resources. *It would appear important that any such networking be mandated to include health-related local agencies.*

Special Committee on Children's Initiatives

Proposal No. 5 – Children's Initiatives directed the Special Committee to examine the current status of Kansas children; review and evaluate public and private sector programs that focus on meeting the needs of Kansas children; consider options and strategies for better meeting the needs of Kansas children; develop for the public and the private sectors of Kansas a long-range comprehensive blueprint designed to meet the future needs of Kansas children; consider ways to enlist private as well as public sector involvement to implement the blueprint; consider any legislative initiatives necessary to implement the blueprint; and consider options for funding components of the blueprint.

Since the Joint Committee members have already received a copy of the report of the Special Committee on Children's Initiatives, the members are aware that the Blueprint for Investing in the Future of Kansas Children and Families is divided into Targets for Change and that there is some overlapping in the Targets. The summaries below are organized by Targets to follow the format of the Committee Report.

Target I – Greater Support to Children and Their Families, includes the following specific health-related strategy (recommendation):

> Require future expansion of KanWork and other public assistance employment programs to include a locally developed plan under which community agencies, **local health departments**, schools, community colleges, and other state agencies coordinate services for clients and their families.

Target II – Invest in Young Children Ages 0-5, includes the following recommendations:

> Every year, beginning with FY 1993, the state must increase its financial support of preventive programs for young children by a minimum of 15 percent until resources are doubled. Funds should come from reallocation of General Fund priorities, a voluntary

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income tax checkoff for children's programs, private foundation funding, federal grants, or a reexamination of all dedicated revenue sources. (Preventive programs as used in this target are those that impact the physical, social, emotional, and cognitive development of young children.)

Establish child death review boards as a tool for investigating and publicizing child abuse.

Require training for health care professionals, educators, social service providers, and other mandated reporters on the prevention and identification of child abuse and intervention for children in abusive situations.

Review the mission of the Kansas Family and Children's Trust Fund and the Children and Youth Advisory Committee.

Target III – Restructure Schools to Respond to Changing Education and Developmental Needs of Children, includes among other specific education recommendations:

Require all Kansas schools to offer a school breakfast program.

The Department of Education and the Department of Health and Environment should work together to prepare and make available a developmentally appropriate curriculum for use in early childhood education programs in Kansas.

Target IV – Improve the Physical Health and Mental Health Status of Children, includes the following recommendations:

Every Kansas child needs access to primary health care from conception to adulthood. Gaps in care for children should be eliminated, particularly for young children and adolescents from families not covered by insurance or government programs. A coordinated system should be devised to ensure access and affordability for every child.

The state should vigorously pursue an avenue to combine all state funds for children's health programs into a single, coordinated program by FY 1998 in order to ensure access to primary health care for every Kansas child and eliminate gaps in care, particularly for young children and adolescents from families not covered by insurance or government programs. Until such a comprehensive, coordinated, consolidated approach to service delivery can be developed, the following interim strategies, which can be components in such a system, are recommended. Whenever possible, particularly for new, innovative programs, private foundation funding or other outside financial support should be sought. The objective for all the following program strategies is an overall reduction in the cost of health care, decreased usage of emergency rooms for nonemergency care, improved access to health care services for children that include primary care, dental care, nutritional services, mental health, and special needs programs.

- Increase early immunization rates by 20 percent each year through financial incentives encouraging local health departments to develop immunization outreach strategies.

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- Support efforts of the Department of Health and Environment to increase early immunization rates.

- Seek private sector support for medial campaigns to publicize the importance of immunizations and train personnel working with young children to alert parents to the importance of immunizations.

- Beginning in FY 1993, require any registered day care home to file forms on immunizations, just as currently required for licensed homes or centers. The Department of Health and Environment should coordinate this information and monitor compliance. Children without immunizations should be contacted by local health departments.

- Establish expedited Medicaid eligibility for children, similar to that now in place for pregnant women to increase early access to health services under the Medicaid program.

- Seek federal waivers to exempt maternal and child health services from physician referral under the Medicaid program in order to decrease barriers to service.

- Expand participation in the EPSDT program to 80 percent of eligible children by 1995 in accordance with federally established guidelines and investigate three specific strategies for expanding EPSDT participation.

- Encourage expansion of the Caring Program, including considering ways the state can participate in the program and including promoting access to adolescent health care. A challenge grant could be one way to bring about state participation.

- As an alternative to participation in the Caring Program, give consideration to the Florida and Minnesota subsidized insurance models designed to increase children's access to health care.

- Require all kindergartners entering school for the first time to have a health examination provided by a physician, nurse, or local health department. It should be the responsibility of parents to provide documentation that such an examination has occurred; however, schools are encouraged to assist parents who find it difficult to obtain an examination by making the school building available for checkups in conjunction with kindergarten roundup or other activities.

- Request the Kansas Department of Health and Environment to study the issue of lead and children and to take any needed action in this area, including outreach and abatement. Make testing available at every local health department.

- Target environmental factors, such as pesticide exposure hazardous equipment, and others that are unique to migrant children in developing migrant health services.

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- Expand school based health clinics in targeted, low-income neighborhoods to increase access to primary care services.

- Evaluate the state primary care grants authorized by the 1991 Legislature and consider expanding such grant programs and including innovative outreach strategies and health education. Projects should be evaluated on the basis of cost effectiveness, improved access to health care, and improved health outcomes.

The Children's Initiatives Committee found that preventive health care, particularly if targeted to prenatal, maternal, and infant care, immunizations, and nutrition programs, is the best investment for Kansans. These programs should reach every child, and the following strategies are recommended to reach that goal.

- Provide state funding to expand the Healthy Start and Maternal and Infant Projects statewide in FY 1993. In addition, target Healthy Start visits to families identified as at risk, such as mothers who received no prenatal care.

- Develop a pilot coupon program to begin in FY 1994 in selected areas where there is a high concentration of at-risk children to provide incentives in the form of coupons given to new mothers for home visits, parenting classes, selected business discounts, and other services.

- Follow up on infants who are automatically eligible for Medicaid for the first 60 days following birth to insure a separate application is made for the child prior to expiration of this time period for the purpose of insuring continuity of care.

- Expand the WIC program, (including outreach) to serve all pregnant women, mothers, and children who are eligible to receive nutrition supplements and other services available through the program. Determine whether additional authority is needed to support current cooperative efforts between the departments of Social and Rehabilitation Services and Health and Environment in cross-referring clients.

- Continue to provide funding in FY 1993 and subsequent years to support efforts to increase the special needs of infants and toddlers with special needs through the Interagency Coordinating Council model developed pursuant to P.L. 99-475. All children served through these programs should be followed for a period of five years so the projected cost savings of early intervention can be reported.

- Develop a system through which a wide range of individuals who may come into contact with a very young child are trained to recognize risk factors that may signal a need for intervention to protect the child or intervention to assure that the child receives services that enable appropriate physical and emotional development. Begin this program in FY 1994 in locations with a high concentration of at-risk children. By FY 1998 either expand the program statewide or eliminate the program.

- By 1995, each local health department should have in place a screening program for the early identification of educational, social, and health problems of young

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children, with services available through the local health department or referral to appropriate community resources.

The Children's Initiatives Committee found that children with handicapping conditions, including seriously emotionally disturbed, mentally retarded, developmentally disabled, and physically disabled children in Kansas sometimes cannot receive services in their homes or community due to a variety of barriers. The Committee recommended the following initiatives to combat this problem:

- Request the Department of Social and Rehabilitation Services to develop reimbursement mechanisms to allow for treatment, preferably in the home or community, without the loss of parental custody and pursue waivers when necessary to further encourage community and home-based care.

- Implement and fund the Mental Health Reform Act pilot project pertaining to children.

- Include mental health needs in any community assessment of children's health care delivery systems.

- Redirect funding from state and private mental health and retardation institutions to community-based programs for children with handicapping conditions.

- Increase level five residential placement capacity for seriously emotionally disturbed youth who may otherwise be institutionalized.

The interim Committee determined that outreach strategies coordinated with social service delivery systems should be devised as a way to ensure that at-risk children are identified and that no child is underserved because of a parent's inability to obtain health care. In order to implement this recommendation, the interim Committee recommended the following strategies:

- Request the Department of Social and Rehabilitation Services to develop a simplified Medicaid eligibility application for children and pregnant women; make such applications available in doctor's offices, clinics, health departments, public and private social service agencies, and other locations; accept such applications by mail; and have an expedited "turn-around" time for follow-up on applications.

- Develop additional incentives to encourage pediatricians and family practice providers who participate as Medicaid providers to assure that children have access to care.

- Require the Department of Social and Rehabilitation Services to develop outreach services that locate Department employees in health department clinics, community health centers, charity clinics, and other locations in which pregnant women and children likely to be eligible for Medicaid are to be found, with workers to explain the program, take applications, and give "on the spot" assessments of probable eligibility and provide other services that will enable clients to take advantage of program services.

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- Reduce hunger in children and improve their nutritional status by increasing participation in nutrition programs, through developing intensive outreach services targeted toward eligible nonparticipants in the food stamp and WIC programs.

- Direct the Department of Health and Environment to develop strategies to link health care programs to other needed services, including those provided through schools, churches, and businesses.

- Support the SAFE KIDS campaign initiated by the Department of Health and Environment as an outreach campaign to reduce preventable injuries and accidents in children.

Target V – Modify Service Delivery System, led the Children's Initiatives Committee to recommend that the state develop an integrated system for children's services involving social service, judicial, health, mental health, and educational agencies at all levels of government. As a first step the state should develop a complete inventory of programs and evaluate how well and how cost effectively they meet basic needs of children and where scarce resources might be reallocated. Among the recommended strategies for implementing this target are the following which could impact on health issues.

- Require state agencies to develop program components to allow "one stop" shopping for services regardless of differing eligibility and program standards. Such initiatives could include co-location near target populations, the development of a universal application form, sharing of outreach personnel, and formal agreements in regard to referral and case management.

- Examine the confidentiality requirements of state and federal laws and regulations to determine whether waivers need to be obtained to allow exchange of client information between public and private providers serving the same family and modify statutes and regulations to remove any barriers.

- Identify and correct policies and laws that create financial disincentives to keeping children in their own home, such as school district responsibilities and insurance barriers.

- Establish a state policy on the number of nonstate, private psychiatric beds for children that are eligible for reimbursement and establish a system for limiting the number of beds in the state for the purpose of reducing institutionalization.

- Seek legislative changes in insurance regulations that encourage hospital placement over community-based treatment. Work with the insurance industry to adjust private coverage plans to reduce any bias toward institutional treatment.

Target VI – Make Business a Partner, contains several recommendations that specifically relate to health, including stating that employers must evaluate the extent to which their own personnel policies and practices are consistent with the targets and initiate any needed changes that are supportive of families and children, including a review of existing health insurance practices. Further, it is recommended that local business groups should inform small business owners about

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Kansas legislation that creates incentives for small businesses to offer health insurance to their employees and larger businesses should encourage their contractors and suppliers to offer health insurance. Finally, the recommendations encourage an effort by the Kansas Employer Coalition on Health to host seminars for local business coalitions which bring together employers, maternal and child health organizations, and other key community groups and leaders.

Target VII – Reduce High Risk Behavior in Children and Families, contains recommendations on three topics that relate directly to health, teen pregnancy, substance abuse, and teen suicide.

The strategies adopted by the Children's Initiatives Committee include a recommendation to evaluate the teen pregnancy prevention program pilot projects initiated in 1991 and expand the program statewide if current projects are effective; a recommendation to develop drop-in centers for pregnant and parenting teens to target prevention of repeat pregnancies; a recommendation to focus pregnancy prevention efforts on young males as well as females; and a recommendation to target public education campaigns toward the financial responsibility of parenthood.

Recommendations relating to substance abuse include a specific recommendation to target substance abuse and early intervention programs toward pregnant women and infants prenatally exposed to drugs or alcohol.

Task Force on Social and Rehabilitation Services

Proposal No. 19 – Department of Social and Rehabilitation Services directed the Task Force to study and evaluate the administrative structure and functioning of the Department of Social and Rehabilitation Services, with an emphasis on improving the cost effectiveness of the delivery of services; to review the effectiveness of the administration of programs and functions with particular emphasis on reducing duplication in the delivery of services, improving cooperation among agencies and administrative units, and maximizing resources through better utilization of matching funds; to review rules and regulations adopted by the federal government and the Secretary of Social and Rehabilitation Services to determine whether these regulations assist or hinder in the administration of programs and functions of the Department and evaluate causes of programmatic cost increases.

The Task Force was divided into four subcommittees -- Mental Health and Mental Retardation; Medical Services and Long-Term Care; Prevention; and Finance. Each of the subcommittees developed conclusions and recommendations that are reported to the full Legislature in the Task Force report in the form of individual subcommittee reports. The recommendations relating to health are subdivided by subcommittee in the following summary.

The Finance Subcommittee spent a considerable amount of its time on the issue of increasing financing for Medical Assistance through increasing the nonfederal funding available to draw federal matching dollars. The subcommittee study focused on provider specific taxes and donations as a means of increasing nonfederal dollars to draw federal matching funds and on increasing the Kansas share of disproportionate share federal funding and making such funding available to more Kansas hospitals. Although the Finance Subcommittee made an initial recommendation that legislation be enacted to establish a 10 percent excise tax on Medicaid payments to all providers tied to matching the additional revenue with federal Medicaid dollars, passage by the Congress of federal legislation following the subcommittee's initial recommendation

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made the recommendation moot. For the same reason, the subcommittee's initial recommendation to maximize federal disproportionate share funding by taxing services for which compensation was not received provided by other than state hospitals in order to increase the state matching available to generate additional federal dollars was rendered infeasible by the new federal legislation.

The Finance Subcommittee has recommended that the Department of Social and Rehabilitation Services consider pursuing available provider tax options and present a proposal to the 1992 Legislature. In light of the Congressional action, such an assessment would likely be made against general revenues of health care providers or take the form of a bed tax.

The Subcommittee on Finance recommends that legislation be introduced to give the Department of Social and Rehabilitation Services a first class claim against an estate to enable recovery of expenditures made for medical care. The subcommittee also endorsed a proposal in the C level budget to fund an estate recovery unit at an estimated cost of $257,842. The proposed unit and estate recovery program is based on a successful Oregon estate recovery program.

The subcommittee also considered the options available under the Medicaid program to utilize managed care and contracting for medical services as a means of controlling expenditures and improving access for Medicaid clients and concluded that both hold promise for Medicaid in Kansas. The subcommittee recommendation urges the Department to be creative and innovative in this area through contracts with HMOs, extension of the primary care case management system, etc.

Mental Health and Mental Retardation Subcommittee recommendations are found in two separate subcommittee reports within the SRS Task Force Report. One report deals with mental retardation and the other with mental health.

The recommendations in regard to mental health include continued implementation of the Mental Health Reform Act and concurrence with a policy of continued downsizing of the state mental health hospitals, but note that the latter is dependent on the development of strong community-based mental health programs. The subcommittee also recommends funding for the mental health reform pilot project for children and adolescents included in the Mental Health Reform Act, but not funded by the 1991 Legislature.

The subcommittee recommends mandating that all Medicaid eligible clients, including children and adolescents, be screened through a mental health center prior to admission to any private facility for mental health treatment. The subcommittee notes problems with nursing facilities for mental health (formerly known as ICF-mental health facilities), and recommends that Mental Health and Mental Retardation within Social and Rehabilitation Services have programmatic responsibility for such facilities and develop standards specific to such facilities. In terms of seriously disturbed children and adolescents, the subcommittee has recommended the enactment of legislation that would establish regional interagency councils to develop and implement individual service plans with primary emphasis on determining the services necessary to maintain the child in his or her own family and school setting.

The second subcommittee report submitted by the Task Force Subcommittee on Mental Health and Mental Retardation concerns mentally retarded and other developmentally disabled individuals. In terms of specific recommendations, the subcommittee supports the introduction of legislation that would enlarge the statutory definition of mental retardation to further define mental retardation and to add developmental disabilities such as autism, cerebral palsy, epilepsy, and other physical or mental impairment to the statutory definition.

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The subcommittee also recommends enactment of H.B. 2530 that is currently in the House Committee on Public Health and Welfare and that would allow the delegation of noninvasive nursing procedures in community settings that serve persons with developmental disabilities.

Adoption of a five-year plan that would have all persons (1,400) currently on the waiting list for community services receiving such services by 1995; reduce the census of state mental retardation hospitals by 83 clients a year to 497 by 1997; serve all children with mental retardation or developmental disabilities by 1995; eliminate all large nursing facilities for the mentally retarded by 2000; and have a service coordination mechanism serving 10,500 persons in place by 1997 is also recommended.

Other recommendations include state hospital consolidation; creation of a staff of transition counselors; returning special education funding to at least 90 percent; establishing and funding a Kansas Resource Center on Autism; and establishing standards for community services and performance competency levels for community staff.

The Subcommittee on Prevention recommends that the highest priority for state expenditures for social services (including medical) be in the areas of prevention and primary care, with state resources redirected to these areas. The highest priority should be given to social and medical services directed at children and youth and targeted toward young children age 0 to 5. As does the Children's Initiative Committee, the subcommittee recommends that a children's budget be developed as a part of the regular budget process.

The Prevention Subcommittee is recommending that continued emphasis be placed on substance abuse prevention with targeted state funding directed to children and youth. It is recommended that the Department of Social and Rehabilitation Services give priority to strengthening the regional prevention centers and make such centers a focal point for community prevention activities directed not only to substance abuse but to other high-risk behaviors that share common risk factors such as teen pregnancy.

The subcommittee recommends that the Legislature consider substantive health-related legislation and appropriations action in the light of whether they move Kansas toward the goal of preventive and primary care; that access to preventive and primary care (including universal prenatal care) be assured for all children aged 0 to 5 by the 1995 Session and that specified steps be taken to reach this goal, including the submission by state agencies of strategies to the Joint Committee by the 1994 Session; that local health departments should play a larger role in the delivery of primary and preventive care for children, with consideration of enhanced state financial assistance for those agencies that agree to take on an expanded role; that outreach services be increased to improve participation in the EPSDT component of Medicaid; and that a pilot project directed toward pregnant or parenting teens be initiated. In addition, the subcommittee recommends that Social and Rehabilitation Services take the initiative in identifying and developing additional areas for cooperation with other state agencies and local programs, particularly in the areas of prenatal care and health care for young children.

In terms of long-term care, the Prevention Subcommittee concluded that Kansas needs to decide now whether it will continue to maintain an expensive institutional model of long-term care or begin to redirect funding and service delivery to community alternatives. It is recommended that the first step in moving toward expanded community alternatives to adult care homes is the development of a strong case management capability at the community level. The subcommittee also recommends that legislation be enacted requiring preadmission screening prior to <u>any</u> adult care home admission (the House bill now in the House Committee on Public Health and Welfare).

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The Prevention Subcommittee recommends that the long-term goal that is implemented through the development of adequate in-home and community long-term care should be a decrease in the adult care home population, and in the short-term, holding the size of the adult care home population static. The subcommittee further recommends that this be the overriding standard by which proposed initiatives in long-term care are measured by the Legislature.

Following subcommittee review of the policy change in determining Medicaid eligibility approved by the 1991 Legislature, the subcommittee noted that although the change has aroused concern due to federal regulations that limit the ability of an individual to protect income for a spouse, the new eligibility standard does represent a step toward redressing the current biases in the Medicaid program.

The Subcommittee on Medical Services and Long-Term Care made several general recommendations and a number of specific recommendations that relate to health care delivery. In terms of general recommendations the subcommittee recommends that governmental resources, in terms of the Social and Rehabilitation Services medical programs, be expended to help the greatest number of persons, with an emphasis on prevention, early intervention, and primary care services. Medical Assistance services should be directed less to individualized high-cost acute care procedures that are directed solely to prolonging life, without regard to quality of life or cost effectiveness, rather than on individualized high-cost acute care procedures.

Other general recommendations include giving prenatal care to all prospective mothers, with outreach necessary to accomplish this goal to be initiated by SRS and through cooperative agreements by other state and local agencies; giving a high priority in terms of prevention and early intervention to health education and the education of Medical Assistance clients in appropriate use of health care services and self care; a state policy that emphasizes in-home care and independent living options, with a resultant redirection of state resources toward this type of care; a recommendation that state and local agencies work cooperatively with local entities to establish community-based planning processes concerning health care, including the relationship of charity care to other methods of providing primary care; and that the Joint Committee on Health Care Decisions for the 1990s regularly hear reports from entities studying health care in order to facilitate coordination among them.

The subcommittee also recommends the development of a comprehensive and coordinated health care system and that the state follow the principles and actions noted below to facilitate changes in health care financing and delivery in Kansas.

1. State policy should recognize that an effective health financing system must be a partnership between individuals and families, government, and the private sector.

2. An effective system must ensure universal access, quality care, and control of charges and expenditures and state policies concerning Medical Assistance, health insurance, and other health issues should be reviewed to determine whether they assist in moving toward these goals.

3. The executive branch should examine the feasibility of centralized purchasing of all health care purchases made by the state.

4. Kansas should join with other states to contain pharmaceutical costs and take full advantage of OBRA 1990 options relating to prices and rebates.

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5. The medical industry should be a partner in health care reform and control of expenditures and should review its pricing structure and bring increases in charges to an annual level that exceeds the regular rate of inflation by no more than 50 percent. If a voluntary effort of this type is not successful, the Legislature should explore means of implementing and enforcing cost controls.

6. Communication should be initiated with the Kansas Congressional delegation requesting that a study be undertaken of shifting responsibility for long-term care from the states to the federal government.

7. Social and Rehabilitation Services should routinely review excessive service use to identify service abuse and situations where the quantity of service appears to be in excess of community norms and take appropriate action to curtail such use and recover expenditures for inappropriate services.

8. Institutional Medicaid providers should furnish evidence of a code of conduct for institutional employees that is enforced and that is effective in preventing fraudulent activities, including over-utilization and inappropriate utilization.

In terms of specific recommendations, the Subcommittee on Medical Services and Long-Term Care makes the following recommendations:

- that the Legislature explore additional ways to recruit and retain professional health care providers, particularly in the area of primary care and including reexamination of the existing medical and nurse scholarship programs, the establishment of additional training programs for mid-level health care providers, and the exploration of provider liability issues;

- that mid-level health care providers be used for the purpose of increasing access to primary and preventive care;

- that the Joint Committee on Health Care Decisions for the 1990s be used by the Legislature to continue to monitor implementation of the charitable health care provider program;

- that the medical community reevaluate its role in the provision of health care to Medicaid clients and low-income individuals and be more open in working with the Medicaid agency and local social service providers to find ways to overcome barriers to access that now exist;

- that the Commissioner of Insurance compile data from claim forms on the actual incidence of Medicaid clients suing providers;

- that efforts be continued to increase the percent of participation in the EPSDT program by Medicaid eligible children;

- that efforts to increase immunization rates remain a high priority;

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- that consideration be given to expansion of the Healthy Start and Mothers and Infants program statewide and that the programs specifically target visits to families identified as at-risk, such as mothers who receive no prenatal care;

- that Social and Rehabilitation Services explore with the Kansas Hospital Association, the Kansas Medical Society, and Blue Cross-Blue Shield of Kansas possible means of expanding the Caring Program for Children or the development of some other type of insurance designed to increase children's access to health care, including the purchase of group health insurance where available for Medicaid eligible dependents;

- that the Legislature give attention to the level of AFDC grants to ensure that children and their mothers have adequate means to meet basic health and other needs;

- that the WIC program be expanded, including the use of state funds, to ensure that all pregnant women receive services;

- that the Department look at alternatives in managed care to increase access to and cost-effective care for Medicaid clients; and

- that the community-based care projects funded by the 1991 Legislature be monitored and evaluated and that consideration be given to continued support and expansion if the projects appear to be successful in increasing access to cost-effective care.

Following review of the results of the change in the method of determining nursing facility eligibility for Medicaid to 300 percent of SSI eligibility and the effect of federal rules on the ability of spouses to divide income for the purposes of eligibility under this criteria, the subcommittee, recognizing the implications of the income cap, recommends that eligibility remain at 300 percent of the SSI income level for one person and further recommends that communication with the state's Congressional delegation be undertaken to urge modification of the federal regulation that disallows division of income in this type of circumstance.

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