Approved: 1/25/95
Date

MINUTES OF THE HOUSE COMMITTEE ON APPROPRIATIONS.

The meeting was called to order by Chairperson Robin Jennison at 1:30 p. m. on January 19, 1995 in Room 514-S of the Capitol.

All members were present except:
Representative Carmody, excused
Representative Gross, excused

Committee staff present: Paul West, Legislative Research Department
Jim Wilson, Revisor of Statutes
Mike Corrigan, Revisor of Statutes
Lenore Olson, Committee Secretary

Conferees appearing before the committee:
Janet Schalansky, Acting Secretary, Department of Social and Rehabilitation Services (SRS)

Others attending: See attached list

Chairperson Jennison directed the Committee to turn to the introduction of new bills. Jim Wilson, staff, briefly explained four bills which had been requested: 1) 5 RS 0259 regarding employment security fund control ratios; 2) 5 RS 0214 school district finance, increasing base state aid per pupil; 3) 5 RS 0184 securities act fee fund, ending balances; and 4) 5 RS 0218 state board of education, administration of the certificate fees fund.

A motion was made by Representative Helgerson, seconded by Representative Wilk, to introduce the four bills described by staff. The motion carried.

A motion was made by Representative Nichols, seconded by Representative Helgerson, to introduce draft bill 3 RS 2559 concerning the Kansas police and firemen's retirement system. The motion carried.

Janet Schalansky, Acting Secretary, SRS, presented a briefing and overview of the Department of Social and Rehabilitation Services (SRS). Ms. Schalansky explained SRS' organizational chart and administrative services (Attachment 1). She presented an in-depth review on SRS' Actively Creating Tomorrow (ACT) welfare reform initiative which is intended to get people off welfare by encouraging them to work using a system of monetary incentives and penalties. Ms. Schalansky said SRS is waiting for approval from three federal agencies to waive federal requirements in order for Kansas to continue receiving federal aid and keep state welfare reform. Once the state has waiver approval, implementation should take from four to six weeks (Attachment 2).

Also distributed by Ms. Schalansky were the following items:

Information on a waiver to discontinue coverage for high risk behavior related illnesses, including a letter to former SRS Secretary Donna Whiteman from Richard Brummel, Associate Regional Administrator for Medicaid in which Mr. Brummel indicates he doesn't believe SRS can limit reimbursement based on the diagnosis or type of illness (Attachment 3);

A background primer on long-term care options for Kansans (Attachment 4);

Information on the SRS CHOICE program (Attachment 5);

A report on the current status of the Kansas Medicaid waivers (Attachment 6);

An update on securing bids for the next Medicaid Management Information Systems (MMIS) Fiscal Agent Contract (Attachment 7);

A report on the Kansas Social Services Information System (KISSIS) (Attachment 8);

Charts on the Capitated Managed Care project timeline for Wyandotte, Shawnee, Douglas, Leavenworth and Johnson Counties (Attachment 9);

A summary of key federal welfare reform legislation (Attachment 10).

The meeting adjourned at 2:45 p.m.

The next meeting is scheduled for January 25, 1995.

APPROPRIATIONS

DATE 1/19/95

NAME	ADDRESS	REPRESENTING
Joyce Sugrue	Topeka	SRS
Janet Schalansky	"	SRS
J. G. Scott	"	"
Tim Hoyt	Tonganoxie	"
James Crawford	Topeka	Intern - Rep. Wells
Cleta Reneyer	Sabetha	Right to Life of Ks
Jane Rhys	Topeka	KS Council on Dev. Disabilities
Shannon Jones	Topeka	SILCK
Josie Torres	Topeka	Families Together
MaryEllen O'Brien Dwight	Topeka	Assoc. Tech. for Kansans
Gina McDonald	Topeka	KACIL
Erika Aldrich	Osage City	RCIL
Martha Hodgesmith	Topeka	KARF
Marty Kennedy	Topeka	DOB
JILL CRUMPACKER	GOVERNOR'S OFFICE	LEGISLATIVE LIASON
Milly Phillips	Lawrence	Rep. McClure
Kathryn Ward	Olathe	Juv. Offender Parents
Emma Knight	Olathe	
Rosie Cooper	Topeka	Keys For Networking
Dodie Lacey	Topeka	KCSL
JK Shively	TOPEKA	Ks. Legal Services
Judy Kinard	Topeka	Ks Mental Health Coalition
[illegible] Robertson	Topeka	Ks Gov. Consulting

APPROPRIATIONS

DATE 1/19/95

NAME	ADDRESS	REPRESENTING
J Cottnight	Topeka	KSC
Steve Allen	Lawrence	
Sandy Strand	Lawrence	KINH
Tom Bell	Topeka	KCHA
John Federico	"	Pete McGill + Assoc

BILL GRAVES, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

JANET SCHALANSKY, ACTING SECRETARY

HOUSE APPROPRIATIONS COMMITTEE

SRS OVERVIEW

PRESENTED BY: JANET SCHALANSKY, ACTING SECRETARY

JANUARY 19, 1995

1/19/95
House Appropriations Date
Attachment 1

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

TABLE OF CONTENTS

Mission Statement

The Kansas Department of Social and Rehabilitation Services empowers individuals and families to achieve and sustain independence and to participate in the rights, responsibilities and benefits of full citizenship, by creating conditions and opportunities for change, by advocating for human dignity and worth, and by providing care, safety and support in collaboration with others.

Vision statements

Services will be provided in a respectful and humane manner which recognize the capacities of the whole person, building on personal strengths and allowing consumers greater control of their own destiny.

Services to children and adults will assure safe and stable environments for maximum personal development.

Individuals and families receiving services from SRS will be partners in goal-setting, decision-making, service planning, and outcomes.

Services provided to SRS consumers will be individualized and implemented in a culturally sensitive manner.

Communication with individuals, families and external organizations served will be marked by courtesy, responsiveness and follow through.

Services will emphasize prevention and be provided in settings such as homes, schools, work places and other locations which preserve human dignity and promote community integration.

Through a process of internal and external collaboration at all levels, SRS will achieve a cohesive human service system which brings together sufficient resources to improve the quality of life for Kansas citizens.

Individuals and families who receive SRS services will be assisted in a timely manner by employees who are empathetic and caring.

SRS will provide leadership in maintaining a competent and diverse workforce committed to the delivery of family-friendly and person-centered services of the highest quality.

SRS will advocate for the resources needed by employees to accomplish the mission.

SRS will be committed to continuous quality improvement with informed decision making based on employee participation, feed-back from consumers, analysis of data from monitoring, and evaluation of services and outcomes.

The credibility of the organization will lie in its flexibility and adaptability, and in an openness which inspires public confidence and high staff morale.

SOCIAL WELFARE IN KANSAS

1859
- Wyandotte Constitution: "institutions for the benefit of the insane, blind, and deaf and dumb, and such other benevolent institutions as the public good may require" -- counties prescribed by law to provide services.

1862
- Cities and townships selected by state legislature to be overseers of the poor within their jurisdiction.
- With authority divided between county and township, relief measures often poorly coordinated and inconsistent.

1931
- Welfare commission appointed by Governor Woodring to study welfare problem aggravated by the Great Depression; make recommendations to Legislature.

1932
- Emergency Relief Act passed by Congress: Reconstruction Finance Corporation distributed funds to states for work-relief wages to needy, qualified participants.
- Kansas Emergency Relief Committee (KERC) created to administer aid.

1933
- Congress passed Federal Relief Act; KERC administered federal relief projects.
- Problems resulted because authority divided among county commissioners, township trustees, and city officers.
- State law changed to allow all counties to appoint poor commissions: counties assumed primary responsibility.
- Coordinated administration between KERC and county offices improved; 113,591 cases served by early 1935.
- Works Progress Administration (WPA) absorbed much of relief activity.
- State's practice to maximize federal funds and turn social welfare over to county officials.
- State placed emphasis on procuring federal relief but provided little from state funds: state ranked thirty-ninth among states in per capita relief grants from May 23, 1933 to July 31, 1934.

1936
- State constitution amended to allow state to participate in programs created by the Social Security Act; aid to the blind and aged, aid to dependent children (ADC) and unemployment insurance.

1937
- State board of Social Welfare established by Kansas Welfare Act to develop state plan for federal programs: composed of five part-time members appointed by Governor and a single administrator.
- State financed certain welfare programs but Act preserved county autonomy: each of 105 county commissions was designated as a board of social welfare.

1944
- Kansas Vocational Rehabilitation (VR) program first administered by State Board of Social Welfare, moved to the State Board for Vocational Education to comply with federal legislation.

1949
- State Department of Social Welfare with two divisions: social welfare and institutional management established by legislature: limited supervisory responsibility over welfare; counties retained administrative and financial control.

1968
- VR program transferred from State Board of Vocational Education to State Department of Social Welfare and designated a division of Rehabilitation Services: included Disability Determination Services (established 1955), Vocational Rehabilitation Services, and Blind Services programs.

1972
- Supplemental Security Income (SSI) enacted by Congress, replacing grants to the states for aid to the aged, blind, and disabled.
- Implementation date of January 1, 1974 left Kansas officials with the least-popular programs such as ADC and general assistance.
- State welfare aid to counties reached $17 million compared with total county expenditures of $18 million.

1973
- Department of Social and Rehabilitation Services (SRS) with a Cabinet level secretary, Dr. Robert C. Harder replaced both the State Board and the Department of Social Welfare.
- Division of institutional management was renamed Division of Mental Health and Retardation Services.

1974
- County administration transferred to state through SRS: state government assumed financial responsibility for welfare; 105 county welfare offices consolidated into six regions and thirty-five districts across state.

1976
- Regional offices eliminated.
- Thirty-five district offices reduced to seventeen area offices: move enabled department to be more responsive to clients.

1978
- SRS, umbrella agency, included division of mental health and retardation, income maintenance (including Medicaid); vocational rehabilitation; children, youth and adults (providing social services); special programs (including alcohol and drug abuse, services to the blind, and emergency preparedness); and administration.
- All area directors reported directly to the Secretary.

1979
- Governor John Carlin appointed task force to examine SRS organization and operations.

- Some recommendations were implemented: Division of alcohol and drug abuse created; charge to plan, develop and implement regional program of prevention, intervention and treatment services.

1981
- Kansas Legislature trimmed medical expenditures by eliminating state funded General Assistance -- Medical only program due to budget constraints.

1982
- Youth Services and Adult Services each led by a Commissioner created by Governor's Executive Order.
- The three youth centers at Atchison, Topeka, and Beloit and the youth rehabilitation centers at Osawatomie and Larned moved from the direction of Commissioner of Mental Health and Retardation Services to that of Commissioner of Youth Services.

1983
- Kansas Commission of the Deaf and Hearing Impaired established within SRS Rehabilitation Services.

1984
- New MediKan Program created, limiting further eligibility for medical assistance for state funded General Assistance clients.
- Rehabilitation Act extended, mandating a Client Assistance Program (CAP) in each state, Projects with Industry and Independent Living programs.

1985
- Several cost savings initiatives passed by legislature by 1985 limiting Medicaid service coverage; restricted formulary for prescription drugs, Primary Care Network (PCN) program, and incentives to encourage outpatient procedures vs hospital admissions.

1986
- Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 passed: increased Medicaid coverage to pregnant women and children, mandated the identification of third party resources and required the computation of the federal match on an annual basis.
- Annual computation inversely proportional to a state's per capita income resulted in increase in federal financial participation (FFP) in Kansas from 50.17% in FY 1986 to 56.07% in FY 1990.
- Rehabilitation Services designated by Legislature as lead commission for transition planning services for special education students at least sixteen years old.

1987
- Governor's Office of Drug Abuse Programs established to coordinate more than twenty-one state agencies receiving $43 million in alcohol and drug abuse funds.
- Kansas pioneered welfare reform efforts with passage of the KanWork statute, a model closely mirrored by the Federal Family Support Act of 1988.

1988
- State legislation with significant impact on Medicaid passed: Division of Assets law and provision of coverage for children up to age two expanded eligibility for medical assistance.

1989
- Qualified Medicare Beneficiary Program as part of the federal Medicare Catastrophic Act of 1988, implemented in Kansas providing coverage of Part B Medicare premiums, deductibles and co-insurance: in first year, 85% of Federal Poverty Level (FPL) criterion, to be increased incrementally to 100% of FPL in 1991.
- SRS area offices reduced from seventeen to fifteen; Winfield and Pratt absorbed into Garden City, Hays, Hutchinson, and Emporia areas.

1990
- Eligibility criteria modified for many Medicaid groups: pregnant women and infants covered at 150% of FPL and children ages one to six at 133%; early and periodic screening (KAN Be Healthy) program expanded; spousal impoverishment laws permitted more resource to be retained by a community spouse; Family Support Act of 1988 established medical benefits up to twelve months for persons losing AFDC eligibility medical benefits due to employment.
- Attempts to reduce the state-funded MediKan program again unsuccessful.
- SRS fifteen area offices reduced to twelve; Chanute absorbed Pittsburg and Parsons and new area office created in Lawrence absorbing Hiawatha and Osawatomie offices.
- Americans with Disabilities Act (ADA) of 1990 guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, state and local government services, and telecommunications.
- Regional Prevention Center System (ADAS) completed with twelve centers covering 105 counties.

1992
- Rehabilitation Act extended to 1997 including provisions geared to achieving goals and objectives of the ADA.
- Change of name by legislature from Kansas Commission of the Deaf and Hearing Impaired to Kansas Commission for the Deaf and Hard of Hearing (KCDHH); removed KCDHH from provisions of the sunset law.
- SRS adopts its Family Agenda, a three year plan for the enhancement of services to children and families.

1993
- SRS adopts Family Initiative, a five year plan to raise drug-free youth, a broad-based public and private partnership.
- Alcohol and drug counselors registration bill setting standards for treatment counselors passed by legislature.
- Omnibus Budget Reconciliation Act of 1993 (OBRA '93) including disproportionate share hospital reductions, reduction in AFDC and Food Stamp administrative match to 50%, capped entitlement for family support services and other changes passed Congress.

Kansas Department of Social and Rehabilitation Services

Janet Schalansky, Acting Secretary
(913) 296-3271

Mission: "The Kansas Department of Social and Rehabilitation Services empowers individuals and families to achieve and sustain independence and to participate in the rights, responsibilities and benefits of full citizenship by creating conditions and opportunities for change, by advocating for human dignity and worth, and by providing care, safety and support in collaboration with others."

Administrative Services

Ann Koci, Commissioner
(913) 296-3241
– Administrative services for the department and area offices
– Data processing, accounting, audits and budgeting

Alcohol and Drug Abuse Services

Andrew O'Donovon, Commissioner
(913) 296-3925
– Coordinates efforts with local community services to provide alcohol and drug abuse prevention, education and treatment programs

Income Support/ Medical Services

Candy Shively, Act. Commissioner
(913) 296-6750
– Cash assistance programs (Aid to Families with Dependent Children, General Assistance, Low Income Energy Assistance Program, Refugee Assistance, burial assistance and emergency assistance)
– Food Stamps
– Medical assistance programs funded by Medicaid and MediKan.
– Community-Based Long-Term Care and Community Living and Day programs
– Child Support Enforcement

Management Services

Rita Wolf, Director
(913) 296-3329
– SRS budget, caseload projections and reports
– Current data and information about SRS programs and activities.
– Reviews & monitors existing client-centered contracts & grants.
--Emphasize customer outcome objectives, performance indicators & measures.

Mental Health and Retardation Services

George Vega, Commissioner
(913) 296-3773 (voice)
(913) 296-3471 (TDD)
– Administers the State's four mental health institutions
– Administers the State's three mental retardation hospitals
– Provides aid for community mental health centers and community mental retardation centers

Rehabilitation Services

Glen Yancey, Commissioner
(913) 296-3911 (voice)
(913) 296-7029 (TDD)
– Kansas Industries for the Blind; Business Enterprise Program; Rehabilitation Teaching; the Rehabilitation Center for the Blind
– Kansas Vocational Rehabilitation Center/Salina
– Vocational Rehabilitation Unit/ Topeka
– Transition Planning, Independent Living and the Commission for the Deaf and Hard of Hearing
– Directs vocational rehabilitation services to persons who are blind, visually impaired or deaf-blind
– Disability and blindness determinations for the U.S. Department of Health and Human Services

Workforce Development

Director (Vacant)
(913) 296-3273
– SRS personnel, staff training and development, administrative hearings, employment preparation services, volunteer services and the SRS Customer Relations Office
– Two federally mandated work programs:
JOBS/KanWork program for AFDC recipients
MOST program for food stamp recipients
– JOBS/KanWork offers transitional services to eligible individuals who become employed
– Child care services for AFDC, General Assistance, food stamp recipients and other income eligible persons

Youth and Adult Services

Carolyn Hill, Commissioner
(913) 296-3284
– Provides services to protect the health and welfare of children
– Oversees the operation of the four state youth centers
– Foster care and adoption services
– Adult abuse investigations and adult guardianships

How can we help you?

If you have questions about what programs are available through SRS, program eligibility or the application process for any SRS program:

Contact your nearest local SRS office or one of the following area offices. Several of the area offices have ombudsmen to help you determine who to call and/or what resources are available.

SRS AREA OFFICES

The 12 SRS Area Offices and the local offices located in each of the state's 105 counties determine eligibility and process applications for: public assistance, medical assistance, food stamps, investigate allegations of abuse and neglect of both children and elderly adults. SRS Area Offices also coordinate foster care services for those children who are placed in the custody of the State by the courts, provide direct services to the home-bound elderly and disabled, and enforce child support orders.

Chanute Area Office
O.D. Sperry, director
Sandra Robb, ombudsman
1500 W. 7th
Chanute, KS 66720
(913) 431-7100

Emporia Area Office
Joe Myers, director
1015 Scott
Emporia, KS 66801
(316) 342-2505

Garden City Area Office
Dale Barnum, director
907 Zerr Road
Garden City, KS 67846
(316) 272-5800

Hays Area Office
Gene Dawson, director
3000 Broadway
Hays, KS 67601
(913) 628-1066

Hutchinson Area Office
Gary Nelson, director
501 N. Monroe
Hutchinson, KS 67504
(316) 663-5731

Kansas City Area Office
Eva Whitmire, director
Robena Farrell, ombudsman
I Gateway Center 66101
Kansas City, KS 66117-0248
(913) 371-6700

CHILD & ADULT ABUSE HOTLINE
1-800-922-5330
All calls are confidential

Lawrence Area Office
Jim Wann, director
Ernie Dyer, ombudsman
1901 Delaware
Lawrence,KS
(913) 832-3700

Manhattan Area Office
Flordie Pettis, director
327 Colorado
Manhattan, KS 66502
(913) 776-4011

Olathe Area Office
Mike VanLandingham, director
401 W. Frontier Lane
Olathe, KS 66061
(913) 768-3300

Salina Area Office
Dave Jacobs, director
Ann Rollins, ombudsman
2130 S. Ohio
Graves Plaza
Salina, KS 67401
(913) 826-8000

Topeka Area Office
Oliver Green, director
235 Kansas
Topeka, KS 66601
(913) 296-2500

Wichita Area Office
John Sullivan, director
Jennifer Keller, ombudsman
230 E.William
Wichita, KS 67201
(316) 337-7001

FRAUD & ABUSE HOTLINE
1-800-432-3913
All calls are confidential

YOUTH CENTERS

Youth Center at Atchison
Harold Allen,, superintendent
(913) 367-6590

Youth Center at Beloit
Denis Shumate, superintendent
(913) 738-5735

Youth Center at Larned
Dell Hayden, superintendent
(316) 285-2131

Youth Center at Topeka
Ben Coates, superintendent (act)
(913) 296-7709

STATE INSTITUTIONS

Kansas Neurological Institute, Topeka
Bob Day, superintendent
(913) 296-5301

Larned State Hospital
Mani Lee, superintendent
(316) 285-2131

Osawatomie St. Hospital
Stephen Feinstein, superintendent
(913) 755-3151

Parson State Hospital
Gary Daniels, superintendent
(316) 421-6550

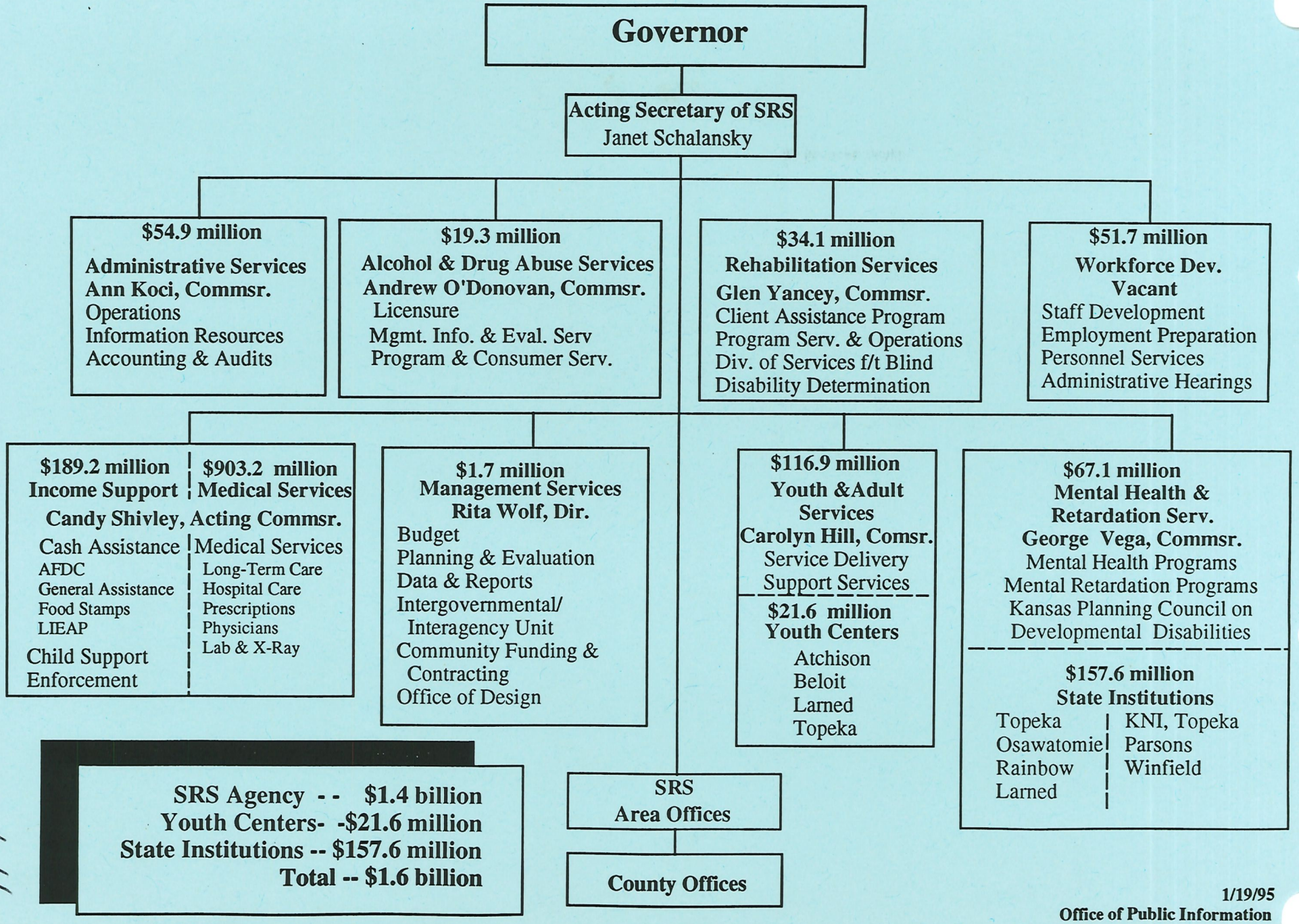
Rainbow Mental Health Facility, Kansas City
Martha Town, superintendent
(913) 384-1880

Topeka State Hospital
Randy Proctor, superintendent (act)
(913) 296-4222

Winfield State Hospital and Training Center
William Brooks, supt. (act)
(316) 221-6660

1-10

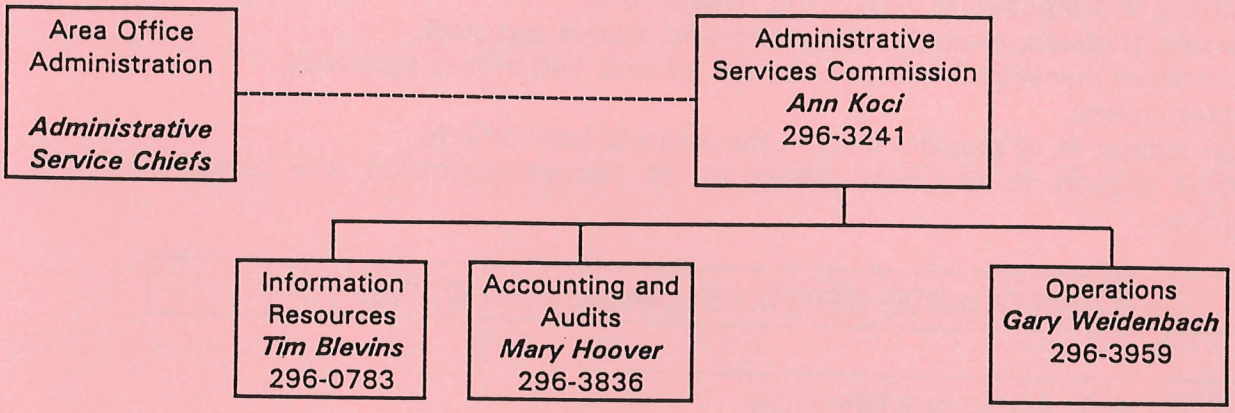
SRS Organizational Chart and FY 1994 Actual Expenditures



1/19/95
Office of Public Information

ADMINISTRATIVE SERVICES

Administrative Services will provide quality operational support enabling SRS staff to deliver services.



Subprogram	Division	Budget Amounts *(in millions)* FY 95	FY 96 Level A	FY 96 Level B	FY 96 Level C
0120	Area Office Administration	$34.5	$32.6	$36.1	$36.1
0150	Administrative Services	4.2	3.9	4.3	4.3
0190	Information Resources	15.0	12.6	14.1	15.6
Totals		**$53.7**	**$49.1**	**$54.5**	**$56.0**

Budgetary Issues.

- Budget reductions to achieve Level A include 14.5% staff shrinkage and elimination of inventory replacement plan. Shortfalls are due to committed expenditures for facility rents and ADA compliance. The Commission is only able to make reductions in salaries to stay within the Level A allocation.

- Inadequate staffing as well as no funds for inventory replacement plan limits ability to perform responsive customer services.

ADMINISTRATIVE SERVICES

AREA OFFICE ADMINISTRATION (Subprogram 0120)

Area Office Administrative Services provides the infrastructure and support services to over 4,000 agency employees who work in 105 counties in twelve management areas throughout the State. This is the business division of the Area Offices and provides the following services:

- Accounting and processing of payment transactions.
- Purchasing of goods, materials and services for clients and staff.
- Local facilities management responsibilities for over 140 offices statewide.
- Inventory control.
- Clerical support to all program units in the area and local offices.
- Technical support in the area offices for all telecommunication and computer equipment.

ADMINISTRATIVE SERVICES (Subprogram 0150)

ACCOUNTING AND AUDITING DIVISION

Agency Allocations Management. Responsible for preparation and monitoring of the agency cost allocation plan and agency allocations, and for coordinating special accounting projects.

Receivables Management. Responsible for the receipt and record control of all agency receivables, and for the cash management of all state, federal, and special funds within SRS. The unit is also responsible for federal grant award quarterly reporting.

Audit Services. Responsible for financial and compliance audits of grants, contracts and cost reports for the rate setting systems and for internal financial, compliance and performance audits for all SRS commission, sections, area offices and institutions. There are three program audit units in the division are Nursing Facility - ICF/MR Programs, Grants and Contracts, and Internal.

OPERATIONS DIVISION

The Operations division has responsibility to coordinate administrative activities of the field and central office Commissions and Programs in the following areas:

Facilities Management: Identify and solve facility management and planning issues which address safety, office design and workstation functionality, and cost benefit analysis.

Payables, Grants and Contract Management: Has primary responsibility for coordinating all payments obligated by the agency which include client benefits, vendor payments, grants, contracts and leases.

Procurement and Materials Management: Has primary responsibility for purchasing, inventory control, warehouse and supply distribution center, and the agency central mail.

ADMINISTRATIVE SERVICES

INFORMATION RESOURCES DIVISION (0190)

The Division of Information Resources (DIR) is the computer and telecommunications organization for SRS agencies. DIR performs these major functions for the agencies:

- Develops new information systems; enhances and maintains existing information systems.
- Provides computer and operational support services.
- Provides computing and telecommunications infrastructure.

Major information system projects of the agency currently underway are:

Agency-wide Information Systems Plan (AWISP)
Child Support Enforcement System (KESSEP)
Kansas Social Services Information Systems (KSSIS)
Local Area Networks SRS offices, institutions and youth centers (LANs)
Medicaid Management Information System(MMIS)
Voice and Data Improvements in SRS Offices and Institutions
Welfare Reform
Data General Office System Replacement
KAECSES System Backlog of Improvement

Significant Agency Initiatives/Challenges

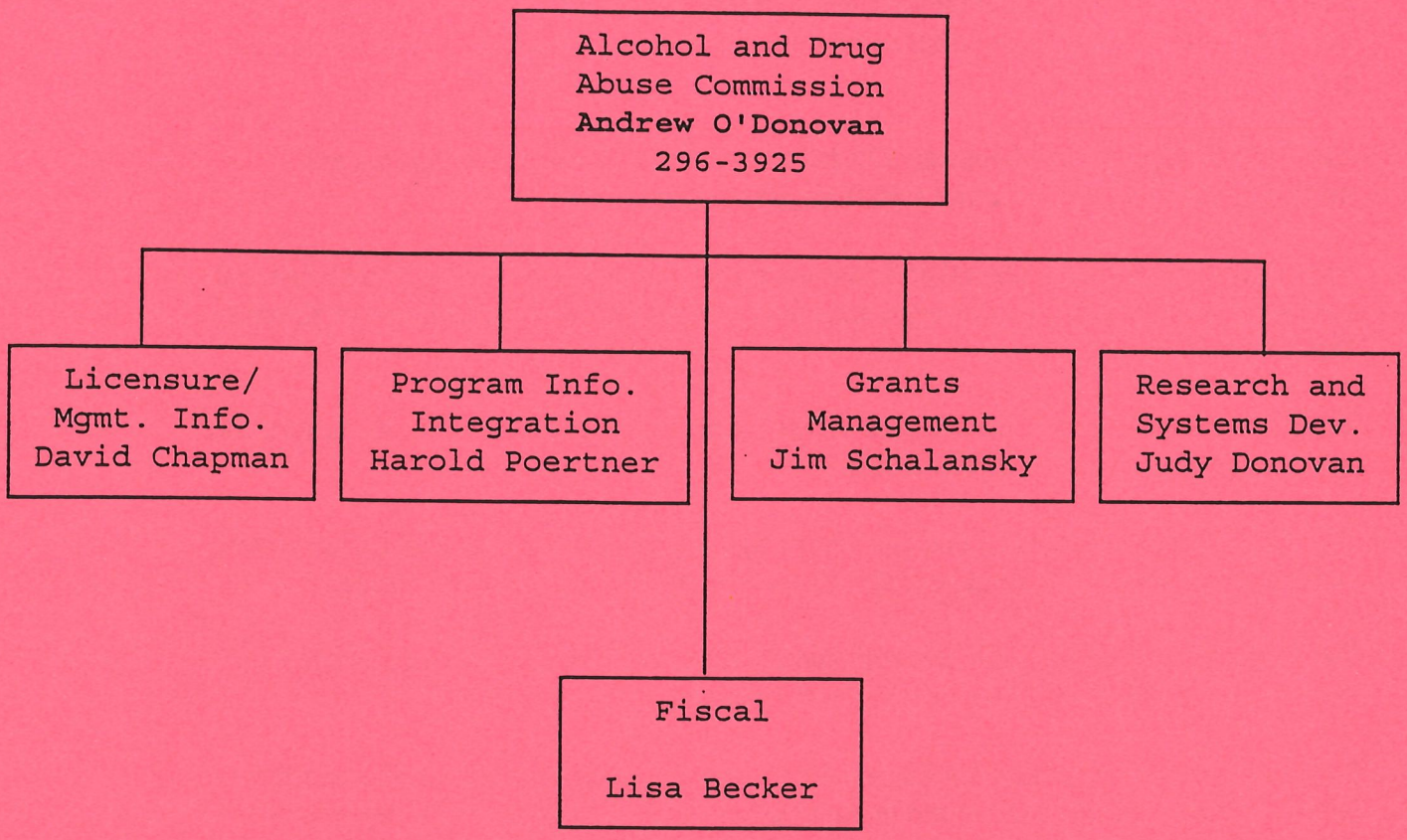
- Obtaining adequate numbers of qualified staff to achieve agency mission.
- Implementing information technology within the agency to improve productivity of SRS staff and clients.
- ADA compliance.
- Performance based audits.
- Maximizing federal enhanced funding
- Funds management.

Accomplishments

- IRM Planning Process Improvements.
- KAECSES Performance Improvement Program.
- New KsCares System for the Work and Child Care Programs.
- KMIS System Processing Cost Reductions.
- Voice and Data Telecommunications Improvements for New Staff.
- Laser Printer to Print Bar Codes on Income Maintenance Envelopes.
- Replacement of the Topeka Data General Office Automation System.
- Development of standard workstation specifications.
- Direct entry of vendor payments at local office.
- Development of specifications for purchasing.
- Federally approved cost allocation plan.
- Cost savings resulting from agency audit function.
- Development of facilities rent cost tracking system.
- Survey completed on rent cost in communities (40% return).

ALCOHOL AND DRUG ABUSE SERVICES

The ADAS mission is to provide leadership in reducing alcohol and other drug abuse in Kansas by creating conditions for healthy families and communities through a comprehensive continuum of services. These services are based on research, designed to be culturally relevant, and focus on the family and community.



There has been a slow but growing recognition that alcohol and other drug abuse is the root cause of many of the serious problems facing Kansans. Substance abuse strains our health care system, as well as social services, the education and criminal justice system. These problems are estimated to cost Kansans $1 billion each year. The Kansas Department of Social and Rehabilitation Services/Alcohol and Drug Abuse Services (ADAS) has a lengthy history of providing leadership for substance abuse prevention and treatment services.

The State Alcohol Program was established in 1972 (K.S.A. 65-4001) and the State Drug Program in 1973 (K.S.A. 75-5375). These problems functioned separately until the Commissions were brought under SRS in 1975. In 1980 a Governor's Task Force implemented Executive Order No. 17 (Section 18) which established the State Alcohol and Drug Program as a full Commission under SRS. The charge was to provide leadership for a regionalized program of prevention, intervention and treatment services.

ADAS provides administrative leadership by promoting effective public policy and developing and evaluating programmatic resources. These responsibilities are concentrated in five areas:

- Planning, developing and evaluating a regional system of community-based prevention, intervention and treatment services in the 12 SRS management regions. This continuum includes a Regional Prevention Center, and various levels of treatment funded through and managed by private contractors.

- Operating a management information system that collects, analyzes, and evaluates data and other information for program and policy planning, evaluating and public education purposes.

- Ensuring quality through licensing 275 public and private treatment programs and certifying more than 800 Kansas substance abuse counselors.

- Providing training and technical assistance services to increase the skills, knowledge and the capacity of professionals to more effectively respond to the diverse needs of Kansas families and communities.

- Developing collaborative, coordinated and cooperative relationships at the local, state and national levels to enhance effectiveness.

  Significant progress has been made in providing national and state leadership, in reducing substance abuse and in creating conditions for healthy families and communities.

- Developed a nationally-recognized regional program of prevention and treatment so Kansans have access to quality services in all 105 counties.

- Developed and strengthened the Regional Prevention Center system through a research-based risk and protective factor model that has received national and state support. A 1992 Kansas Legislative Committee on Prevention strongly recommended that preventive services should be a priority and that the 12 Regional Prevention Centers be expanded to serve as a focal point for community-based prevention. The committee noted there are common risk factors not only for substance abuse and other problems such as violence, teen pregnancy, and school dropout.

- Was a key developer of the Kansas Family Initiative, the state's first comprehensive program to assist families in raising drug-free successful youth. Through a public/private partnership, families have access to information, skill-building workshops and a statewide support network.

- Focused on families at risk and those with special needs: funded 10 specialized treatment programs for addicted women and their children in eight regions; developed treatment services for addicted youth; funded new prevention and treatment services for Hispanic

and African American families; and created policy that allows pregnant women and those HIV/AIDS priority admission to treatment.

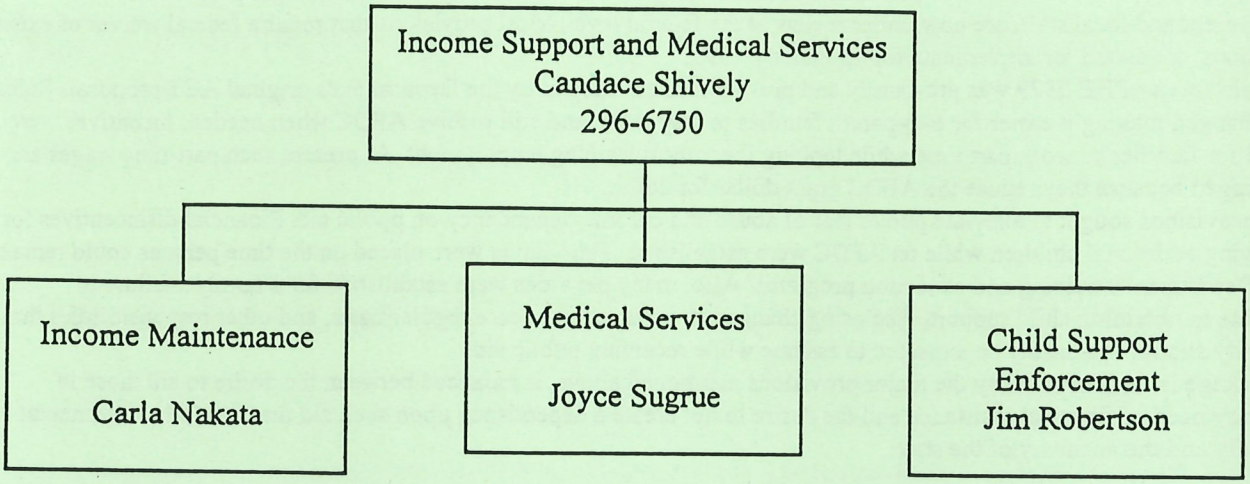
- Developed strategies to increase earlier interventions to treatment: 9 Intervention Referral Specialists that are placed in the SRS Area Offices; and Intervention Referral Specialists located in the Kansas City and Topeka health departments to assist those with HIV/AIDS and other sexually transmitted diseases to get immediate treatment for their addiction.

- Implemented the state-of-the-art Addiction Severity Index, an instrument that is administered on ADAS-funded clients at treatment admission, discharge and six-month followup. Several areas of the person's life is evaluated: alcohol use, other drug use, health, family/social, employment, legal and psychological.

- Developed a management information system that collects and analyzes data on: all client admissions; the Addiction Severity Index; State/regional/county risk assessments; and youth and household surveys and household telephone survey data.

- Increased the professionalism of those working in prevention and treatment: developed and provided a statewide training system with core curriculum; implemented licensure standards for counselors working in alcohol and drug treatment.

Income Support and Medical Services



Income Maintenance Division

Cash Assistance

Aid to Families with Dependent Children (AFDC)

- This is a federal/state matching funds program created by the Social Security Act of the 1930's.
- During the 1990's this program has aided 45,000 families each year.
- There are approximately 30,000 families who receive such aid in any given month.
- 40% of these families will receive AFDC benefits for less than one year. Nearly two-thirds will be back to work within 2 years.

General Assistance (GA)

- This is the second largest program of cash assistance and is entirely state funded.
- In it's present form General Assistance focuses on two distinct populations. The program serves poor two parent families who, despite their present lack of work, are not eligible for AFDC. This program serves nearly 2,000 families each year. There are approximately 700 families receiving assistance in any given month. Since there are two job seekers in each GA family the time on assistance is quite low, averaging 4 months per episode. The FY 96 budget preliminary request for this GA population is roughly $4 million, or $117 per person. The term "preliminary" is used here because a major feature of our welfare reform efforts would transfer this entire population to the AFDC program on January 1, 1995. If this reform effort receives federal approval there would then be no such GA eligibility group in FY 96. A control group would be maintained for waiver evaluation purposes.
- A second group served by the present GA program are those without children who cannot support themselves due to a serious physical or mental disability. The average monthly benefit per person is $156.

Low Income Energy Assistance Program (LIEAP)

- This is the third major program of the Cash Assistance budget. LIEAP, which is wholly federally-funded, had it's origin in the federal response to the rapidly increasing cost of energy following the Middle East oil crisis of 1973. The winter benefit is a one-time payment which averages $170 per household. There is a cooling program provided in the summer months for income-eligible persons those whose physical well being is threatened by Kansas' summer heat.

Food Stamps

- This federally-funded program is offered to all households, with or without children, whose incomes fall below 130% of national poverty levels. At the present time this program supplements the food budgets of 75,000 Kansas households each month.

Medical Assistance

- Lastly, the vast majority of households receiving Cash Assistance also receive SRS medical coverage in some form. There are many others, primarily aged and disabled Kansans in their own homes or in nursing facilities, who receive medical coverage but none of the above financial assistance. This benefit is afforded to nearly 200,000 persons. This $700 million+

program is mentioned here because it is the responsibility of the Income Maintenance staff to establish eligibility policy and to serve those who apply for coverage.

Welfare Reform

ACT for Families, while not a formal part of the Governor's FY 95 budget proposal, drew the attention of the 1994 Legislature. This proposal was blended with several other reform bills introduced and culminated in the welfare reform package contained in HB 2929. The provisions of this bill, as well as several other no-cost changes proposed by IM management and local staff, are now under review at the federal level. Most provisions that require federal waiver of existing regulations, are slated for implementation in January 1995.

The main focus of HB 2929 was pro-family and pro-work as envisioned by the Department's original ACT proposal. Rules were changed making it easier for two-parent families to stay intact and still receive AFDC when needed. Incentives were created for families to work part time while looking for truly sustaining employment. At present such part-time wages are discouraged because they reduce the AFDC grant dollar for dollar.

Other provisions sought to alleviate public fear of abuse and chronic dependency on public aid. Financial disincentives for conceiving additional children while on AFDC were established. Time limits were placed on the time persons could remain in the Department's training and education programs. Also, many penalties were established for a family's failure to cooperate in obtaining child support, disclosing changes in circumstances on a regular basis, and other responsibilities that the family should reasonably be expected to assume while receiving public aid.

The package is, as illustrated by the major provisions mentioned above, is balanced between the desire to aid those in temporary need of financial assistance and the desire to not create a dependency upon such aid that would be detrimental to the family and the economy of the state.

Other Budget Highlights and Notable Activities

During FY 95 staff continue to work toward converting most of it's Cash Assistance benefits from checks and food stamps to electronic benefit transfer (EBT). It is plannedthat a request for proposals to design and operate such a system will be released this fiscal year. This effort will be done in partnership with several other states in order to get the best possible price.

Division of Medical Services

The mission of the Division of Medical Services is to improve the quality of life of Kansas indigent children, adults and elderly through the provision of a full range of health services that are preventive in nature or medically necessary and are provided through the most effective and economic method.

Accomplishments

SRS has made a shift from institutional to community based care for the elderly and disabled. The following initiatives have assisted in this effort:

- Implementation of nursing facility pre-admission screening;
- Three new home and community based services waivers;
- Increasing the number of individuals utilizing the home and community based services waiver for the elderly and persons with disabilities;
- Community re-entry for residents of nursing facilities;
- Community resource development in cooperation with the Department on Aging;
- A request for a waiver from the federal government so that nursing facility services and expenditures are more controllable; and
- Implementation of a case mix reimbursement methodology for nursing facilities.

SRS is making a shift from a traditional fee for services health care system to a managed health care system. The following initiatives are in progress:

- The planning phase for a prepaid capitated managed care program.
- The renewal of the waiver for an expanded and improved primary care case management program has been requested.
- Federal funds have been maximized through agreements with local health departments, local education agencies, youth services, mental health and retardation services and the State Departments of Health and Environment and

Aging.

- Development of a Medicaid Management Information System is under way. This system pays medical claims, monitors quality of care and has other functions.
- A variety of cost savings measures have been initiated including collection of third party obligations and assisting in the establishment of court ordered medical support.

Initiatives in Progress and On-going

- Strengthen the process for input from consumers of services.
- Expansion of long term care options for the elderly and persons with disabilities to a more appropriate balance between community based and institutional services.
- Complete the conversion from a fee for services based system to a managed care system.
- Continue to explore ways to be more cost effective in the delivery of health care services.
- Complete the reprocurement of and the implementation of the next contract for the Medicaid Management Information System.
- Continue to strengthen fraud detection and legal follow up.

Child Support Enforcement Program (CSE)

In 1975, Congress enacted Title IV-D of the Social Security Act to counteract the ballooning tax burden of public assistance to children left unsupported by one or both parents, and to improve the lives of the one in four children living in poverty. Federal law requires each state to establish an effective statewide child support program (CSE) to improve the quality of life for children; to reduce expenditures for Aid to Families with Dependent Children (AFDC), food stamps, , foster care, and medical assistance; to help families become independent of public assistance; and to return the responsibility of supporting children to parents whenever possible.

Program Functions

The Kansas CSE Program is a joint federal , state, and county operation which must satisfy numerous specific federal requirements concerning all phases of operation. CSE must provide a full range of support services, from establishment of orders to modification and enforcement, in two types of cases:

1) Public Assistance (PA)- When a child's custodian applies for AFDC, that child's child and medical support rights are assigned to the State. If CSE collects support in an AFDC case, the first $50 is passed through to the assistance family. The remainder, and any collection of past due support, is used to reimburse the state and federal governments for the public assistance provided to the child's family. Any support collections beyond the claim for reimbursement are passed on to the family.

2) Non-PA - Federal law requires providing the same child and medical support services to anyone, regardless of income, who applies for support enforcement services. The rationale is to prevent the need for public assistance by insuring reliable support payments, and to provide equal treatment under the law for all children. It is important to note that approximately 60% of Non-PA cases have received AFDC in the past.

Funding

By operating a program in compliance with federal requirements, Kansas qualifies for three types of federal IV-D funding:

1) Kansas retains a percentage (presently 41%) of support collections recovering assistance paid to AFDC families; 2) Kansas receives reimbursement, currently 66%, of the allowable administrative costs of the IV-D program; and 3) Kansas earns an incentive of 6 to 10%, each, for PA and Non-PA collections. The Non-PA incentive is limited to 115% of the PA incentive.

By using available funding mechanisms, the Kansas CSE Program has always been a cost effective, revenue producing program.

CSE Achievements

The Department of SRS is the designated Title IV-D agency for the State of Kansas. IV-D services are provided in all areas of the state by 487 full time and 26 part time SRS staff, by contracts with four prosecuting attorneys, with the Office of Judicial Administration (OJA) for the services of court trustees in 15 judicial districts, and with private resources (collection agencies, credit bureaus, and process servers).

The current caseload consists of approximately 120,000 PA/ Non-PA cases serving 250,000 Kansans.

The enactment of beneficial legislation, addition of staff, and implementation of the KAECSES computer system have dramatically improved the performance of the CSE Program.

Over the past eight years, collections increased 460%; from $20,000,000 in FY-87 to over $92,000,000 in FY94. Kansas has been recognized as one of the top ten states nationally in terms of percentage increases in collections.

Another fiscal benefit results from closure of AFDC cases when IV-D support collections exceed the AFDC grant. CSE's services for those cases automatically continue, to reduce the chance of the family returning to AFDC-dependence, but the State benefits from the AFDC cost avoidance. IV-D collection efforts in FY-94 resulted in the closure of 4,225 AFDC cases.

Current Initiatives

- In hospital paternity establishment - involving hospitals in seeking voluntary acknowledgements at the time of birth
- Medical support enforcement - an effort to force absent parents to actually provide health insurance coverage for their children
- Enhanced computerization - a project to establish a federally required certifiable statewide child support computer system
- Privatization - an effort to utilize private resources to perform appropriate child support functions which can be done more efficiently or effectively
- Implementation of Welfare Reform provisions - expanding services to recipients of medical, food stamps, and child care assistance
- Cost-Recovery fee - implementation of a cost recovery fee in non-public assistance cases

Proposed Legislation and Budget Issues

- Administrative processes for the establishment and enforcement of support orders
- Centralization of payment processing
- Continuation and expansion of the use of private resources

Kansas Population Growth 1990-2005

85 Years and Older

1990	41832
1991	46177
1992	50521
1993	54866
1994	59210
1995	63555
1996	66414
1997	69274
1998	72133
1999	74993
2000	77852
2001	80023
2002	82194
2003	84365
2004	86536
2005	88707

The Kansas Division of the Budget projects that between 1990 and 2005, the total population of Kansas will increase by 5.1%.

During the same period, Kansas population age 85 and over will increase 112%.

Kansas Nursing Facility Population

In 1990, 26,155 Kansans were in Nursing Facilities.

Age Group	Population	Percentage In Nursing Facilities	Nursing Facility Residents
85+	41,832	30%	12,550
75 thru 84	115,595	8%	9,248
65 thru 74	184,550	0.94%	1,742
Under 65	2,135,597	0.12%	2,615
	2,477,574		26,155

By 2005, if patterns of institutionalization remain the same, 40,881 Kansans could be in Nursing Facilities.

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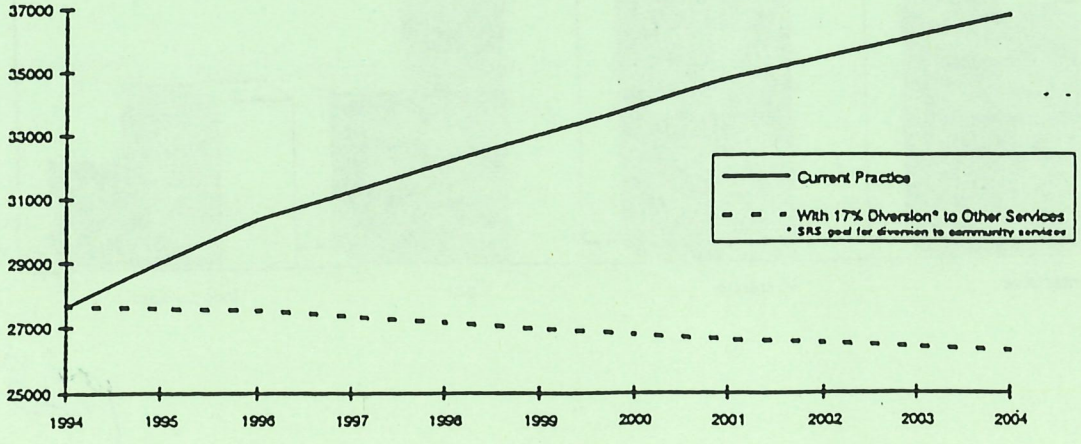
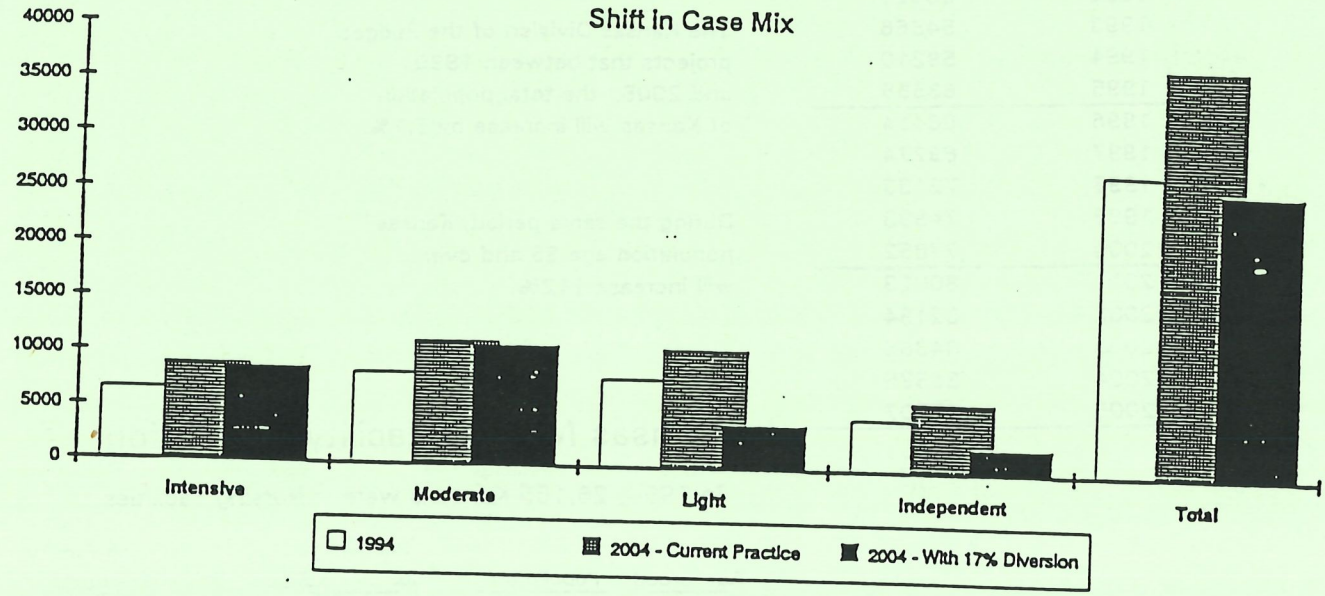
Under 65	2,225,311	0.12%	2,670
	2,604,664		40,881

Nursing Facility Growth In Case Load

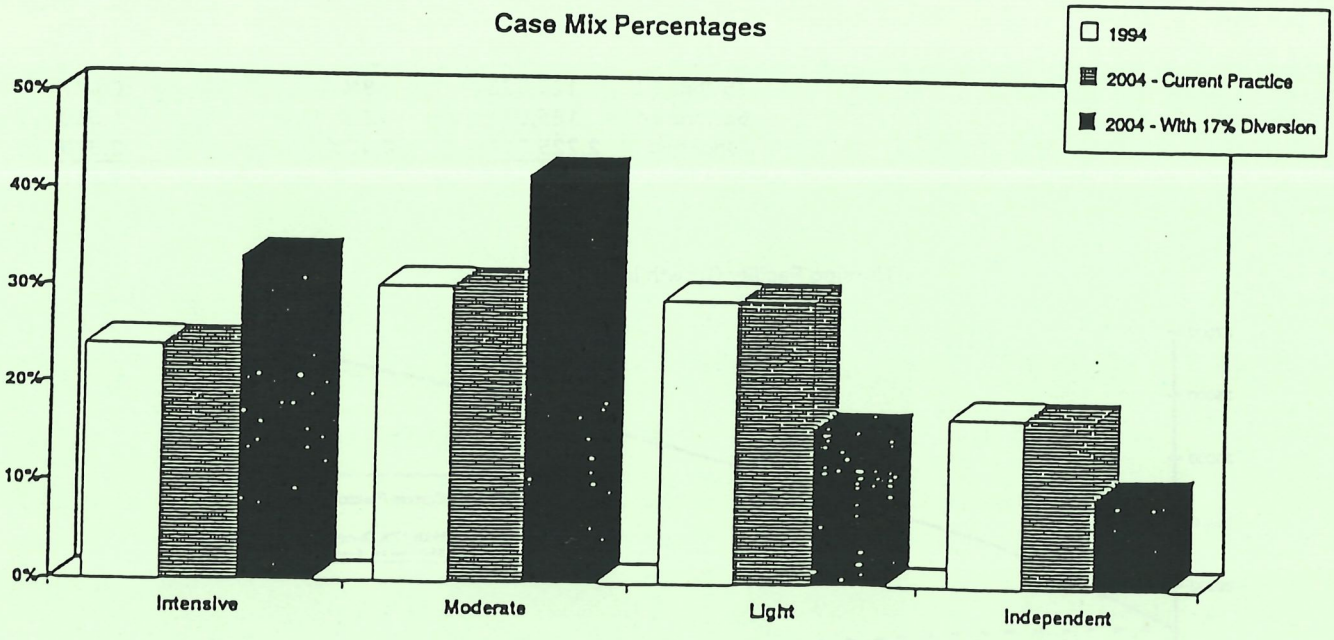


Nursing Facility Case Load

Shift in Case Mix

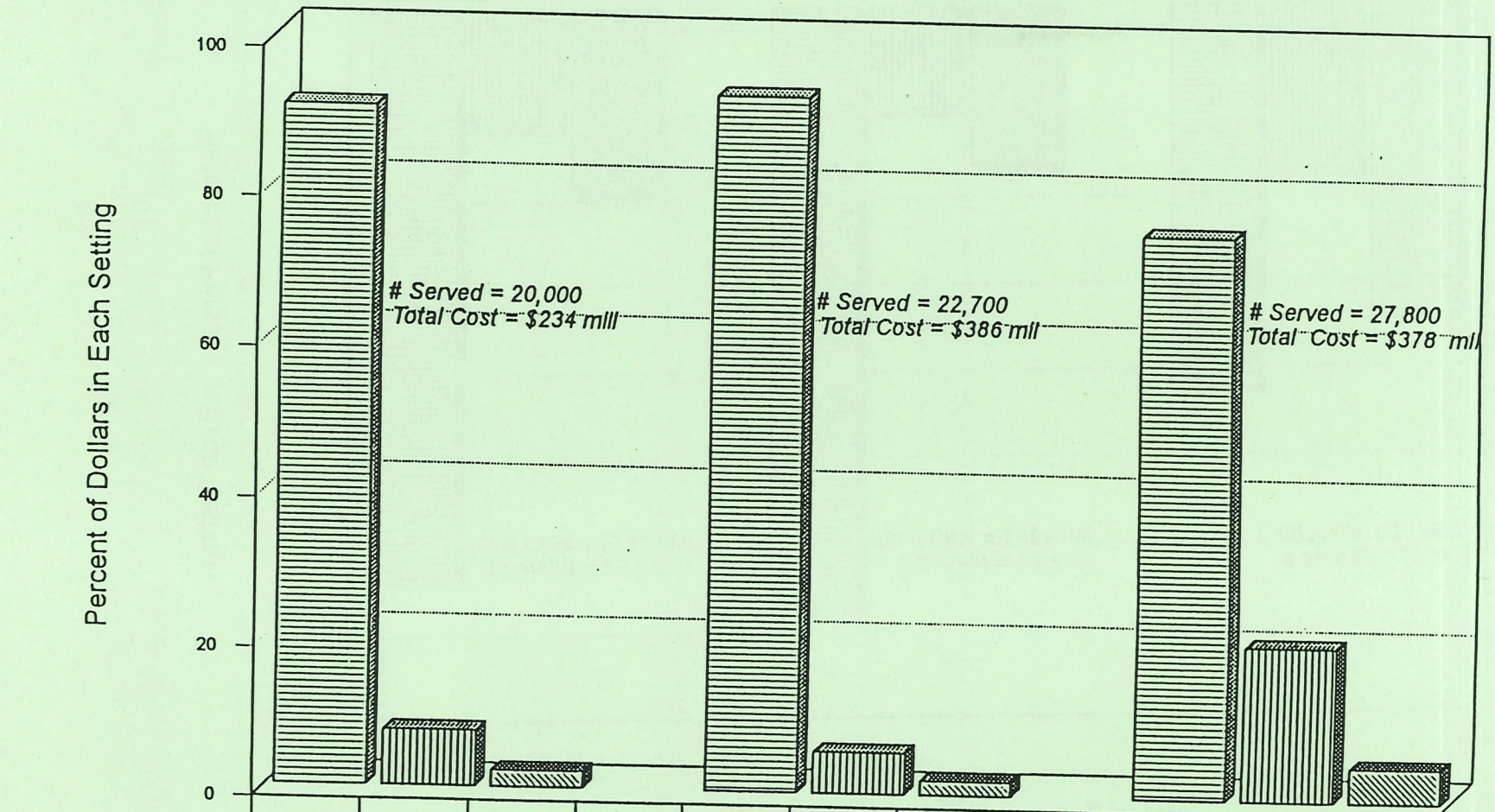


Case Mix Percentages



SRS Long Term Care for the Elderly & Disabled

Percent of Expenditure Mix by Care Setting in FY 2000 Under Present and Proposed Institutional/Community Care Mix



% Each Setting	NF	HCBS	IE	NF	HCBS	IE	NF	HCBS	IE
	90.6	7.3	2.1	92.8	5.4	1.8	74.9	20.6	4.5
	FY 94			FY00-No Changes			FY00-Desired Mix		

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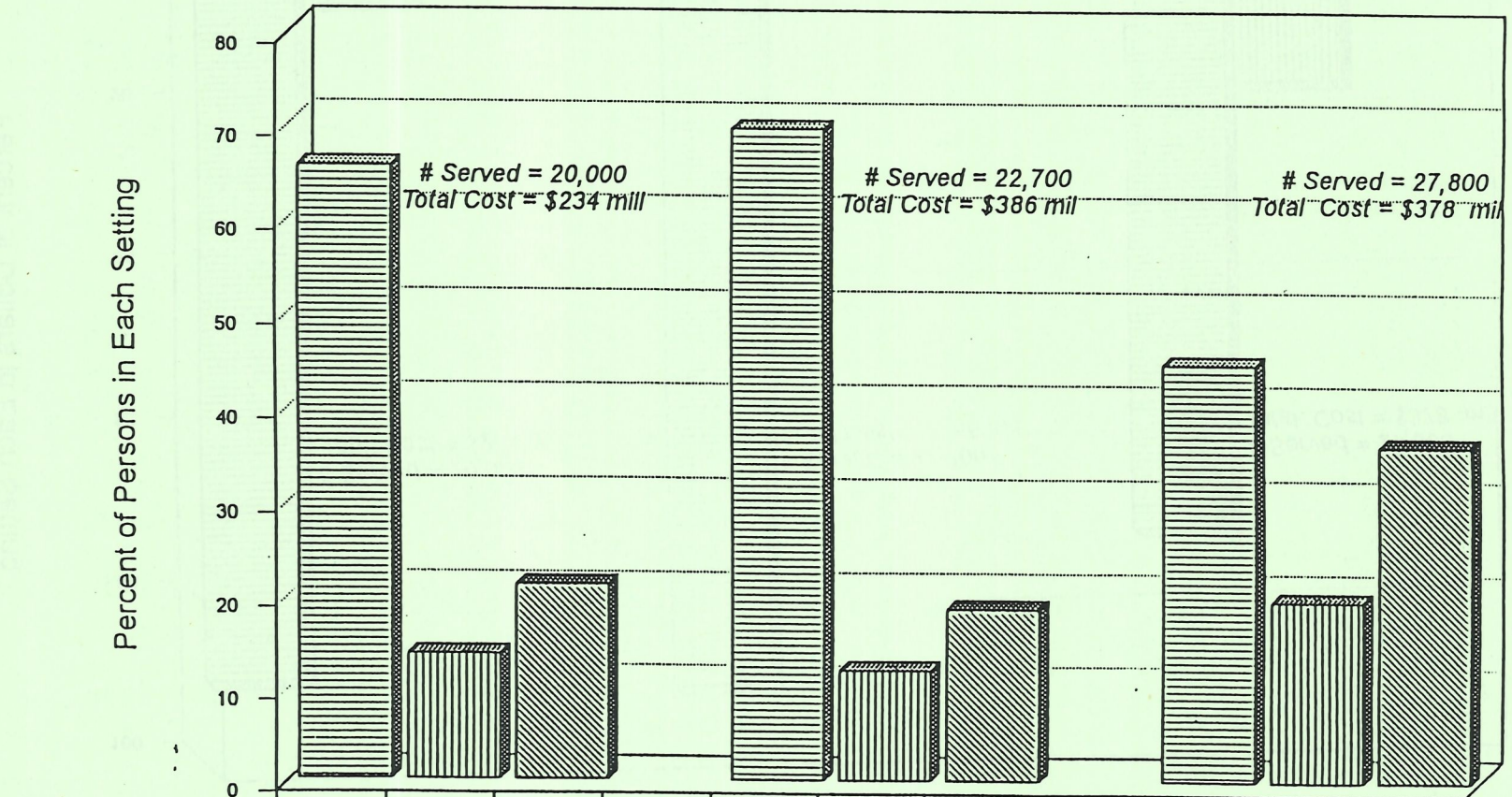
SRS Long Term Care for the Elderly & Disabled

Percent of Persons to be Served by Care Setting in FY 2000 Under Present and Proposed Institutional/Community Mix



	NF	HCBS	IE		NF	HCBS	IE		NF	HCBS	IE
%, Each Setting	65.5	13.5	21		69.6	11.9	18.5		44.6	19.4	36
	FY 94				FY00-No Changes				FY00-Desired Mix		

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Kansas Medicaid/MediKan Expenditures
Fiscal Year 1989 - Fiscal Year 1995

Medical Assistance	FY 89 Expenditures	FY 90 Expenditures	FY 91 Expenditures	FY 92 Expenditures	FY 93 Expenditures	FY 94* Expenditures	FY 95* Approved
Regular Medical Assist							
Inpatient Hospital	78,046,890	127,054,506	133,933,091	143,059,055	151,392,535	165,684,828	174,948,849
Outpatient Hospital	6,392,225	8,537,570	10,264,078	12,468,031	14,804,998	15,903,798	15,537,332
Lab & X-Ray	2,691,462	3,342,663	3,838,878	4,400,920	4,747,759	4,650,723	3,692,908
Prescribed Drugs	26,780,884	29,684,713	35,562,450	46,120,116	58,588,151	69,676,926	72,510,134
Physician	29,828,483	36,123,967	41,150,030	53,624,765	61,967,361	64,103,776	71,798,525
Dental	3,749,707	4,218,282	4,719,202	5,649,714	7,033,120	6,955,310	7,411,403
Community MH Center	8,586,097	10,139,556	12,255,594	13,653,443	13,973,839	19,732,493	14,895,543
Supplies	1,965,946	2,931,180	3,311,827	3,831,915	4,767,638	5,832,333	6,333,946
Medicare Buy-In	8,115,411	9,634,167	9,960,700	11,258,032	12,970,412	16,010,722	17,816,833
Home Health Agency	2,916,862	3,829,902	5,729,894	7,964,103	10,289,964	12,241,481	13,740,127
Rehabilitation Services	0	521,990	2,181,295	3,262,558	8,227,275	23,613,908	24,925,346
FQHC, RHCs, ARNPs	196,978	389,404	1,111,409	2,206,086	3,468,185	5,196,031	4,783,734
Transportation	1,507,179	1,877,468	2,011,753	2,335,361	2,616,946	3,150,247	3,332,367
Vision	1,452,622	1,696,183	1,915,237	2,202,985	2,532,993	2,674,733	3,038,502
Local Health Department	2,114,688	3,130,757	2,644,565	2,047,050	1,851,970	1,981,684	3,035,708
Other Services**	4,407,151	6,093,823	3,421,043	3,519,357	4,027,802	4,003,896	5,291,878
Claims & Adjustments	(909,396)	(1,296,977)	3,665,852	1,411,627	1,565,266	(52,603)	0
Subtotal Reg Med Assist	177,843,189	247,909,154	277,676,898	319,015,118	364,025,957	421,360,286	443,093,135
Adult Care Home							
NF & SNF***/NF-MH	118,200,450	136,958,149	153,679,259	173,329,703	183,802,794	208,238,204	220,231,819
ICF-MR	19,134,074	26,066,357	32,343,811	33,390,170	35,910,596	35,724,105	38,504,368
Adjustments	3,093,129	4,418,036	775,272	2,005,678	1,628,153	2,652,656	1,615,633
Subtotal Adult Care Hom	140,427,653	167,442,542	186,798,342	208,725,551	221,341,543	246,614,965	260,351,820
Community Based Services							
Waivers	3,503,656	4,925,148	7,772,961	15,082,005	25,704,440	47,764,614	55,121,315
Subtotal Comm Based Svc	3,503,656	4,925,148	7,772,961	15,082,005	25,704,440	47,764,614	55,121,315
Total Medical Assistance	321,774,498	420,276,844	472,248,201	542,822,674	611,071,940	715,739,865	758,566,270

NOTE: Pended claims placed in year incurred.

*Includes Youth SGF for Behavior Management.
**Other Includes: Non-CMHC Partial Hospitalization, Psychologist, Ambulatory Surgery Center, Podiatry, Chiropractic, & Hearing Services .
*** SNF terminology discontinued in 1991, expenditures reflected in NF category.

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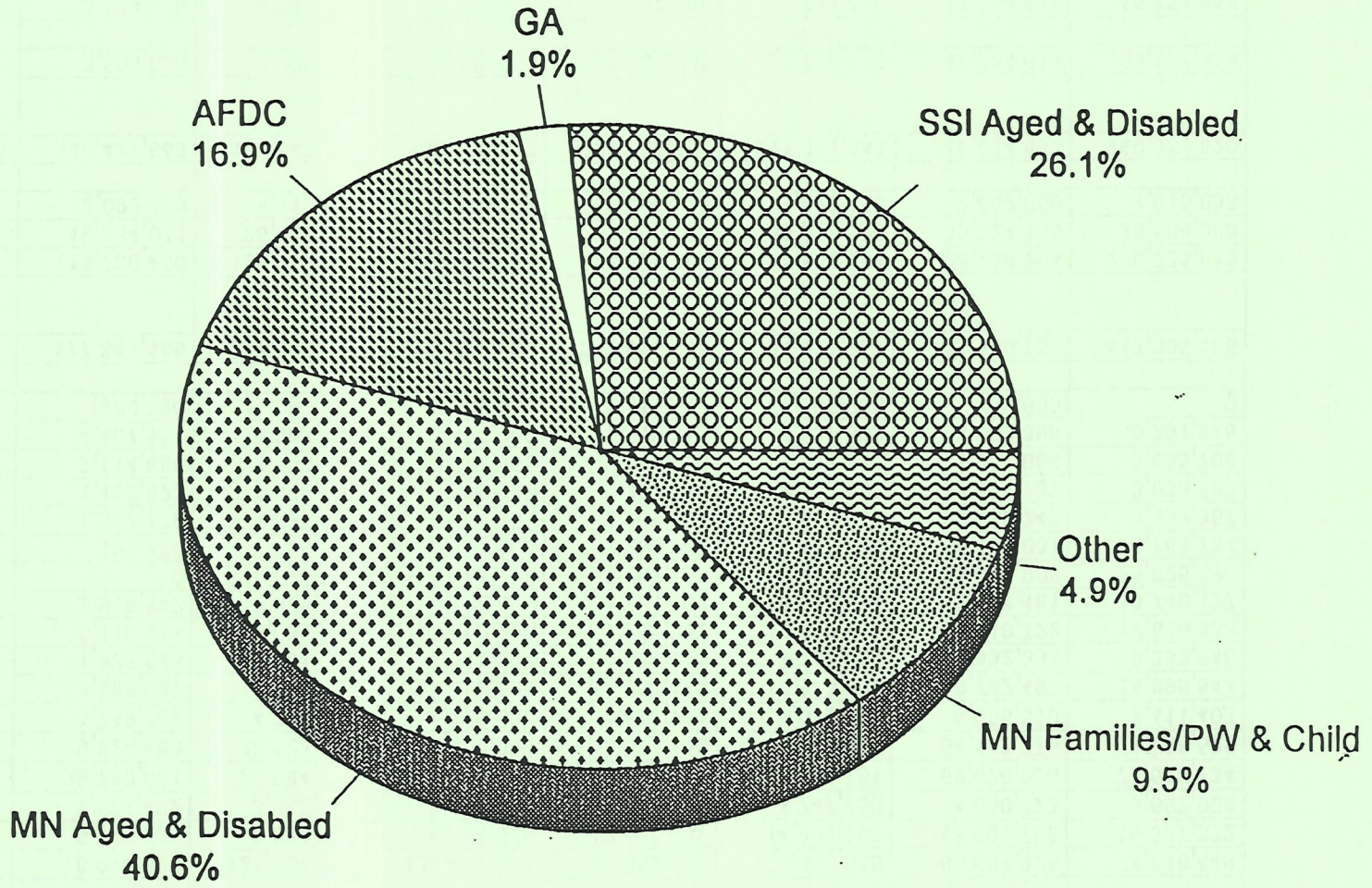
Attachment 1

Medical Assistance, Expenditures by Major Eligibility Groupings

Fiscal Year 1994



FY 1994 Actual: $715.7 million.

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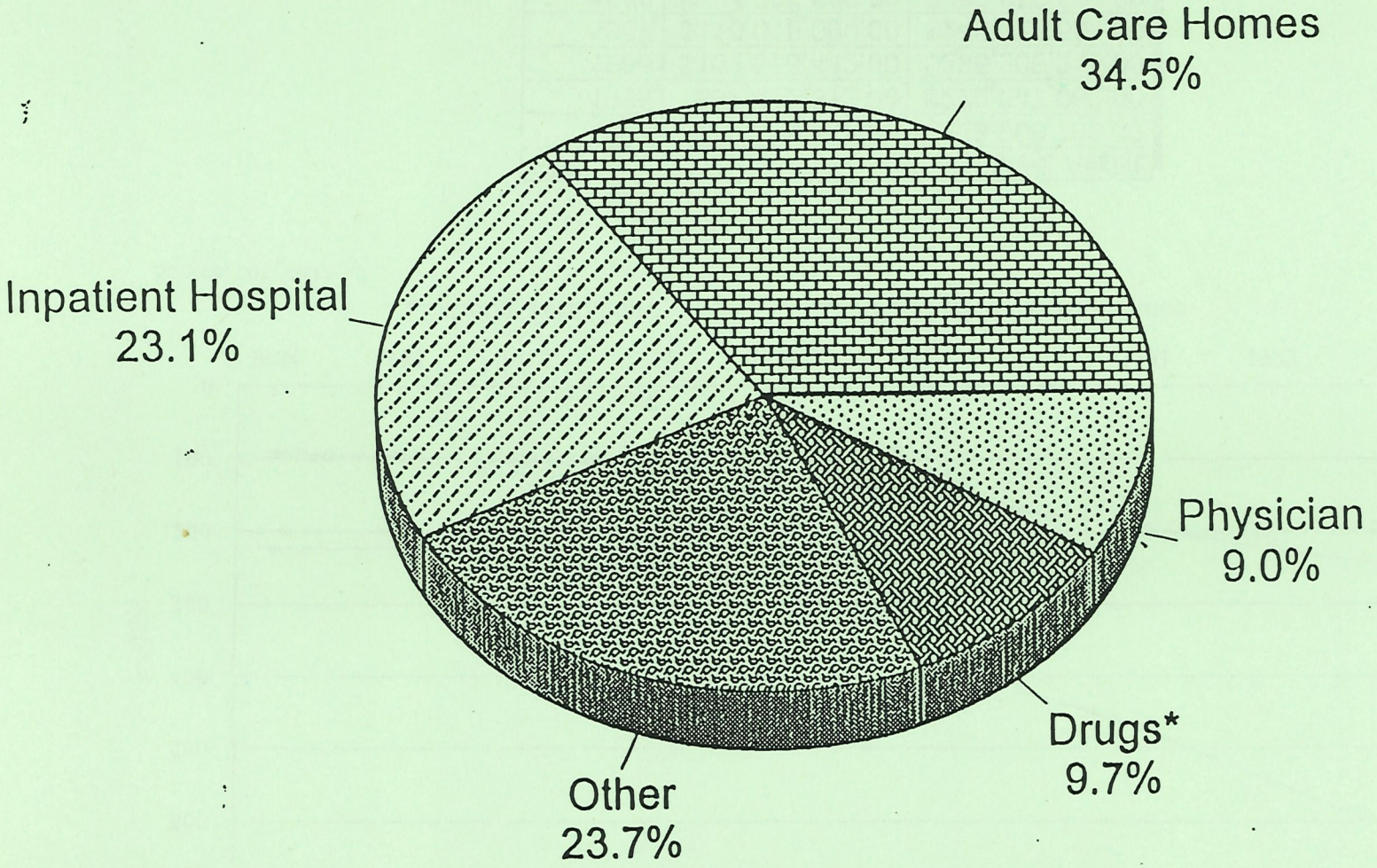
Medical Assistance, Category of Service Expenditures

Fiscal Year 1994



FY 1994 Actual: $715.7 million

*Excludes Drug Rebate Receipts of $13,549,649

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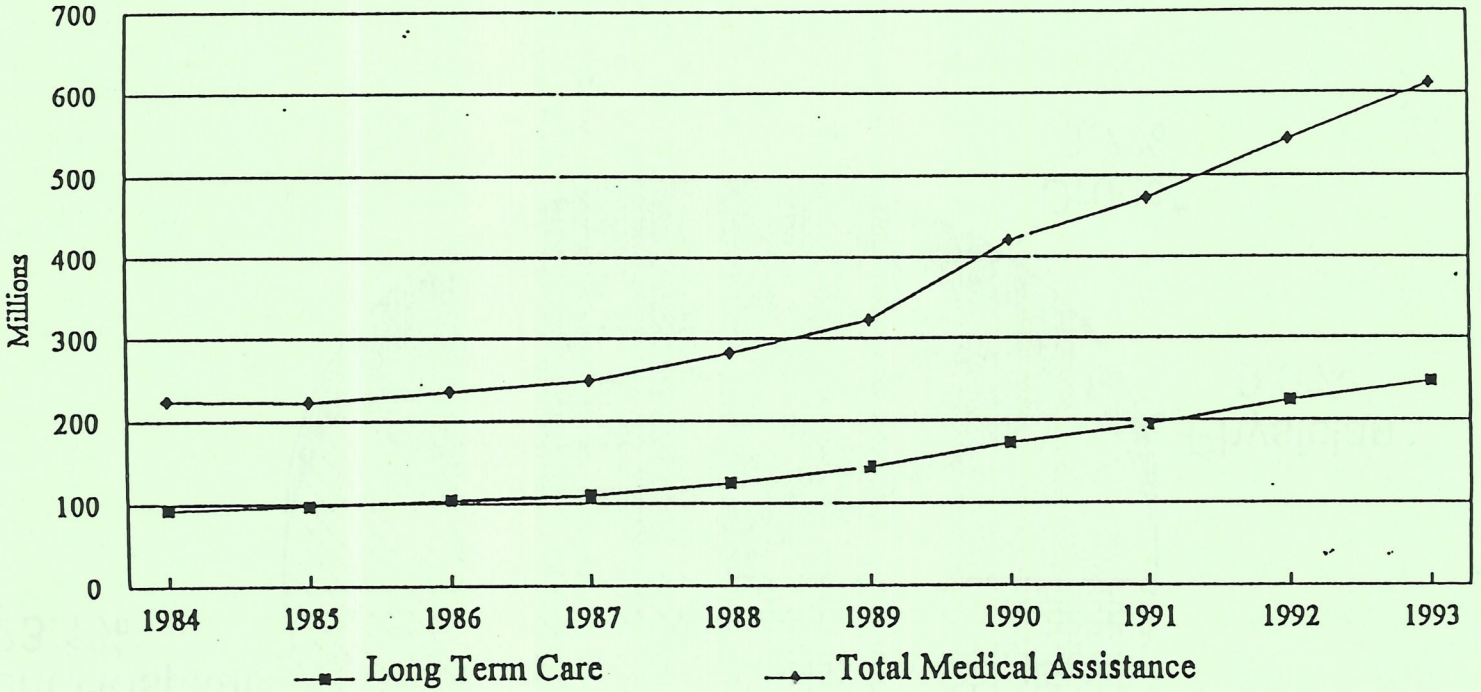
Long Term Care Expenditures

State Fiscal Year 1984 - 1993



Source: cos_hist.wk3

SFY	LTC	Total Med. Assist.
1984	$92,668,882.00	$223,909,786.00
1985	$97,412,312.00	$222,247,062.00
1986	$104,576,442.00	$235,206,215.00
1987	$110,018,090.00	$248,651,551.00
1988	$124,755,650.00	$282,656,500.00
1989	$143,931,309.00	$321,774,498.00
1990	$172,349,250.00	$420,276,844.00
1991	$194,380,856.00	$472,248,201.00
1992	$223,684,866.00	$542,822,674.00
1993	$246,995,784.00	$611,071,940.00

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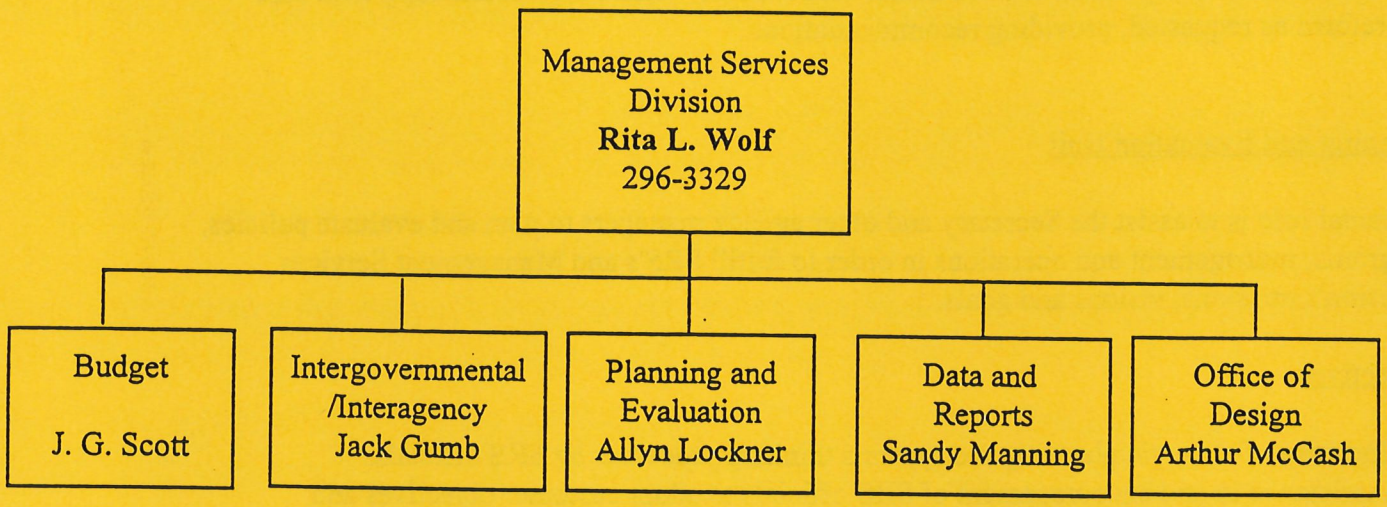
Management Services

The Management Services Division exists to assist the Secretary in leading and managing SRS by constructing independent policy recommendations; by monitoring and reviewing policy implementation; by providing fiscal, statistical, and design support services; and by providing information, coordination, research and technical assistance to the rest of SRS.



Budget Unit

Principal role is to take a broad independent view of programs' objectives seeking the most strategic and realistic deployment of limited state funds, federal funds and human resources.

Objectives

- Responsible for the Department's budget preparation process.
- Chief liaison with the Division of Budget and Legislative Research staff subsequent to the Governor's Budget Recommendation and throughout the appropriation process.
- Development of caseload estimates.
- Development of and maintenance of budget data to respond to internal and external inquiries into the use of appropriated funds.

Intergovernmental/Interagency Unit

Principal role is to increase agency options to determine which federal rules and regulations should be implemented as required and which should be protested as not in the best interests of Kansas.

Objectives

- Establishment of partnerships between local, state and federal agencies to improve programs by coordination on issues related to agency delivery of services and regulatory requirements.
- Development of position papers and Congressional correspondence, conveying the Department's position supporting or protesting federal rules and regulations.
- Coordination with the division and program staff to develop federal waiver requests to enhance client service or funding geared toward guiding clients to independence and self-sufficiency.
- Research of timely issues such as health care reform, welfare reform and long term care reform as requested, providing recommendations.

Planning and Evaluation Unit

Principal role is to assist the Secretary and other agency managers to plan and evaluate policies, programs, management and operations in order to fulfill SRS's and Management Services Division's missions, visions and goals.

Objectives

- Increase of strategic planning and systems thinking processes by SRS officials.
- Assistance to and encouragement of SRS officials to adopt customer objectives and performance indicators and measures and the necessity of linking them to SRS mission and goals.
- Review and monitoring of contracts and grants for duplication, coordination, cost, purpose and outcome.
- Evaluation of agency policies, programs, management and operations to ensure effectiveness and efficiency.

Data and Reports Unit

Principal role is to prepare non-fiscal federal reports and provide timely answers to ad hoc data requests internally and externally.

Objectives

- Establishment of a clearinghouse in SRS for the release of ad hoc data.
- Development of management reports for SRS Secretary, Commissioners and Legislators on an ongoing basis.
- Revisions and rewrites to FAME, (family data) now a statewide system, to maintain its integrity and visibility until the implementation of Kansas Social Service Information System (KSSIS).
- Coordination with division units on waiver requests especially with cost effectiveness

calculations.

Office of Design

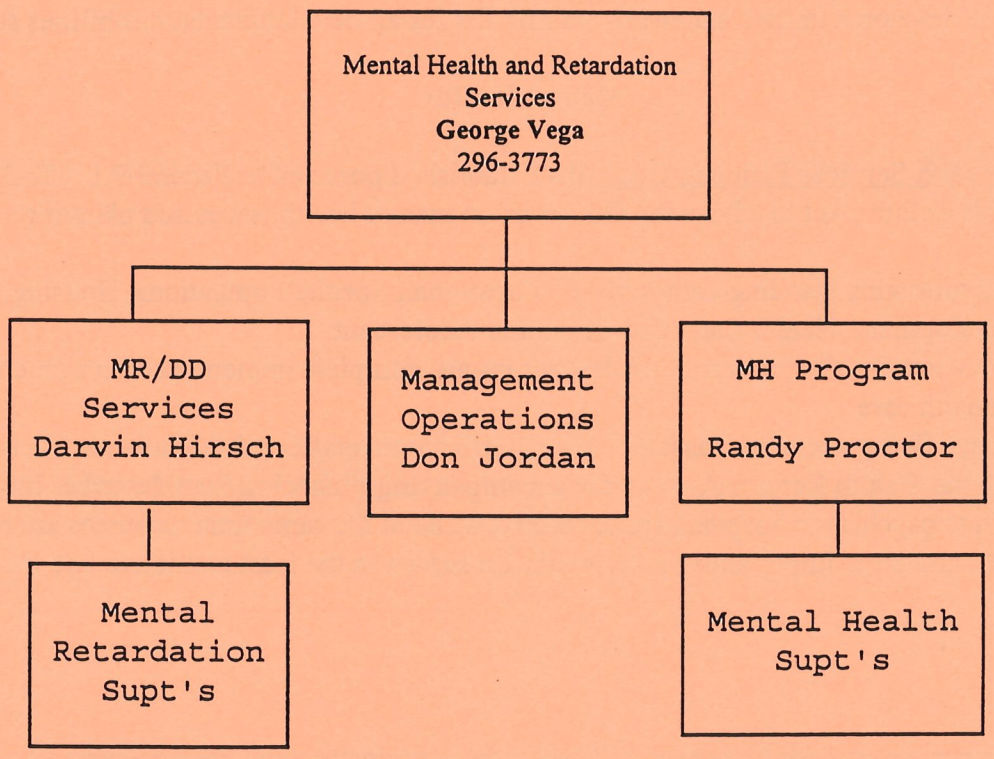
Principal role is to oversee the design and production of many of the department's printed materials and displays.

Objectives

- Expansion of client base and encouragement of clients to use a broader and more sophisticated range of social marketing tools while publications and exhibits are in the planning stage.
- Customers' satisfaction with finished products.
- Completion of computer needs assessment because of recent developments in the computer industry with respect to graphics technology.
- Continuation of quality publications and exhibits.

MENTAL HEALTH AND RETARDATION SERVICES

Mental Health and Retardation Services (MH/RS) joins with others to provide individually-tailored supports which integrate people into a real life through a person-centered model of service. Our vision for Kansas citizens who are seriously mentally ill and/or developmentally disabled is they will live, work, play and learn in natural, inclusive settings. They will direct their individual plan, be supported in the context of family and friends, and the plan will respect their lifestyle and culture. MHRS funds services for people with disabilities in apartments and homes, in small and large community-based congregate settings, and in state operated institutions. MHRS is committed to supporting and serving through well trained staff every individual according to their respective lifestyles, in a safe environment.



Mental Retardation and Developmental Disability Services

Accomplishments

- 340 persons are being provided supported employment and 178 are being provided supported living through consolidated grants.
- Overall census at the three state mental retardation institutions has been reduced by 201 using HCBS/MR funds.
- Nine regional Mental Retardation Coordinators have been hired.
- 541 families will be receiving $200 per month cash subsidy by January, 1995.
- $1,476,025 for support services is being provided by community mental retardation agencies through consolidated grants.

- HCBS/MR funding is paying for supports and services for 1500 people in the community.
- The number of Kansas counties unserved by community mental retardation centers was reduced by two, leaving only three unserved counties.

Challenges

- Place 63 additional people from state mental retardation institutions to meet census reduction goals.
- Increase the number of community mental retardation agencies willing to serve persons with severe and multiple disabilities.
- Increase services to children with developmental disabilities and their families.
- Continue efforts to convert congregate residential settings and sheltered workshops to supported living and supported employment.
- Implement closure of at least one large, private ICF/MR.
- Provide education for consumers and families about their rights, guardianship, benefits, and services/supports so they can make informed, responsible choices.
- Begin work to develop a unified statewide waiting list for all developmental disabilities services.

Mental Health

Governor's Mental Health Services Planning Council - Established pursuant to Federal P.L 102-321 and the Kansas Mental Health Reform Act to advise the Governor on mental health issues and planning.

- Maintains the following standing committees: Vocational, Special Populations, Housing, Human Resource Development, Health Care, and Child and Adolescent.
- Current priority issues: Children and Adolescent issues, complete implementation of mental health reform, and health care.

Mental Health Reform - Being acclaimed as the "most significant mental health initiative in Kansas in over twenty years" the Mental Health Reform Act and the accompanying Financing Plan describes how the escalating costs of State psychiatric hospitals are contained while at the same time resources are reallocated to community programs, and most importantly, individuals are served in the least restrictive and most normal setting possible.

Accomplishments

- All 27 community mental health centers (CMHC) are participating and are screening all affected referrals to the state hospitals.
- A total of 182 state psychiatric beds closed (OSH-92; TSH-90: LSH-30)
- Goals - Complete the third and final phase of reform in the LSH catchment area.
- The CMHC "certified match" arrangement provides the opportunity to use state funds in addition to Medicaid funds to maximize Federal Financial Participation in CMHC services.
- CHMCs provide screening services for Medicaid referrals to psychiatric units of local hospitals.

Mental Health Information Systems - With the Mental Health Statistical Improvement Project (MHSIP) grant computerized data collection system has been developed which includes information from the CMHCs and state hospitals. The system is used to produce statistical reports on clients, services and staff in the planning and monitoring of mental health programs for the state and reporting to the federal government.

Community Support Systems - These services are provided for adults with severe and persistent mental illness.

Accomplishments

- The establishment of consumer-run and family self-help mental health programs which are an important part of Mental Health Reform philosophy. During FY 1994, MHRS provided funding for establishment and continuation of 12 local consumer-run, mental health, self-help organizations and one statewide consumer-run coordinating and technical assistance organization.
- Joint funding by Kansas Rehabilitation Services and MHRS, (state and federal) for development of supported employment programs at 12 mental health centers. The purpose of these projects is to allow persons with serious mental illness to choose, get and keep jobs and to contribute to their community.
- In conjunction with Kansas Department of Commerce and Housing, established $1 million set aside of federal funds for rent subsidies for mental health consumers.

Homeless Program Accomplishments - Kansas' ACCESS programs (part of a federal research grant) were renewed for FY 1995 ($1,948,588) for programs in Topeka and Wichita, which have contacted more than 400 homeless people since the programs start-up in May 1994. These programs target homeless people with serious mental illness, many of whom also have substance abuse problems.

Violent Sexual Predator Program - SRS is in the process of establishing the Violent Sexual Predator Treatment Program as mandated in SB 525. Until space becomes available at the Larned Correctional Mental Health Facility, the agency is using space at Larned State Hospital. We have received approval to hire staff and will soon have positions filled. The first resident committed under the bill was received at LSH Friday, October 21, 1994.

Nursing Facilities for Mental Health - The agency has been successful in reducing the number of medicaid funded nursing facility beds allocated for housing persons with mental illness (NFs/MH). The agency was successful in contracting with Sedgwick County Department of Mental Health to provide community based services for the residents of Heartland Rehabilitation Center, an NF/MH of 80 beds, which ceased operation because of a business decision by the owner. SRS also has a contract with Johnson County Mental Health Center to provide the necessary community mental health services to allow the closure of their NF/MH by 1/1/95.

Flood Relief - As a result of the floods of 1993, much of Kansas was declared a federal disaster area by the President. The state received a total of $663,889 to address the mental health needs of victim/survivors. SRS-MHRS was responsible for the administration of the project, and local CMHCs provided direct services to the communities and individuals affected by the flood. Over 5,000 victims and communities in Kansas were assisted in recovery efforts.

Childrens' Mental Health Services

Accomplishments

Mental Health Reform - Increase of funding for community based services serving children with severe emotional disturbance and their families. Decrease in state hospital bed utilization.

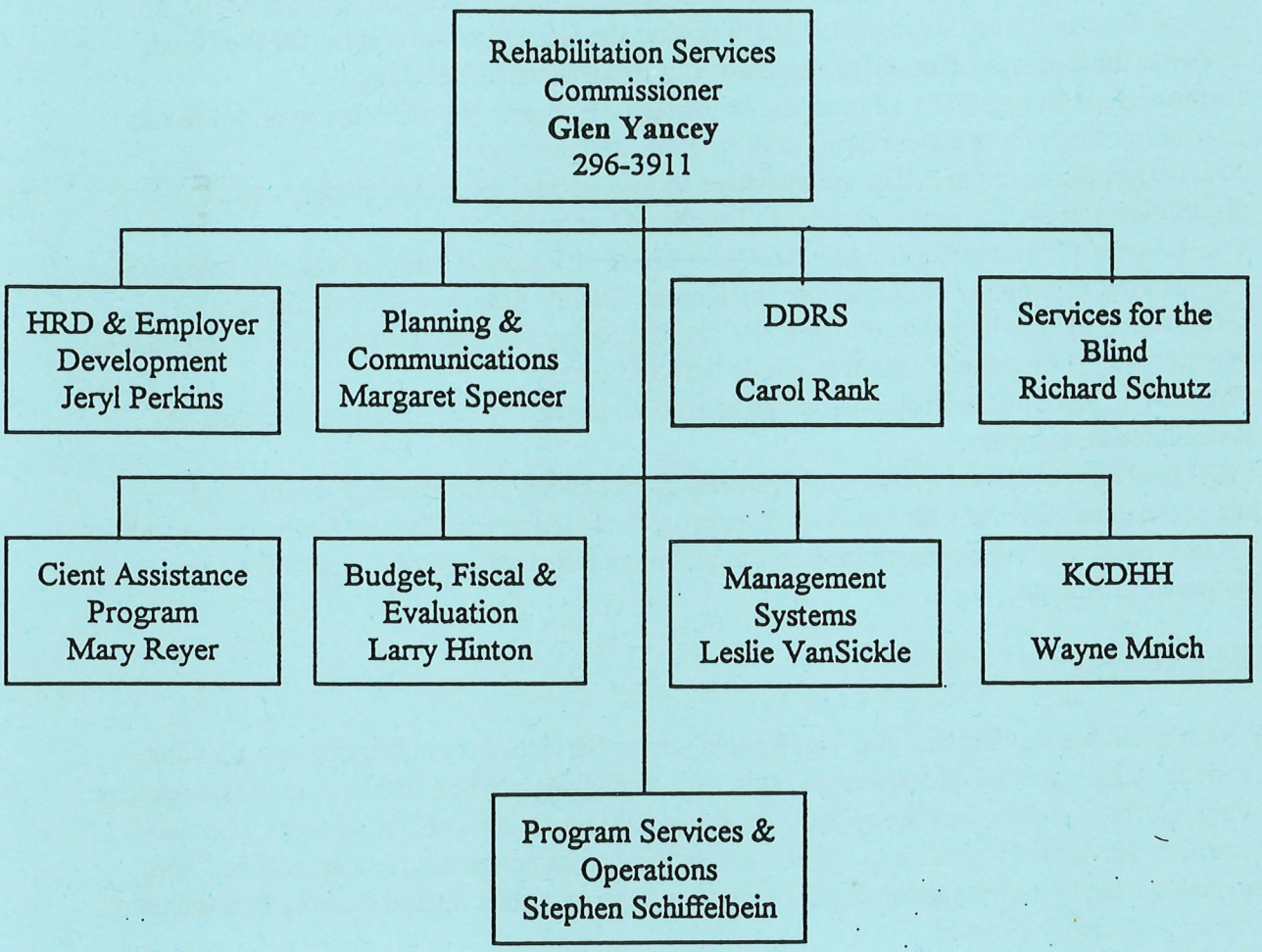
Development of New Systems of Care - Nationally significant and highly competitive federal grant awards for children's mental health applied for, and awarded to Sedgwick County Department of Mental Health in 1993, and a consortium of counties in southeast Kansas, headed by the Labette Center for Mental Health Services, located in Parsons. Increased parent involvement in the operations of the two federal grants described above is a major feature of the system of care designed. Parent involvement in decisions made about service delivery is nationally recognized as the cutting edge of new and more effective models for community based mental health services.

Wraparound Models of Service Planning - In collaboration with advocates for children with severe emotional disturbance, and their families, Mental Health and Retardation is implementing a program of wraparound demonstration projects in several rural communities. Wraparound is a process designed to meet individual needs for children and families when all other services have fallen short.

Goal: Increase/expand community-based, non-traditional services for children/adolescents with serious emotional disturbances and their families.

REHABILITATION SERVICES

Working in partnership with Kansans with disabilities to achieve their goals for employment and independence.



EMPLOYMENT FOR KANSANS WITH DISABILITIES IS OUR NO. 1 PRIORITY

People with disabilities are among the most disadvantaged in our society, experiencing high levels of unemployment and poverty. The vast majority of Kansans with disabilities want to work, however only about 30% are employed. **Therefore, Rehabilitation Services has established employment for Kansans with disabilities as our No. 1 priority.** To achieve this goal, Rehabilitation Services administers the following programs:

* **Vocational rehabilitation services** are customized according to each consumer's abilities, interests and goals. Services may include: vocational assessment, guidance and counseling;

training; mental or physical restoration; supported employment for persons with severe disabilities; rehabilitation technology; and job referral and placement. Eligibility for services is determined in accordance with federal regulations. Services are provided through 95 rehabilitation counselors stationed in 30 SRS offices throughout Kansas. Rehabilitation Services also operates the Kansas Vocational Rehabilitation Center in Salina and the Vocational Rehabilitation Unit in Topeka. Funding for vocational rehabilitation services is favorable for the State, with a match rate of 21.3% state to 78.7% federal.

* **The Division of Services for the Blind** (DSB) directs delivery of vocational rehabilitation services to persons who are blind, visually impaired or deaf-blind. Other DSB programs include Kansas Industries for the Blind, Topeka; the Rehabilitation Center for the Blind, Topeka; the Business Enterprise Program; and Rehabilitation Teaching.
* **Independent living** funds 12 community centers which provide information and referral; peer counseling; independent living skill training; and advocacy.
* **Transition planning services** are provided to help special education students with disabilities prepare for the adult world of work and community living.
* **The Kansas Commission for the Deaf and Hard of Hearing** offers advocacy; information and referral; interpreter coordination; the Kansas Quality Assurance Screening for certification of sign language interpreters; and the Safety Communication Sticker program for vehicles driven by people who are deaf or hard of hearing.
* **The Client Assistance Program** serves as an ombudsman for applicants and clients of Rehabilitation Services.
* **The Disability Determination and Referral Services** program makes disability and blindness determinations for the U. S. Department of Health and Human Services on most Social Security Disability Insurance and Supplemental Security Income claims filed or reviewed in Kansas.

CHALLENGES AND ISSUES

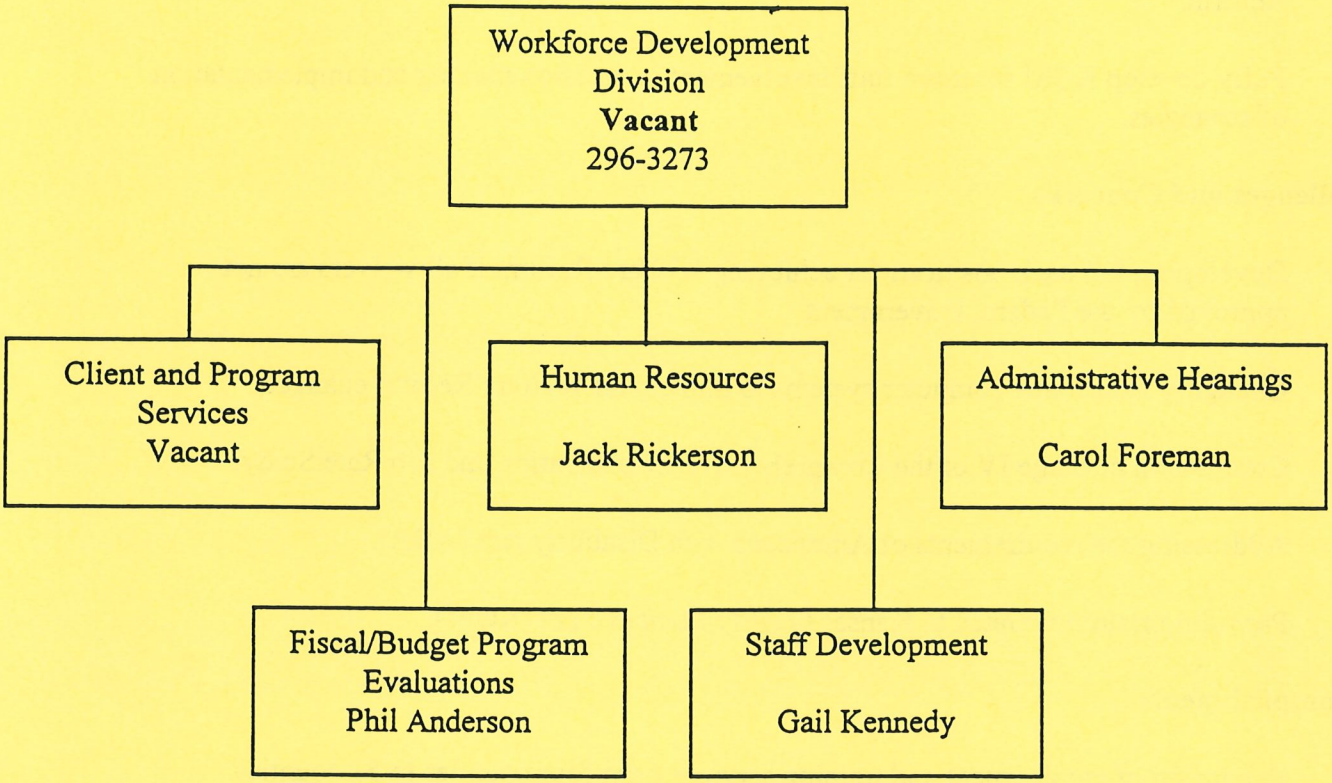
* Within available funding and staffing, Rehabilitation Services provides transition planning services to help special education students with disabilities prepare for work and independent living. Current staffing has the capacity to serve only about 20% of the students who need transition services. Program expansion with additional transition counseling staff has been proposed based on recommendations from consumers at public forums and the Rehabilitation Services Advisory Council.
* Disability Determination and Referral Services is experiencing a significant increase in the number of claims to be processed, from about 17,000 in 1991 to a projected 32,404 in 1995. Staff and other operational resources, which are financed by the Social Security Administration, have not kept pace with this increase.
* Durable medical equipment and emerging assitive technology have the potential to be of great benefit for citizens with disabilities, helping them maximize their employment opportunities and increase their abilities to live independently. Such equipment is customized to meet an individual person's specific needs. Modification in purchasing procedures to comply with federal requirements for consumer choice is recommended.

ACCOMPLISHMENTS DURING THE PAST 4 YEARS

* During FY 1994, 1,786 Kansans with disabilities were rehabilitated. Nearly 86%, or 1,535 individuals, achieved employment. During the first full year of work, these 1,535 Kansans with disabilities will generate more than $11.5 million in new wages, a significant contribution to the Kansas economy. During SFY 1991-1994, a total of 6,268 Kansans with disabilities were rehabilitated.
* Cooperative agreements with SRS Mental Health/Retardation Services have expanded the capacity of private community rehabilitation programs to provide supported employment and supported living for persons with mental retardation/developmental disabilities; and established supported employment programs at mental health centers for persons with severe and persistent mental illness. Emphasizing integrated, community-based services, these programs are an alternative to costly institutional services.
* Rehabilitation Services and the Kansas State Board of Education jointly manage a five-year federal systems change grant to improve transition services and increase opportunities for post-secondary success for special education students with disabilities.
* In 1993, the Kansas Legislature authorized $300,000 to expand independent living center services in the southwest, southeast and Kansas City areas.
* The Division of Services for the Blind has received a federal grant to improve and expand independent living services for older Kansas citizens with severe visual impairments. The funding will total $900,000 over a five-year period.
* Rehabilitation Services has established grants and fee-for-service agreements with more than 40 community rehabilitation service providers, reflecting the importance of collaboration in serving people with disabilities, and the value of partnerships with private organizations.
* A reclassification of counselor and field management positions in September 1992 resulted in reduced turnover and stabilized services for Kansas citizens with disabilities.
* Rehabilitation Services has fully matched available federal funding and received additional reallocation funding for the past three years, thus maximizing services for Kansans with disabilities.
* Kansas Industries for the Blind has been designated the provider of remanufactured laser printer cartridges to state agencies, enabling KIB to provide a needed product and employ persons who are blind without state subsidy.

WORKFORCE DEVELOPMENT DIVISION

Workforce Development will provide leadership in the development and provision of employment and training opportunities and services to SRS customers, ensuring opportunities to participate in full citizenship.



Problems or Issues

- Assure the effective implementation of Welfare Reform as envisioned by the 1994 Kansas Legislature.
- Need for resources to support the delivery of child care program due to the increased child care funding available.
- Implementation of training related to Welfare Reform, Family Agenda, and Family Initiative.
- Implementation of training outlined in American Civil Liberties Union Lawsuit Settlement.
- Provide Child Support Enforcement full administrative process.
- Development of a Return to Work Program for the safe return of injured employees as soon as possible.

- Design a position audit philosophy and capability to ensure the integrity and equity of classification decisions.

- Enhancement of the Department's selection processes and capability to ensure a capable and motivated workforce and to avoid negligent hiring situations.

Possible Solutions

- Aggressively seek Federal Welfare Waivers in order to implement Kansas Welfare Reform.

- Fully develop KQM for more staff involvement in decision making and implementation of strategies.

Challenges and Concerns

- Developing fall back positions for achieving Welfare Reform if all waivers are not approved by the Federal Government.

- Changing mainframe computer systems to implement Welfare Reform changes.

- Completion of Stage IV of the Comprehensive Classification and Job Rate Study.

- Addressing the requirements of Americans with Disability Act (ADA).

- Providing training related to Kansas Quality Management (KQM).

Accomplishments

- Expansion of employment and training services from four counties to 51 counties.

- Automation of Federal employment, training and child care program case management, payments and reports systems.

- Implementation of four stages of the Comprehensive Classification and Job Rate studies.

- Provision of a combined centralized, decentralized training delivery system.

- Development of a media production program that has completed numerous media and audiovisual presentations for the Department.

- The development and maintenance of the SRS Training Center facilities and Library.

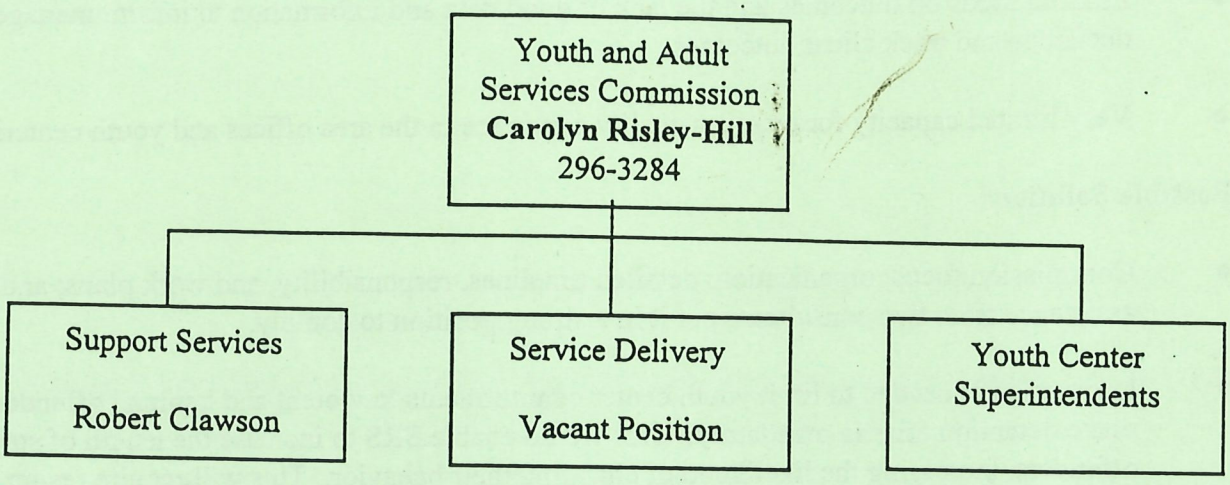
- Resolved and estimated 250 inquiries per month by providing information, referral and advocacy services.

- The fair hearing process disposed of 1,594 cases in Fiscal Year 1994.

- Assisted 111 welfare clients to be hired within the Department during Fiscal Year 1994.
- Provided opportunities for volunteerism within all SRS umbrella agencies.
- Expanded the opportunities for quality child care through increased funding from $9 million to $31 million.

Youth and Adult Services

Youth and Adult Services creates conditions for family members and communities to safely care for and nurture one another by responding to social conditions that threaten individual well-being and public safety. Responsibilities include child welfare, juvenile justice and adult protection programs for SRS.



The Commission's programs and mission are carried out by social service staff in the 12 area offices; the Comprehensive Evaluation and Treatment Unit in Topeka; the four Youth Centers at Atchison, Beloit, Larned and Topeka; its central office operations; and in collaboration with contracting agencies, other Commissions within SRS and other state and community organizations with similar goals. The Commission's goals are:

- To provide for the safety and security for children in their own homes or in other permanent families in order to achieve their maximum potential as productive citizens.
- To provide protection and care to vulnerable adults in the least restrictive setting consistent with their care needs.
- To reduce unlawful and violent behavior of juveniles.
- To provide for public safety through juvenile correctional programs that protect the community and provide for habilitation of offenders.
- To deliver effective social services to children, youth, adults and families in collaboration with other key players in the child welfare, juvenile justice and adult protection delivery systems.

Problems and Issues

- Compliance with a lawsuit settlement which was reached with the American Civil Liberties Union in June, 1993.

- Juvenile crime, including increased commitments of offenders to youth centers, causing overcrowding and decreased lengths of stay.

- Inappropriate use and overuse of detention facilities, resulting in overcrowding and litigation.

- Reductions in the total number of children and youth in custody have not reached the commitment made to the 1992 Legislature.

- The need to serve more disabled and frail adults in their own homes and communities.

- Limited focus on outcomes and the lack of good data and information to inform management decisions and track client outcomes.

- Very limited capacity for ongoing quality assurance in the area offices and youth centers.

Possible Solutions

- Commission focus; organization; detailed timelines, responsibility, and work plans; and assistance from two consultants put it in a strong position to comply.

- Legislation is needed to limit youth center commitments to violent and habitual offenders and to make detention criteria mandatory. This would enable SRS to increase the length of stay of offenders, increasing the likelihood of changing their behavior. This will require resources to serve non-violent offenders in the community and to focus on prevention as proposed by Alcohol and Drug Abuse Services.

- SRS will propose legislation to require children who are not in danger due to abuse or neglect to be served in their own homes.

- The SRS proposal for Long Term Care Reform entitled "Choices" is both more humane and less costly.

- The Kansas Social Service Information System (KSSIS) enters the design phase in December and will address the concerns of the Legislature, the Division of the Budget, SRS and others about the lack of information.

- The Youth and Adult Service budget now incorporates outcome measures. A collaborative effort on outcome measures in Region VII will initially focus on out-of-home care for children and youth. The Long Term Care Reform package is also outcome focused.

- Increased quality assurance capacity and legal support in the area offices and youth centers as well as legal staff to assist in completion of investigations of allegations of child abuse and neglect in foster homes are part of a proposed risk management package.

Challenges and Concerns

- Compliance with the lawsuit settlement will drain attention and resources from other important endeavors. While the settlement is consistent with the mission and goals of the Commission, it is process rather than outcome focused.

- The interest of some in creating a youth authority to manage juvenile offender programs or both juvenile offender and child in need of care programs promises to focus attention on organizational issues rather than solutions to problems. Any initiatives must include prevention to have long term impact on juvenile crime.

- Continued reliance on out-of-home care as the solution of choice by some players in the child welfare and juvenile justice systems. Inability of SRS to intervene prior to custody consumes unnecessary resources.

- The interest of some in moving the long term care programs to the Department on Aging will focus attention on organizational issues rather than solutions to problems and may reduce focus on the needs of people with disabilities.

- The window of opportunity for enhanced federal financing for the social service information system ends in September, 1996 and will challenge us to complete as much of implementation as is possible by that date.

- The state of the art in outcome based performance in social services is in its infancy. Little assistance is available from other sources.

- Comprehensive quality assurance efforts must focus on outcomes as well as key process measures. Too often, efforts focus exclusively on process measures to the exclusion of outcomes.

- One of the overarching issues for area offices is the expectation they both do what is right for the people we serve and accomplish it within the resources allocated to them. This is exacerbated by the fact SRS staff do not control the intake into our programs.

Accomplishments the Past Four Years

- The adoption of the SRS Family Agenda for Children and Youth and the accomplishment of most of the 29 strategies. This has been a blueprint for serving children and families and is beginning to show positive results.

- The negotiation of a settlement with the ACLU which is both achievable and will be accomplished within current resources.

- Many area offices have succeeded in reducing the number of children and youth in custody, particularly children in need of care. This has been offset by the growth in juvenile offenders statewide.

- The creation of standing teams consistent with Kansas Quality Management has been extremely successful in addressing issues and developing materials in response to the lawsuit settlement, the number of children in custody and adult service and juvenile justice issues.

- Contributions to the Long Term Care Reform package. We believe this is a strong statement about the philosophy of SRS and the outcomes we hope to achieve for disabled and frail adults.

- A new approach to automation with the development of an Information Strategy Plan and the use of a casetool which promise to make design, programming and maintenance much easier.

- Greatly enhanced the receipt of federal funds, reducing our percentage reliance on state general funds by 13% in five years. Attachment A identifies the current mix of funds.

- Initiated a competency-based training system for staff which includes preservice, inservice and advanced training.

- Significantly increased our collaboration with state universities, utilizing their state general funds to draw-down federal dollars for both administrative and training initiatives.

- Initiated the planning year for the new Family Preservation and Support Act passed by Congress in 1993.

- A needs assessment completed by the University of Kansas in collaboration with Wichita State University will form the basis for a strong community resource development planning effort with the area offices.

- A plan for an unleveled system of care has been drafted in collaboration with providers. This will replace the current system which was adopted in 1978.

- The Commission was reorganized on functional lines to take better advantage of our limited resources at the central office. Of particular note is the development of the Field Operations Unit and the recent creation of the Youth Center Operations Unit.

Actively Creating Tomorrow (A.C.T.)
for Kansas children and families

PURPOSE AND PROVISIONS

The purpose of the Kansas Department of Social and Rehabilitation Services' (SRS) Actively Creating Tomorrow (A.C.T.) welfare reform initiative is to:

- **Encourage employment**
- **Promote responsibility**
- **Simplify public assistance program administration**

These changes affect families receiving benefits and services through the Aid to Families with Dependent Children (AFDC), Employment Preparation Services, Food Stamps, Medicaid, and the Child Support Enforcement programs. By supporting families -- rewarding employment, encouraging education, and increasing consistency between public assistance programs -- the likelihood of their becoming self-sufficient will increase.

House Appropriations Cmte
1/19/95
Attachment 2

The SRS Mission:
"The Kansas Department of Social and Rehabilitation Services empowers individuals and families to achieve and sustain independence and to participate in the rights, responsibilities, and benefits of full citizenship by creating conditions and opportunities for change, by advocating for human dignity and worth, and by providing care, safety and support in collaboration with others."

Actively Creating Tomorrow (A.C.T.)
for Kansas children and families

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The Kansas reform initiative, Actively Creating Tomorrow (A.C.T.), includes the following changes:

Reward and Encourage Work

•Work is encouraged by adopting new policies that motivate rather than penalize individuals who seek work and retain employment.

•Earnings of children in school and their resulting savings accounts are exempt.

•Extended medical coverage for persons becoming employed is increased from 1 to 2 years. During the second year, a 25% co-payment is required.

•One vehicle is exempt for all households. Transportation is critical to all families, especially those who work or who are searching for employment.

•Education and training services in the KanWork program are restricted to employable clients who are limited to 30 months of participation, followed by a three-year period of ineligibility for AFDC assistance.

•Both parents are required to register for work in counties with a job service center.

Promote Personal and Parental Responsibility

•Additional children born to a family receiving AFDC will result in little or no increase in cash benefits.

•Families are encouraged to stay together by removing barriers that discouraged two-parent families from participating in the AFDC program. This change will secure matching federal funds for families presently served in the General Assistance program.

•Unmarried minors must live with their parents or responsible adults to be eligible for assistance.

•Recipients are responsible for returning monthly reporting forms on time. If the required monthly information is returned late (after the 5th of the month), cash assistance and food stamp benefits will be decreased.

•Recipients of all public assistance programs, including AFDC, Food Stamps, Medicaid, and Child Care, are required to cooperate with the Child Support Enforcement Program.

•Non-cooperation penalties are changed for participants in the KanWork and Child Support Enforcement programs. Assistance to the household head is reduced during the first three months of non-cooperation. Assistance to the entire household is ended if non-cooperation persists. To end the penalty, individuals must cooperate.

•Persons who voluntarily quit a job are penalized by removing the individual's benefits for three months.

Continued on page 3

Actively Creating Tomorrow (A.C.T.)
for Kansas children and families

- Public assistance is denied to fugitive felons.
- School attendance among children of AFDC families is encouraged within the three-county "KanLearn" pilot. Monetary incentives and penalties accompany attendance and unexcused absences.
- Families must comply with immunization laws as a condition of eligibility for AFDC.

Simplify Program Requirements

- Rules regarding program requirements are more uniform among programs.
- Because ACT standardizes program policies, eligibility and benefits will be easier to understand.
- Administration of programs will be more efficient and accurate.

Other Provisions

- The Family Support Tax Credit was established which allows partial tax credits (70% of donation) to extended family members who contribute to the support of AFDC recipients.
- SRS was authorized to accept donated corporate funds by the establishment of Corporate Individual Trust Accounts.
- Kansas residents may establish Individual Development Accounts (IDA), custodial accounts for education expenses. Children's IDA's are exempt from AFDC eligibility determination.
- The development of an Electronic Benefits Transfer (EBT) system for all cash, food stamp, and medical assistance benefits was authorized.

Actively Creating Tomorrow (A.C.T.)
for Kansas children and families

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FEDERAL WAIVERS

Several policy changes in A.C.T. diverge from existing federal law or regulations. To gain federal approval to carry out new policies, states must apply to the federal government to "waive" standing policies. The following is an outline the waiver process:

Application: When waiver applications are submitted, it is the state's responsibility to ensure cost neutrality with respect to federal funds.

Negotiation: The review and negotiation phase follows the waiver application. This phase can be lengthy depending upon the complexity of the waiver and the intensity of the federal review. During this phase, the federal government assesses the state's capacity to execute a waiver and identifies unacceptable waiver provisions based on regulation and law. States are given the opportunity to refute, clarify, compromise, or withdraw contested provisions during the negotiation phase. House Bill No. 2929 authorizes the department to seek federal waivers, but prohibits any waiver agreement that would result in a cost to the state, regardless of whether the cost entails additional state expenditures or a loss in federal funding.

Terms and Conditions: Following the successful conclusion of the negotiation phase, states are required to establish an evaluation process to prove the effectiveness of the new policies over the life of the waiver. The evaluation must be performed by an objective entity. Program participants will be randomly divided into two groups. Approximately 5 percent will serve as a control group, and will remain within current program policies. Remaining participants will be placed under the new policy changes. The evaluation process will measure differences in both the cost and client outcomes of the two groups. In addition, quarterly financial data must be submitted to the federal government to assess the cost neutrality of the waiver.

Approval: The federal government issues a formal approval when a waiver is granted.

FEDERAL WAIVER STATUS

Kansas submitted its waiver application in July, 1994. However, federal approval has not yet been granted. Due to the size and complexity of the Kansas waiver proposal, negotiations with the initial single federal review team have been altered. SRS must negotiate independently with three separate federal agencies: The Administration for Children and Families (ACF); the U.S. Department of Agriculture (USDA); and the Health Care Financing Agency (HCFA). This change has slowed the waiver approval process considerably.

SRS staff has been in contact with each federal agency to address questions/concerns. Although the federal agencies have indicated formal waiver responses are imminent, SRS still awaits a formal response.

Actively Creating Tomorrow (A.C.T.)
for Kansas children and families

The U.S. Department of Agriculture has shown an unwillingness to approve any waiver request that would reduce benefits to even one recipient. This includes the requirement for cooperation with the Child Support Enforcement program and stiffer penalties for violating program requirements; however, the federal agency has suggested this position will be reviewed before issuing a formal response.

Upon receiving the federal responses, SRS may still need to negotiate to preserve the intent of House Bill No. 2929. Once the state has waiver approval, implementation can begin in six weeks.

Likely Waiver Approvals

From conversations and informal comments from federal agencies, the following waiver initiatives appear likely to be approved:

- Increasing the earnings disregard
- Extending transitional medical coverage to 24 months
- Exempting one vehicle
- Requiring both parents to register for work
- Capping benefits when additional children are born into AFDC families
- Allowing all needy two-parent families to qualify for AFDC
- Requiring minors to live with parents or responsible adults
- KanLearn pilot

Probable Waiver Denials

Federal agencies have indicated two waiver proposals that will not be approved under any circumstances:

- Waiving JOBS target groups and participation rates. This waiver was requested to conform with House Bill No. 2929, which limited participation in the KanWork/JOBS program to employable individuals. Conversely, federal law mandates state JOBS programs to spend 55% of total expenditures on hard-to-serve target groups. The U.S. Department of Health and Human Services lacks the legal authority to waive participation requirements.
- Denying assistance to fugitive felons. The U.S. Department of Health and Human Services raised constitutional issues in connection with this waiver.

Waivers Under Negotiation

The following waiver requests remain in negotiation. For each provision, information is provided on the waiver proposal, federal position, and available options.

- KanWork/JOBS 30-month participation penalty
- Expand CSE requirements
- Standardize late monthly reporting penalty because the proposed waiver will reduce benefits.
- Penalty for non-cooperation with Child Support Enforcement and work requirements

Actively Creating Tomorrow (A.C.T.)
for Kansas children and families

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WELFARE REFORM IMPLEMENTATION

A four-member executive management team directs the implementation of ACT. The executive management team is supported by an implementation committee comprised of five working groups:

- System Development Coordination
- Group Selection
- Cost Allocation
- Public Information
- Welfare Reform Evaluation

The working groups meet as needed, and provide the executive management team progress reports every two weeks. The executive management team continuously advises the Secretary.

IMPLEMENTATION PROGRESS

The following is a listing of progress to date.

- **Automated System Changes**: The policy changes within A.C.T. require complex modifications to several major SRS computer systems. At present, the designed changes have been programmed, or are in final programming stages and the majority of system changes are being tested. Changes to the Child Support Enforcement and Employment Preparation Services systems are expected to be completed in January. By mid-February, the remaining programming affecting cash assistance, Food Stamps, and medical assistance are scheduled for completion.

- **Waiver Evaluation**: The evaluation proposal is being designed. A preliminary draft is scheduled for completion at the end of January. The final request for proposal (RFP) is hindered by the uncertainty of the waiver's status. Information from other states suggests an annual cost of $600,000 - $670,000 for the evaluation component.

- **Training:** Field training on policy changes has been planned. This training will occur during a six-week interim before the implementation of A.C.T. To introduce the SRS current culture focus, cross-functional conferences are scheduled for April.

- **Family Support Tax Credit and Corporate Individual Trust Accounts:** SRS has worked in cooperation with the Kansas Department of Revenue. Tax forms and instructions are now available and have been provided to tax preparers. Staffing to promote this initiative is contingent on the release of funds.

- **Individual Development Accounts:** All implementation issues are tax-related, and are being administered by the Department of Revenue.

- **Electronic Benefit Transfer (EBT):** The state's request for proposal to obtain an EBT vendor has been approved by the federal government. Published bids will be accepted in February. If the procurement process proceeds as anticipated, pilot sites should be operational by December 1995.

Continued on page 7

Actively Creating Tomorrow (A.C.T.)
for Kansas children and families

•**Childhood Immunizations:** SRS is working closely with the Kansas Department of Health and Environment and local health departments to improve AFDC families' access to immunization services. Local health department staff in at least two large counties will soon be offering immunizations in SRS field offices.

•**Mandatory Paternity Establishment:** This policy was implemented immediately upon passage of House Bill No. 2929. This provision, affecting a very small number of AFDC families, clarifies the department's authority to establish paternity when the alleged father is living with an unmarried mother and their children, and is applying for assistance as part of the family.

•**Expansion of Estate Recovery Unit:** Three new positions were filled early in FY 1995. Based on data through December, the unit is expected to collect approximately $1,000,000 this year, a 54% increase over FY 1994 collections of $653,000.

•**KanLearn:** Three KanLearn pilot counties have been proposed, but not approved by the federal government. The KanLearn initiative is scheduled for implementation at the start of the 1995-1996 school year. State Finance Council approval was required for the 10 new positions, however, approval was not requested since the federal waiver request had not been approved as of the last State Finance Council meeting.

•**Time-Limited KanWork Participation:** SRS staff have been instructed to inform participants that education and training plans over 30 months cannot be guaranteed.

•**Medicare Buy-In Improvements Medicare:** "Buy-in" refers to the provision in Medicaid law that requires any Medicaid client who is also eligible for Medicare must have their Medicare premium paid for by the state. Overall, this is a very cost-effective measure. Premiums for Medicare Part B (covering primarily physician, laboratory, and outpatient hospital services) are $46 per month.

Nationally, the average cost of Medicare Part B services is over $100 monthly, and nearly $200 for disabled persons. SRS believes a significant number of actual or potential Medicare beneficiaries within the Medicaid population have gone unidentified. The 20 positions for this effort were filled early in the fiscal year. To date, SRS can document more than 300 Medicaid clients not properly tied into the Medicare program. This first group should save more than $400,000 annually.

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Docking State Office Building / 6th Floor
Topeka, KS 66621 / 913-296-3271
1/95

Actively Creating Tomorrow (A.C.T.)
for Kansas Children and Families

Below is a list of Sections of HB 2929 that did not need waivers and sections SRS originally believed a waiver was needed but was not.

HB 2929	Waiver
New Section 2 / Family Support Tax Credits	No Waiver Needed
New Section 6 / Individual Development Account	No Waiver Needed
Section 11 / Job Preparation and Education & Training (KanWork)	Waiver 6 -- only takes a change in state plan
Section 12 / Transitional Services related to KanWork (i.e. child care, transportation)	No Waiver Needed
New Section 14 / Individual Assistance Support Trust	No Waiver Needed
New Section 15 / Required Immunizations	No Waiver Needed
New Section 20 / Electronic Benefits Transfer	No Waiver Needed / State has filed Advance Planning Document
New Section 21 / CSE Contracting Authority	No Waiver Needed
Medicare Buy-In Unit / Estate Recovery Expansion / System Automation	No Waiver Needed

2 8

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

Waiver to Discontinue Coverage for High Risk Behavior Related Illnesses

January 19, 1995

This paper explores the feasibility of shifting resource allocations currently targeted to provide illness care for disease conditions created by substance abuse to provide additional health promotion and disease prevention services to Medicaid recipients.

The role of personal health habits in decreasing the mortality and morbidity from chronic disease has been well-documented. Altering personal behavior, thus holds the greatest potential for cutting costs of health care in both public and private sectors. Nationwide and in Kansas more deaths, illnesses, and disabilities result from substance abuse than from any other preventable health condition. Of the 22,000 deaths each year in Kansas, more than one in four is attributable to alcohol, illicit drugs, or tobacco use.

When used for long periods of time, tobacco, alcohol and illicit drugs can impair most major organ systems. Cigarette smoking has long been known to cause cancer. Experts attribute nearly 90 percent of lung cancer deaths to smoking. In addition, numerous other smoking-related medical conditions have been identified; coronary heart disease, emphysema, chronic bronchitis, cerebrovascular disease, and cancers of the oral cavity, larynx, esophasgus, and bladder. Smoking also increases the risk of pneumonia and influenza, abdominal aortic aneurysm, and gastric and duodenal ulcers; it is a contributing factor in cancers of the pancreas and kidney; and it is associated with cancers of the stomach and uterine cervix.

Smoking during pregnancy is associated with a number of adverse pregnancy outcomes, including low birthweight, increase perinatal and neonatal mortality, spontaneous abortions, placenta previa, and abruptio placentae. Furthermore, there is evidence that smoking is significantly more common among Medicaid recipients. A recently released research study of Washington State Medicaid clients revealed that smoking prevalence was 44.4 percent among Medicaid-funded mothers as opposed to 16.3 percent for those not Medicaid-funded.

The long-term harmful effects of alcohol abuse are also well-documented. Fifty percent of chronic liver disease is caused by the abuse of alcohol. Alcohol abuse is strongly linked to a variety of other diseases; pancreatitis, cardiomyopathy, peripheral neuropathy, dementia and other central nervous system disorders, cancer, and the fetal alcohol syndrome. In addition, alcohol abuse is an important factor in a host of accident types, including automobile, fires, falls, and drowning. Alcohol is also commonly implicated in most homicides, many suicides, and a majority of domestic violence situations.

The long-term physical effects of using mind-altering drugs (such as heroin, cocaine, and marijuana), are controversial. Much of the medical risk is probably more associated with the circumstances under which illicit drugs are used.

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Shared needles and prostitution are significant contributors to the incidence of human immunodeficiency (HIV) and hepatitis infections. The resurgence of tuberculosis is also strongly linked to illicit drug use. In addition, there is correlation between illicit drug use and incidence of accidents and violence.

Substance abuse adds considerably to the state's total health care bill. The costs for treating the myriad of illnesses and injuries associated with smoking, drinking, and using illicit drugs are overwhelming. In any given year a smoker uses more medical care than a person who has never smoked, and when heavy smokers are hospitalized they stay 25 percent longer than do nonsmokers. Review of the 1990 Behavior Risk Factor Surveillance System, a document which provides state-specific cigarette smoking prevalence, indicates a frequency rate of 30.7 percent (n=124,642) for Kansas males age 35-64 and 18.7 percent for Kansas females (n=77,418). Experts note that people ages 18 to 34 are the group most likely to smoke so frequency rates for this age cohort is most likely higher than that of the 35-64 age cohort. The National Medical Expenditures Survey presents an estimate of the direct medical care expenditures attributable to smoking by payor, citing that for Medicaid the rate is 8.5 percent of total expenditures for the 19-64 age group and 12.7 percent for the over age 65 group. Thus, a conservative estimate of smoking related expenditures paid by the Kansas Medical Assistance Program in 1994 would be over $35m (figure derived by multiplying FY 1994 Regular Medical Assistance expenditures by 8.5%).

Similar trends in health care resource consumption are seen in other types of substance abuse with problem drinkers averaging four times as many days in the hospital as nondrinkers. Studies also show that as much as 40 percent of all patients in general hospitals are there because of complications related to alcoholism. Illicit drug users--particularly people using cocaine or heroin--make more costly visits to the emergency rooms. Costs associated with these resource utilization patterns further burden the Medicaid budget.

A major difficulty in redirecting resource allocations away from illness care to prevention lies first in an inability to determine in most instances those expenditures which occur as a result of substance abuse and those which are due to other etiology. The coding mechanism by which the provider indicates the medical diagnosis under treatment rarely provides concrete linkage between substance usage and disease categories. Only 29 have direct linkage to either alcohol, tobacco, or illicit drug use (see Attachment A). In addition, if one scans the dollar expenditures for those 29 ICD9 codes, the total expenditure of just over $4m is considerably less than estimated for substance abuse related diseases.

ALTERNATIVES

A. Eliminate reimbursement for specified list of diagnoses and use savings to expand benefit package to include prevention activities.

   The largest expenditures are related to ICD9 code 303 Alcohol dependence syndrome ($1.7m) and ICD9 code 304 Drug dependence ($1.16m). Elimination of payment for such treatments is an often voiced public sentiment, but such

action could have far reaching negative consequences. Individuals in need of such services frequently display extremely disruptive behavior which can pose a danger not only to themselves but also to members of society at large. In addition, there is an expanding body of knowledge which supports the existence of a physiological basis for these dependencies; and if so, reimbursement denial limited to these particular disease codes would mean that this set of diseases is treated differently than other physiologically based disease entities.

B. Reimburse outpatient services only and use savings to expand benefit package to include prevention activities.

   The expenditure breakdown on ICD9 code 303 is $916,986 for inpatient and $775,470 for outpatient and on ICD9 code 304 $363,269 for inpatient and $794,767 for outpatient. Inpatient services are required in the most acute phases of alcohol and drug detoxication and failure to reimburse for such services increases the likelihood that individuals will not receive treatment, thus posing significant danger to themselves and other members of society.

C. Maintain current status while implementing a managed care program which will emphasize prevention programs.

STATUS

SRS has written the Health Care Finance Administrator (HCFA) requesting guidance on the appropriate regulatory authority to request a waiver. Their response is attached (Attachment B).

JSL:BL:kaw

Attachments

DISEASES WITH CODE LINKAGE TO HEALTH RISK BEHAVIOR

ICD9 CODE	PATHOLOGY	TOTAL DOLLARS SPENT
265.2	Pellagra (alcoholic)	155
291	Alcoholic Psychoses	258,097
292.0/.11/.12/.81	Drug Psychoses	46,682
303	Alcohol Dependence Syndrome	1,692,456
304	Drug Dependence	1,158,036
305	Nondependent Abuse of Drugs	351,299
357.5	Alcoholic Polyneurpathy	446
359.4	Toxic Myopathy	1,507
425.5	Alcoholic Cardiomyopathy	24,293
472.1	Chronic Pharyngitis (Smoker's Throat)	9,773
491.0	Simple Chronic Bronchitis (Smoker's Cough)	11,374
508.8/.9	Respiratory Conditions due to other specified external agents/due to unspecified external agent	3,966
528.6	Leukoplakia of Oral Mucosa (Smoker's Tongue)	1,011
535.3	Alcoholic Gastritis	42,548
571.0-.3	Alcoholic Liver Disease	496,279
573.3	Toxic Hepatitis ("Dirty Needle" drug induced)	72,950
648.3/.4	Drug Dependency Complicating Pregnancy	39,326
655.5	Suspected damage to the Fetus from Other Disease in the Mother (drugs)	5162
760.70-.73/.75	Noxious Influences Affecting the Fetus via Placenta or Breast Milk; Unspecified Substance/Alcohol/Narcotics/Hallucinogenic Agents/Cocaine	20,530
779.5	Drug Withdrawal Syndrome in Newborn	534
790.3	Excessive Blood Level of Alcohol	200
965.0/967.0/969.6-.7/970.8	Poisoning by Specified Drug; Amphetamines,Barbiturate,Cannabis, Cocaine, Heroin,Hallucinogen,Opioid	48,028
989.8	Toxic Effects of Ethyl Alcohol	18,632
v11.3	Personal History of Alcoholism	55
v15.82/.89	Personal History Presenting Hazards to Health; History of Tobacco Use/Other	0/300
v69.8	Problems Related to Lifestyle; Other	0
		4,303,639

Refer to:
MOB:TC
SC 17

DEC 2 9 1994

Ms. Donna L. Whiteman, Secretary
Department of Social and
Rehabilitation Services
Docking State Office Building
915 Harrison
Topeka, Kansas 66612

Dear Ms. Whiteman:

This is in response to your letter, regarding waiver authority to allow the Medicaid program to discontinue coverage for diagnoses related to smoking, alcohol abuse, and illicit drug use.

At issue is whether a State may limit by diagnosis, illness, or condition Medicaid Services which are not mentioned in regulations at 42 CFR 440.230(c). That regulation unambiguously prohibits a State Medicaid agency from limiting a service which is required to be available under 42 CFR 440.210 and 440.220 solely because of diagnosis, type of illness, or condition.

Medicaid comparability requirements in regulations at 42 CFR 440.240 also restrict the imposition of coverage limits that differentiate by diagnosis, type of illness, or condition.

The waiver authority established under sections 1915(a), (b), and (c) of the Social Security Act (the Act) does not include limiting services by diagnosis, type of illness, or condition. Waiver authority under section 1115 of the Act permits the Secretary to approve experimental, pilot, or demonstration projects which are designed to improve the overall function of the program. Section 1115 allows the Secretary to waive (among other provisions) compliance with sections 1902 and 1903 of the Act.

While HCFA will consider proposals that test alternatives that diverge from our policy goals, it may disapprove or limit proposals which create potential constitutional problems, violations of civil rights or equal protection requirements. Generally, HCFA seeks proposals under this waiver authority which preserve and enhance beneficiary access to quality services.

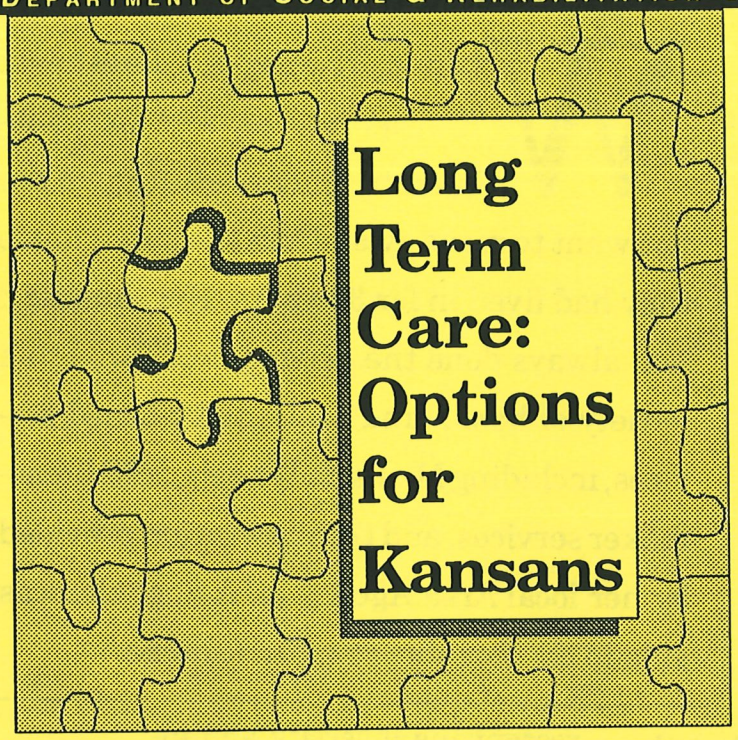
If you should have any questions about this matter, please contact Toni Cordry at (816) 426-6477.

Sincerely yours,

Richard P. Brummel
Associate Regional Administrator
for Medicaid

cc: Robert Epps
Joyce Sugrue
Carol Finkle

3-6



Long Term Care: Options for Kansans

Kansans of all ages are benefiting from changes in the way we care for our neighbors. At the heart of these changes is the belief that everyone, regardless of age or physical capabilities, has a right to live in the most independent environment possible.

For Kansans this changes the way we look at our options for long term care services.

What is long term care

Long-term care means a variety of services for individuals who require assistance with personal, medical or social needs. The need for long term care services can be triggered by medical needs, changes in support systems, or by financial circumstances.

Regardless of social or financial status, most people will experience a need for long term care services some time during their life.

SRS strives to give Kansans long term care assistance in an environment that maximizes independent living capabilities. To do this, SRS offers a wide array of quality, cost-effective and affordable long term care choices that improve the lives of elderly Kansans and Kansans with disabilities and helps to reverse the state's reliance on institutional services.

Resources are available in each county to provide or pay for services. Giving Kansans options for long term care services within available resources is an SRS priority.

But for too long, the only option for the elderly and persons with disabilities was to move to a nursing facility.

There's no place like home

A recent report by the National Academy for State Health Planning showed 20% to 25% of current Kansas nursing facility residents could live in their homes and communities if services were available. Another survey by the American Association of Retired Person's showed more than 90% of elderly persons would prefer to stay in their homes for as long as possible and never enter a nursing home if it could be avoided.

Despite the results of these and other surveys, development of home- and community-based services has progressed slowly.

Kansas Medicaid expenditures for nursing facilities have skyrocketed, up almost $50 million just in the last two years. At the same time, there has been no growth in the number of Medicaid eligible persons being served in nursing facilities.

Institutional care costly

Costly institutional services for those who could be served at home is keeping Kansas from developing community-based services. During state fiscal year 1993 about $185.4 million was spent on nursing facility care and only $6.8 million for community-based services.

Kansas can no longer afford the current long term care system. Change is essential if we are going to build a system responsive to the needs of elderly Kansans and Kansans with disabilities. To meet those needs we must provide opportunities which will allow persons to remain at home near friends and family members.

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What is needed

Since the mid-1970s, SRS has provided quality and cost-efficient in-home long term care services to thousands of frail or vulnerable Kansans. The people we serve are rarely heard in advocacy groups or other organizations.

Trained SRS staff are dedicated to the individuals they serve. SRS staff members are committed to ensuring that the health and safety needs of their clients are met in an environment of choice recognizing diversity and individual strengths.

This publication summarizes SRS long term care programs and highlights steps necessary to provide the services needed by older Kansans and persons with disabilities.

While nursing facilities are an essential and important component of the continuum of long term care, it is clear the current system must expand and promote a more comprehensive service delivery system with a full array of services.

When a 73-year-old Southeast Kansas woman lost her husband to a heart attack she did not want to move away from the small home they had lived in for 33 years. Her husband had always done the driving, but through a variety of home- and community-based services, including Meals on Wheels, SRS homemaker services, and transportation provided by her local Area Agency on Aging, she was able to comfortably remain at home.

RESOURCE

NURSING FACILITY PREADMISSION ASSESSMENT AND REFERRAL PROGRAM

The Nursing Facility Preadmission Assessment and Referral Program (KPAR) was authorized by the Kansas Legislature and implemented in 1993. Preassessment and referral is the **keystone** to a responsive long term care program.

Program goals which reflect federal requirements include:

- Provide persons seeking admission to nursing facilities with information about community-based alternatives to meet their long term care needs (as identified through the assessment).
- Increased access to community-based long term care services in all areas of the state.
- Maintain a comprehensive statewide data base to identify community-based services available or needed.
- Reduce Medicaid expenditures for institutional long term care services by developing and expanding utilization of cost-effective community-based alternatives.
- Increase the number of persons served through community settings.

RESOURCES NEEDED:

The 1994 Legislature transferred responsibility for preadmission assessment to the Kansas Department on Aging beginning Jan. 1, 1995. The new program is called the **Client Assessment, Referral and Evaluation (CARE).**

Kansas Facts:

- Kansas has the 7th highest rate of institutionalization for people over the age of 85.
- About 7% of elderly Kansans reside in a nursing facility while the national proportion is 5%.

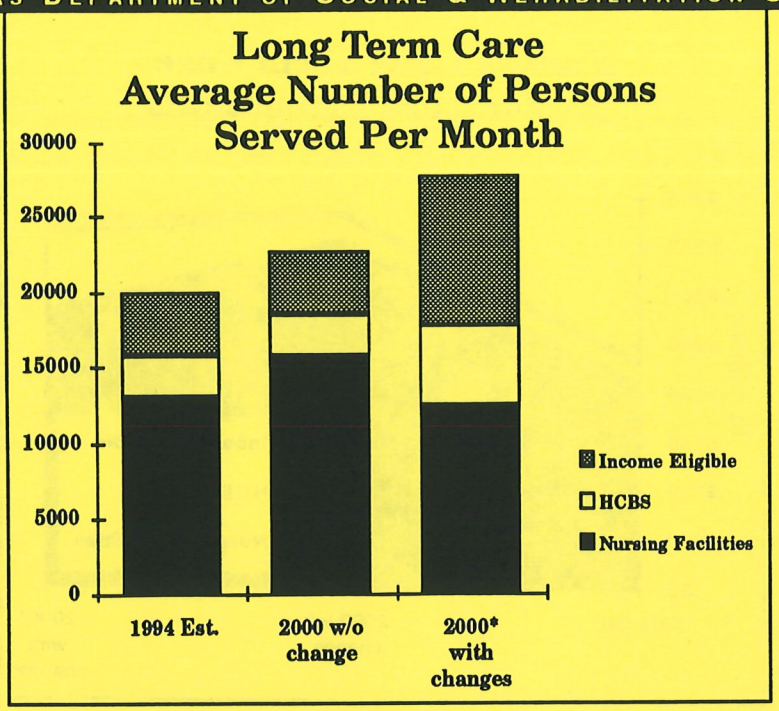
4-2

RESOURCE

COMMUNITY RESOURCE DEVELOPMENT

The Community Resource Development program began in 1993 with an interagency agreement between the Area Agencies on Aging and SRS. Eleven new Community Resources Developers developed or expanded needed community-based alternatives to institutional care for the elderly and persons with disabilities.

Resources developed ranged from county-wide services such as a service providers network, to community programs that found volunteers for home meal delivery and affordable housing.



RESOURCES NEEDED

The Community Resources Developers host monthly workshops to discuss questions and problems and assess community programs around the state interested in developing additional programs.

Frequently listed barriers to service development are:

- lack of start-up funds;
- lack of volunteers;
- a time-consuming decision-making process;
- lack of emergency funds, furniture and other household items for persons wishing to leave a nursing home and return to their communities;
- distances to needed services in rural areas;
- lack of community support to provide needed home- and community-based services.

RESOURCE

THE INCOME ELIGIBLE HOME CARE PROGRAM

The SRS Income Eligible Home Care Program provides services to people who are able to reside in a community-based residence if some services are provided. If services are not provided, these individuals would be at the greatest risk of nursing facility placement or other institutionalization.

Program participants are assessed using the Kansas Preadmission Assessment and Referral criteria and must meet the program's financial guidelines. Persons receiving the services through the Income Eligible Home Care Program do not have to be eligible for Medicaid.

Eligibility is based on personal or medical need, financial need, availability of service providers and budget constraints. Services provided include nonmedical attendant care, case management and residential services.

RESOURCES NEEDED

If we are to enhance community-based services, resources to the Income Eligible program must be increased.

Kansas Facts:

- The number of persons age 85 and over in Kansas is expected to more than double to nearly 84,000 between 1990 and 2005. This group is the most likely to need long term care services.

4-3

RESOURCE

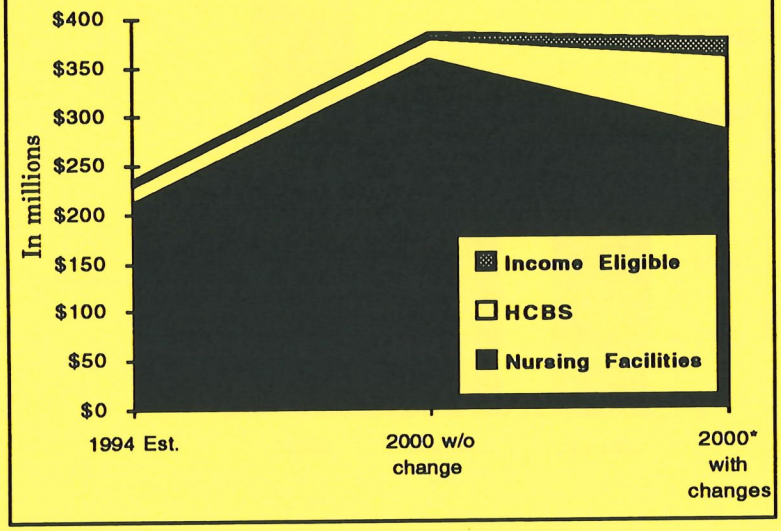
HOUSING ALTERNATIVES

An interagency committee coordinates the efforts of agencies working on long term care issues. The committee includes members from the Kansas Departments of Commerce and Housing, Health and Environment, SRS, Aging, and the K.U. School of Social Welfare.

Committee recommendations to the 1994 Kansas Legislature included increasing the supply of affordable home- and community-based services for Kansans with long term care needs to live as independently as possible. Strategies included identification of current and proposed housing options.

SRS is committed to expanding and developing a variety of in-home and other community-based housing alternatives. Individuals would be offered a choice of care settings, and limited tax dollars would be used more effectively.

Kansas Long Term Care Expenditure Projections



RESOURCES NEEDED

Resources supporting in-home services such as attendant care, respite care and adult day care, as well as simple home modifications, must be available for Kansans with long term care needs.

When the persons can not remain at home, alternative "home-like" housing provides a desirable and cost-effective alternative to nursing facility care.

Resources, including tax incentives, should be available to develop and expand assisted living and residential care facilities in all communities.

Currently, when in-home care can no longer meet an individual's needs, only 1,576 alternative residential care settings are available to about 12,500 Kansans who annually seek out-of-home care.

RESOURCE

COMMUNITY RE-ENTRY PROGRAM

The Community Re-Entry Program is a joint program between SRS commissions of Youth and Adult Services and Income Support/ Medical Services. It helps Medicaid/MediKan recipients return home from a nursing facility through the use of community-based services.

A data base identifies individuals living in nursing facilities who are most able to reenter the community because they function well in various activities of daily living.

These people are asked whether they would like SRS to help them move back into the community. A number of persons are successfully living in Kansas communities, thanks to this program.

RESOURCES NEEDED

Depleted financial resources and lack of housing opportunities have presented program barriers concerning the Community Re-entry Program

Kansas Facts:

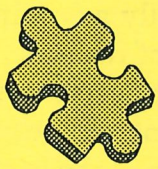
♦ Kansas recently ranked 46th among all states in terms of per capita spending on community-based long term care services.

4-4

RESOURCE

HOME- AND COMMUNITY-BASED SERVICES

Public law allows states to "waive" certain statutory limitations giving them the opportunity to offer cost-effective home and community-based services to eligible persons who otherwise would require care in a nursing facility, hospital or intermediate care facility.



Kansas currently has approval for **FOUR** such waivers:

HOME- AND COMMUNITY-BASED SERVICES NURSING FACILITY WAIVER (HCBS/NF) provides a variety of community-based services to Medicaid-eligible individuals who have a medical need for nursing facility care but choose to stay in the community. Recipients must be 16 years or older and disabled or be 65 years of age or older.

During state FY 1993, 2,543 persons were served through this waiver.

Services provided under the HCBS/NF waiver include case management, homemaker services, respite care, non-medical attendant care, medical attendant care, wellness monitoring, medical alert, residential care, residential personal care, habilitation, night support, adult day care, and adult family homes.

HOME- AND COMMUNITY-BASED SERVICES HEAD INJURY WAIVER provides community-based services to Medicaid-eligible person who have traumatically acquired, non-degenerative, structural brain damage resulting in residual deficits and disability.

Without community-based services these persons would be institutionalized in a head injury rehabilitation facility. Recipients must be 18 to 55 years of age; 75% are currently being served.

HOME- AND COMMUNITY-BASED SERVICES TECHNOLOGY ASSISTANCE WAIVER provides community-based services to Medicaid-eligible children who are ventilator-dependent, or require total parental nutrition or a similar condition to sustain life. Without these services, children receiving these services are at imminent risk of being institutionalized in an acute care hospital . Currently, 27 Kansas children are served by this waiver.

HOME- AND COMMUNITY-BASED SERVICES MENTAL RETARDATION /DEVELOPMENTALLY DISABLED WAIVER provides community-based services to Medicaid-eligible persons who, based on a screening process, meet the criteria for the care provided in an intermediate care facility for the mentally retarded. Without these services, they could be placed in such a facility. Recipients must by five years of age or older.

After a motorcycle accident, 22-year-old Joe sustained a traumatic head injury. Working through the Home- and Community-Based Services Head Injury Waiver which paid for his therapist and transportation, he began regular rehabilitation at a the local health club rather than receiving the treatment at a hospital.

This provided not only needed rehabilitation, but also social and emotional reintegration into his Northeast Kansas Community.

RESOURCES NEEDED

While several areas in Kansas have seen a recent increase in the availability of services, other areas lack these resources.

The development of community-based services must be encouraged so Kansans who wish to remain in their homes and communities can do so.

4-5

RESOURCE

ADULT PROTECTIVE SERVICES

Adults, in Kansas have the right to direct their own affairs unless they have been found incompetent by a court ruling. They also have the right to decide whether or not they wish to be helped.

Sadly, however, there are times some adults need protection. Sometimes they do not recognize they need help or know where to go for help. Examples of such situations include hazardous and unsafe living conditions, illness without medical attention, malnourishment, financial exploitation, physical abuse or exploitation, confusion and inability to make appropriate decisions.

SRS Adult Protective Services receives reports of adult abuse, neglect or exploitation, investigates those reports, and provides services to those individuals at risk of or actually abused, neglected or exploited. Any person 18 years or older unable to protect their own interests and is the suspected victim of abuse, neglect or exploitation is eligible for protective services. Adult Protective Services investigates abuse, neglect or exploitation in homes and communities.

Reports of adult abuse should be made by telephone, in person or in writing to your local SRS office. Reports during non-business hours should be made to local law enforcement offices. **Reports can also be made to the SRS Adult Abuse Hotline at 1-800-922-5330.** Your identity will remain confidential.

Abuse/neglect of residents in adult care homes should be referred to the Kansas Department of Health and Environment at 1-800-842-0078. SRS and KDHE work together to correct problems identified in nursing facilities.

RESOURCES NEEDED

While problems of adult abuse, neglect or exploitation can be identified, it is often more difficult to identify long term solutions because of the lack of community resources in some areas. The lack of community resources is especially acute in more rural areas of Kansas.

Guardians and conservators for adults, persons who can act on behalf of and in the best interest of a vulnerable adult, are also needed. Many areas of Kansas have long waiting lists of elder adults seeking guardians or conservators. Volunteers are needed to fill this need.

RESOURCE

NURSING FACILITY PROGRAM

As of January, 1994, out of 367 nursing facilities in Kansas, 359 facilities with a total of 27,702 beds were participating in the Kansas Medicaid Program.

All services provided in nursing facilities are prescribed by a physician and based on an individualized treatment plan which may include any of the following services:

- Skilled nursing care;
- Specialized rehabilitation services;
- Therapies;
- Social services;
- Pharmacy services;
- Dietary requirements;
- Activity programs;
- Assistance with daily living skills.

RESOURCES NEEDED

A vast disparity exists between the wish of most elderly persons or persons with disabilities to stay in their homes and communities and the reality of a very high rate of nursing facility placement in Kansas.

(Continued)

4-6

NURSING FACILITY PROGRAM
(Continued)

Between July 1, 1992 and June 30, 1993, nursing facilities served 13,300 persons in Kansas. Total expenditures for this same period were $185.4 million. This represents more than 30% of the total Kansas Medicaid expenditures.

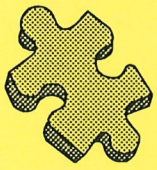
Although nursing facility costs have increased at a tremendous rate, the proportion of the Medicaid budget expended for nursing facilities has remained fairly constant because regular Medicaid costs have also undergone significant increases.

However, the regular Medicaid program has also undergone tremendous increases in number of clients provided services, while the number of recipients in nursing facilities has remained almost constant. Nursing facility Medicaid expenditures increased over 70% between state fiscal years 1986 and 1991, while the number of recipients has increased only 7% during the same time period.

An elderly western Kansas woman recently experienced a decline in her physical condition due to progression of a disease. A light stroke left her with some residual weakness on her left side, weak, and unable to walk far without assistance. The woman truly wished to remain at home. Through the HCBS/NF waiver, SRS staff developed a plan to cover the woman's personal care needs, medication administration, meal preparation, housekeeping tasks, laundry, shopping and night support. The coordinated plan allowed her to remain in her home.

RESOURCE

NURSING FACILITY QUALITY ASSURANCE AND REIMBURSEMENT WAIVER



The 1993 Kansas Legislature authorized SRS to contract with nursing facilities and to limit the growth of number of Medicaid paid beds to 14,500. SRS has applied to the federal Health Care Financing Administration (HCFA) for a waiver to implement this proposal.

When approved, it will guarantee access to quality nursing facility care while slowing down the tremendous cost increases associated with Medicaid-certified nursing facilities in Kansas. With a decrease in nursing facility costs, funding can be used for much-needed development of community-based services in Kansas.

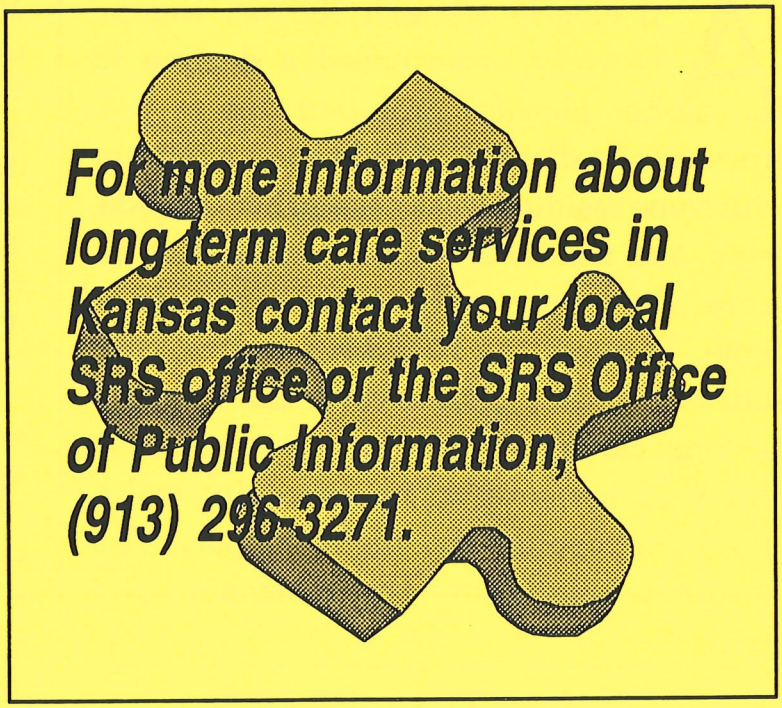
Kansas currently spends more than 90% of its available funds for long term care assistance on nursing facilities, leaving very little for other services.

There is broad recognition of the need for long term care assistance to be addressed in a variety of settings for elderly Kansans or persons with disabilities. But expansion of community options will only be possible if money now being used exclusively for nursing facilities can be redirected to build up community services.

Kansas Facts:

♦ Kansas has the nation's highest number of licensed skilled nursing and intermediate care facilities beds per 1,000 population for persons age 65 and over.

4-7



Kansas Department of Social and Rehabilitation Services
Donna L. Whiteman, Secretary
Joan Finney, Governor
915 SW Harrison / Sixth Floor / Topeka, KS 66612-1570
(913) 296-3271

Myths & Facts

About the SRS CHOICE Program

Choosing Home Or Institutional Care Environments

Myth: SRS will only enter into agreements with nursing facilities willing to negotiate the lowest rate.

Fact: SRS will enter into contract agreements with nursing facilities meeting quality of care standards.

Myth: Once Medicaid-reimbursed nursing facility beds are filled, other Medicaid beneficiaries needing nursing facility care will be denied that care.

Fact: There are an additional 500 beds under the waiver. Because less than 90% of existing Medicaid-certified beds are now occupied, it is expected it will take years before even existing beds are filled. Under the waiver, SRS will be able to reopen negotiations or amend agreements if more institutional services are needed in an area.

Myth: Quality assurance programs are not in place, which will result in poor care at decreased costs for Medicaid beneficiaries.

Fact: Quality care is currently assured through the licensure and certification process demanded by state and federal regulations. Programs already in place that assist in monitoring quality of care in nursing facilities are the Kansas Department on Aging's Ombudsman Program and the SRS Institutional Abuse, Neglect and Exploitation Program.
The implementation date for the waiver, should it be accepted by the federal government, is July 1, 1996. By that time, the Case Mix Demonstration Project quality assurance system will be tested and operational. In addition, the federal government requires a set percentage of nursing facilities be reviewed yearly as a method not only to monitor appropriate utilization of Medicaid services, but also to notify SRS of any quality of care issues needing to be addressed.

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Attachment 5

MYTH: SRS is using this application to decrease the Medicaid budget.

FACT: Negotiated agreements with Kansas nursing facilities will allow any savings resulting from the waiver to be channelled to the development of needed community services. This will allow Medicaid beneficiaries to remain in their own homes and communities. Rather than cutting the Medicaid budget, this waiver would shift dollars from one program, institutional care, to another, home and community care.

MYTH: Because the overall population in Kansas is aging rapidly, there will be a much bigger need for institutional nursing facility care in the near future.

FACT: The old paradigm that the majority of elderly people require institutional care is simply wrong. Medical technology has advanced to the point that people with several long term care needs can be provided that care in their homes.

According to a number of surveys, home- and community-based care is the choice of the vast majority of the elderly and persons with disabilities.

MYTH: Medicaid beneficiaries will be moved constantly between nursing facilities causing "transfer trauma," illness and death.

FACT: There should be minimal need for residents to transfer to another facility under the waiver unless the facility does not meet minimal quality care standards or the facility does not choose to offer a proposal to provide Medicaid services or work with SRS to meet Medicaid beneficiaries needs.

In addition, numerous studies show "transfer trauma" is decreased significantly by preparing nursing facility residents being moved to a new home and involving them in transfer planning.

MYTH: SRS is putting the "cart before the horse" by trying to reduce institutional beds before expanding home and community services.

FACT: Savings from the waiver will go directly toward development of community services while assuring nursing facility residents access to quality care.

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MYTH: Kansas needs to wait before applying for this waiver to determine the effect of any new federal health care plans concerning long term care.

FACT: Long term care is not clearly addressed in new federal health care plans. By moving ahead with innovative, cost effective methods of care and reimbursement, the state will be more likely allowed to develop its own proposals and less likely to be mandated to make changes by the federal government. This is a pro-active step toward health care reform.

MYTH: Medicaid beneficiaries would have no voice in where they live or how long they reside in a specific nursing facility.

FACT: Medicaid beneficiaries would continue to have the choice of nursing facilities willing to enter into an agreement with the Kansas Medicaid program. SRS plans to enter into agreements with enough nursing facilities in a particular region to meet the needs of persons in the area.

MYTH: Case mix reimbursement, which reimburses nursing facilities based on the level of care needed for residents in the facility, will be eliminated under the waiver.

FACT: SRS has been working closely with the federal case mix project manager to insure any reimbursement methodology will be based on a nursing facility's case mix average. Under the waiver, a nursing facility's daily reimbursement rate would fluctuate based on resident care needs. As resident care needs increase, the daily rate would also increase and likewise as resident care needs decrease, so would the daily rate. There will be no way a nursing facility can decrease care to increase profits under the waiver.

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KANSAS MEDICAID WAIVERS

The following is a report on the current status of waivers SRS has or is preparing to submit to the Health Care Financing Administration (HCFA):

Managed Care

SRS is developing a statewide managed care program that will address Kansas's diverse populations. There are three major components to the managed care program in Kansas: primary care case management, capitated managed care, and the Community Care of Kansas waiver (a Research and Demonstration Waiver, or the 1115 waiver).

Primary Care Network/Capitated Managed Care

*The Primary Care Network (PCN) program is a Primary Care Case Management waiver program started in February, 1984 using a 1915 (b) waiver from HCFA. This model uses health care providers as case managers for clients, and has shown cost containment without compromising quality, access and continuity of care. This managed care model is expected to be successful in smaller communities in Kansas. It is currently available to clients in seven counties: Douglas, Johnson, Leavenworth, Saline, Sedgwick, Shawnee and Wyandotte. It includes clients who are eligible for Medicaid, MediKan, SSI and General Assistance.

*A renewal waiver application for the PCCM managed care model was submitted to HCFA in October, 1994. The renewal application expands and strengthens the PCCM program. The waiver application would continue the existing PCN counties and incrementally add additional counties. All counties in Kansas would be covered by July, 1997. SRS expects approval of this application this month.

*The renewal application also included capitated managed care which will be a contractual program with Health Maintenance Organizations. Under capitated managed care, a set monthly fee is paid in advance to HMOs to provide medical services. The capitated model includes clients who are in AFDC and Poverty Level Women and Children programs.

*In December, 1994, the HCFA requested additional information on capitated managed care. SRS withdrew the capitated portion of the waiver application to prepare more documentation for HCFA. SRS will submit an amendment to the original PCCM waiver request in April.

Community Care of Kansas Waiver

*Community Care of Kansas (CCK) is a managed care project being tailored to the Wichita area beneficiary population. A special five-year research and demonstration waiver (an 1115 waiver) is expected to be ready for submission to HCFA by late spring.

*The Community Care of Kansas waiver has evolved over the past year from an initial collaborative effort by the Sedgwick County Medical Society and the four hospitals in Wichita. It now encompasses commitment and participation by the Kansas Health Foundation, the Kansas University School of Medicine, Federally Qualified Health Centers, County Mental Health Providers, and health care leaders from affiliated rural service areas (Finney, Montgomery, Bourbon and Crawford counties).

*CCK is designed to demonstrate a community-wide approach to Medicaid managed care that will foster the development of managed care in rural and small urban communities; preserve and enhance choice of providers for vulnerable, underserved populations; and improve health outcomes by assuring a continuum of care tailored to the special needs of Medicaid families and low-income

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*The CCK demonstration model's service delivery system will be established as a non-profit prepaid health plan governed by a board of directors with active input by Primary Care and community service organization groups.

LONG TERM CARE WAIVER REQUEST

THE CHOICE WAIVER

*The CHOICE (Choosing Home or Institutional Care Environments) waiver is **one component** of the agency's long term care reform plan to develop a continuum of care for the elderly and persons with disabilities. A main purpose of the waiver is to ensure the number of nursing facility beds the Kansas Medicaid program will pay for is limited to those needed to meet consumer need and preference of service location.

*The CHOICE waiver would allow SRS to contract with nursing facilities for a specified number of nursing facility beds for reimbursement.

*The waiver is expected to slow the tremendous cost increases associated with Medicaid certified nursing facilities in Kansas while guaranteeing access to quality nursing facility care. It is also expected to help develop much-needed community based options for persons with long term care needs.

*A waiver application was submitted to HCFA in March, 1994. HCFA responded with a series of questions. Many of the questions concerned the effect of possible transfer of residents, and its effect.

*SRS held a public hearing on long term care options, including the CHOICE waiver application, on December 6, 1994. After the public meeting, SRS prepared responses to HCFA, which were submitted January 6. In the SRS response, clarification was provided showing the cost-effectiveness of the waiver will be gained by controlling Medicaid nursing facility bed growth, not by transferring residents.

*HCFA will grant or deny the waiver by the end of March. Kansas Legislative authorization is necessary to implement this waiver if SRS receives HCFA approval.

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MMIS REPROCUREMENT

Project Goals

The Kansas Department of Social and Rehabilitation Services (SRS) is in the process of securing bids for the next Medicaid Management Information Systems (MMIS) Fiscal Agent Contract. It is the Department's intent through this process to acquire effective, efficient fiscal agent services including a replacement MMIS which will utilize updated technology in order to deliver the best possible services to Medicaid recipients within available resources.

Timeline and Actions To Date

The contract with the current fiscal agent, Electronic Data Systems (EDS), expires in June of 1995 with three one-year extension options. The Department has elected to extend for one-year only and thus implement a new MMIS under a new contract effective July 1,1996. Key dates include: issuance of the RFP in September, 1994; award of a new contract in March, 1995; and implementation of a new MMIS July 1, 1996.

Actions to date include the following:

September 19, 1994 — **An RFP was issued to the public.** The RFP was developed based on input from numerous function-based work groups whose members included staff from all SRS divisions/commissions as well as from the Department of Administration.

October 26, 1994 — **A pre-proposal conference was held.** A total of 372 questions were received from potential bidders prior to the conference in response to the RFP.

November 16, 1994 — **RFP Addendum One was issued.** The following items were included in the addendum: 1. Responses to questions received from potential bidders. 2. Significant additional requirements related to the Managed Care initiative which has been mandated by the legislature. 3. Additional on-line Ad Hoc reporting capabilities.

December 12, 1994 — **RFP Addendum Two was issued.** This addendum consisted primarily of responses to questions received regarding the contents of Addendum One. With this addendum, the proposal due date was extended from December 16, 1994 to January 12,

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1995. This extension was given, in response to requests from potential bidders, to allow bidders sufficient time to incorporate the Managed Care requirements that were addressed in Addendum One. This change is not expected to impact the target dates for contract award or project implementation.

January 12, 1995 — **Bids were received.** Two bidders, Electronic Data Systems (EDS) and Blue Cross Blue Shield of Kansas (BCBS), submitted proposals.

Major Changes and Enhancements

The state has incorporated numerous system enhancements and functional changes into the RFP requirements. The winning bidder will be responsible for incorporating these changes effective July 1, 1996.

- Updated Technology - The state is requiring a complete replacement of the current base MMIS system. The new system must accommodate changes more quickly and efficiently than does the current system.

- Medicaid/MediKan ID cards - Currently the fiscal agent issues paper Medicaid/MediKan ID cards monthly to all recipients. SRS plans to phase out the issuance of these monthly paper cards and issue permanent plastic ID cards instead. Medical providers will use the information on the card to access eligibility information electronically via the eligibility verification system or the voice response system both of which will be developed and maintained by the fiscal agent. The fiscal agent will pilot this permanent ID card process in two (2) areas of the state for four (4) months beginning July 1, 1996, and then will implement the new process statewide. Implementation of the plastic ID cards will require the new fiscal agent to greatly expand the state's electronic and telephone-based eligibility verification capabilities statewide. Per legislative initiative, SRS Division of Medical Services staff, together with Electronic Benefit Transfer (EBT) Project staff, reviewed the feasibility of using the EBT card for Medicaid thus avoiding duplicate card issuance. There are problems inherent in attempting to do this. Cash and foodstamps, for which the EBT card is designed, are issued to families or "caseheads" whereas Medicaid benefits are issued to individuals. SRS is currently reviewing two different approaches to this issue and will make a final decision before MMIS contract negotiations begin.

- Managed Care - Some managed care related system enhancements will be incorporated by the incumbent MMIS fiscal agent prior to July 1996. Capitated managed care programs will be provided to AFDC and Poverty Level Pregnant Women and Children populations. These programs will be phased in. An anticipated 80 percent (80%) of the state's Medicaid population will receive some form of managed care by July 1, 1997. This care will be provided through a primary care case management program (which requires fee-for-service payments) and capitated programs which will exclude some Medicaid-covered services. Therefore, the contractor will be required to maintain a fee-for-service payment system as well as implement systems to accommodate capitated managed care processing. The contractor will be required to process recipient enrollment information, capitated payments and encounter data. Because the Managed Care project is scheduled to begin implementation in 1995 during the design/development/implementation of the MMIS, staff resources for the management of both projects will be limited and we may find it necessary on occasion to adjust target dates for one project to accommodate the other.

- Ad Hoc Reporting - SRS will require that the MMIS incorporate an Ad-Hoc reporting and support capability that will provide special reports when needed. This will require that monthly reports be extracted and transferred to a database each month where the state will receive on-line, real-time access. A user-interface will be available to the state for requesting Ad-Hoc reporting from the MMIS database using batch processing of the requests. The state's intention is to have these reports available on-line, real-time through PC's located both at state and fiscal agent sites. It is also the State's intention to use the database to produce reports other than the standard monthly reports from the database in an on-line, real-time environment.

Funding Issues

An Expenditure Summary which details the project costs is attached.

Project expenditures to date have been limited to the cost of the consultant services that were obtained for the development of the RFP. Consultant services have been provided through contract with David M. Griffith and Associates. These services are eligible for 90% Federal Financial Participation.

The bulk of the project cost will be realized in FY96 and subsequent years, after the new contract is awarded. In FY96, $6 million is budgeted for the design, development, and implementation (DDI) of the replacement system and contract. This figure is an estimate. Though bids have been received, the cost proposals will remain sealed until evaluations of the technical proposals are complete. Actual costs won't

be available until a new contract is awarded. The estimated $6 million will be expended in addition to the FY96 cost of current fiscal agent operations since the current system must continue to operate until the new system is implemented. DDI costs are eligible for a combination of 90% and 75% FFP.

Acquisition of a new MMIS under a new contract can, if done well, be of great benefit to the state.

MMIS Reprocurement Project Expenditure Summary
1/13/95

	Amounts Budgeted		Expended-To-Date	State General Fund
David M. Griffith, Consulting Services (eligible for 90% FFP)	FY94	$138,770	$138,770	$13,877
	FY95	$ 65,000	$ 46,236	$ 4,624
	FY96	$ 67,275	$ 0	$ 0
MMIS Replacement/ Design/Development/ Implementation (DDI)	FY96	$6,000,000*	$ 0	Approximately $600,000. The majority of the implementation year cost will be eligible for 90% FFP. Some items , however, will be funded at 75%.
New MMIS Operations	FY97	$13,000,000 (Projection is based on current operations.)	$ 0	

*This DDI cost is in addition to the FY96 cost of current fiscal agent operations (approximately $13,000,000 annually).

KANSAS SOCIAL SERVICES INFORMATION SYSTEM (KSSIS)

DESCRIPTION: A Child Welfare Information System Project for the Youth and Adult Services Commission in SRS.

PROJECT IMPORTANCE: Services to clients and data collection at the present time is primarily a manual process. KSSIS will automate the process of providing services making the workers use of time more efficient and effective which provides more time for direct client service. Collection of data statewide will become standard and consistent.

HISTORY: The 1994 legislature appropriated approximately $5.3 million for the state's share of an information system for Youth and Adult Services. In July 1994, this committee recommended to the Finance Council Authority the release of $1.893 million for SFY95 to begin the development of the KSSIS system. In September of 1994, the Finance Council Authority released the recommended funds for the KSSIS project.

STATUS: In September 1994, the KSSIS Steering Committee designated Mike Purcell as the KSSIS Project Manager, Bob Hedberg as the KSSIS System Program Manager, and Mike Worthington as the KSSIS Technical Manager.

In November 1994, a Request For Proposal (RFP) was issued for contractor support for the project. Bids closed on the RFP on December 2nd. The Procurement Negotiating Committee is currently negotiating with the vendors who bid their services in order to get a contractor on board in early January.

In November 1994, a Request for Proposal (RFP) was issued for contractor support for training technical and program staff on the use of the Information Engineering Facility IEF/CASE Tool. Bids closed on the RFP on December 12th. Evaluations of the bids have just been completed. Plans are to negotiate with the vendors the first week of January.

An update to the Implementation Advanced Planning Document (IAPD) was submitted to the Administration for Children and Families (ACF) on December 13th.

Recruitment of program staff from the local offices and from central office for the design and implementation of the system has also begun. Four Social Work Supervisors joined the project on December 19th. One central office staff person is expected to join the project the first part of January.

The expected accomplishments for January 1995 are to have a contractor on board for the KSSIS Project, have a contractor on board to do the training on the (IEF) CASE/Tool and begin the design of KSSIS with the start of the BAA-1 phase. Starting the design is dependent on having the two contractors on board and the training completed.

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BUDGET

	SFY95	SFY96	SFY97	Total
Salary and Wages	$1,106,499	$1,976,307	$1,343,740	$4,426,546
Capital Outlay	5,153,974	3,507,972	0	8,661,946
OOE	1,312,624	3,026,019	970,897	5,309,540
Total	$7,573,097	$ 8,510,298	$ 2,314,637	$18,398,032

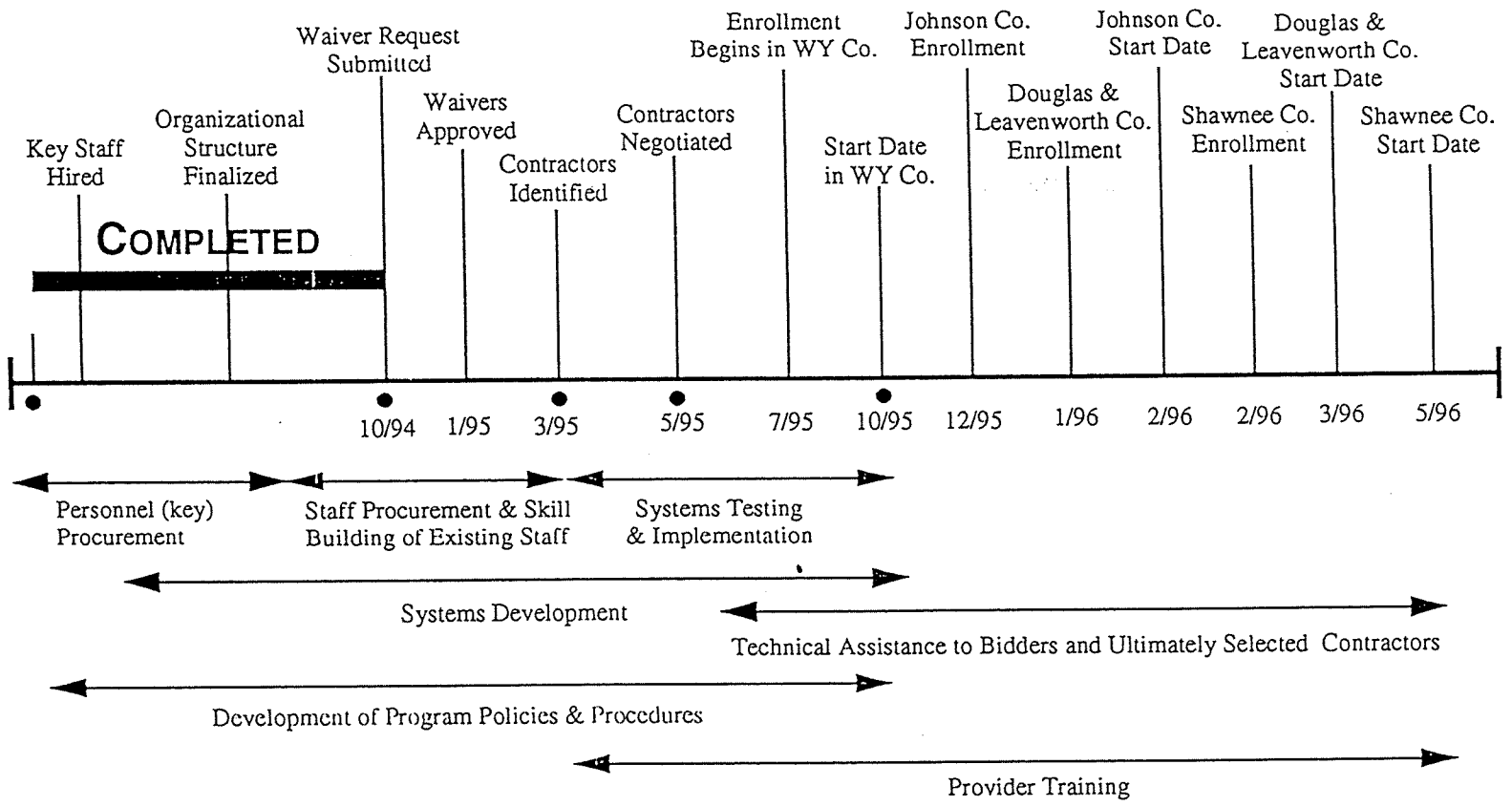
SCHEDULE

BAA-1: High level design of the activities and processes KSSIS will need to meet Youth and Adult Services organizational goals.

BAA-2: Detailed design of the data, activities and processes KSSIS will need to meet Youth and Adult Services organizational goals.

BSI: Construction of the screens and reports, completion of design and generation of code.

CAPITATED MANAGED CARE PROJECT TIMELINE FOR WYANDOTTE, SHAWNEE, DOUGLAS, LEAVENWORTH AND JOHNSON COUNTIES



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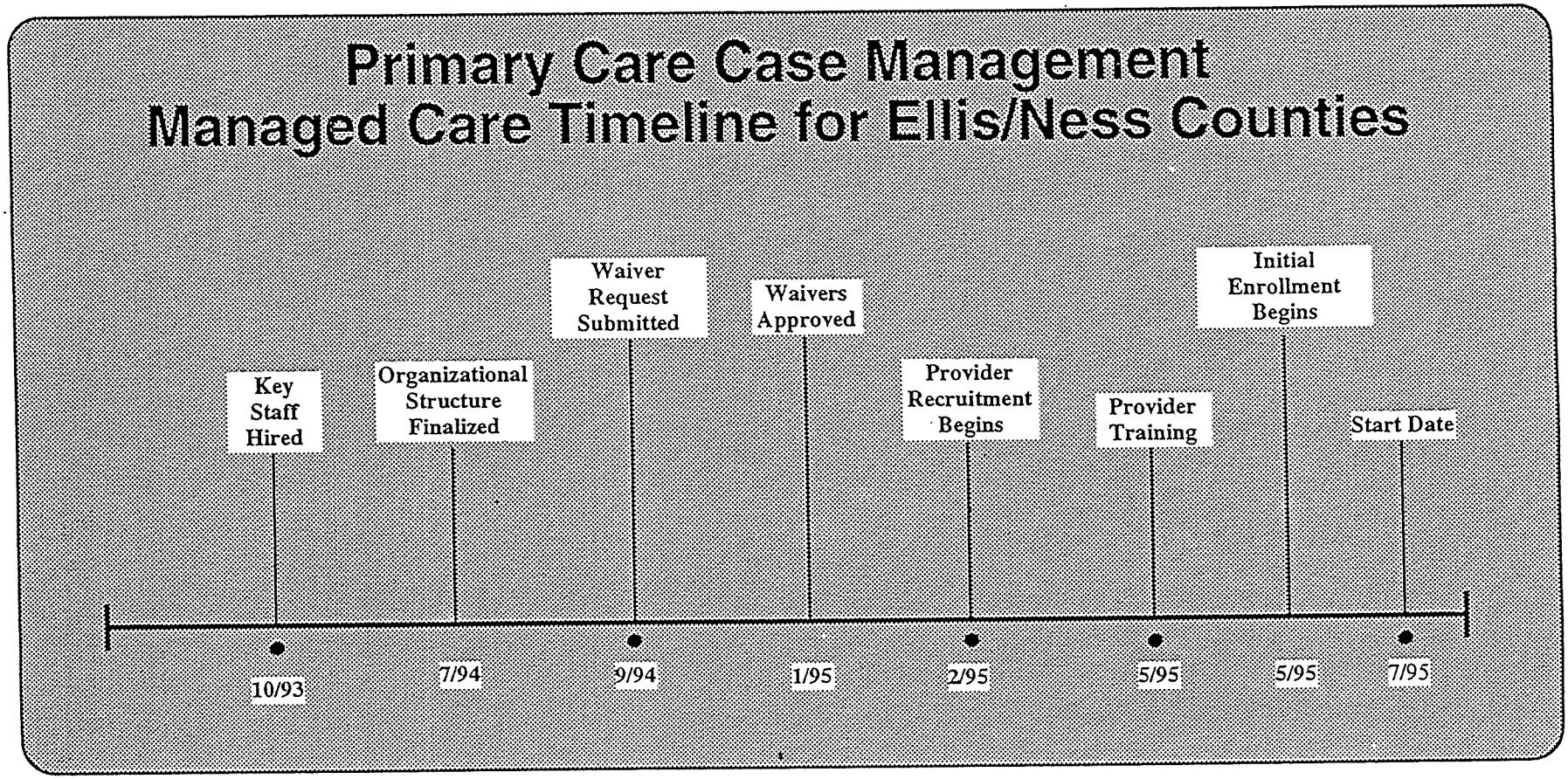
Primary Care Case Management
Managed Care Timeline for Ellis/Ness Counties



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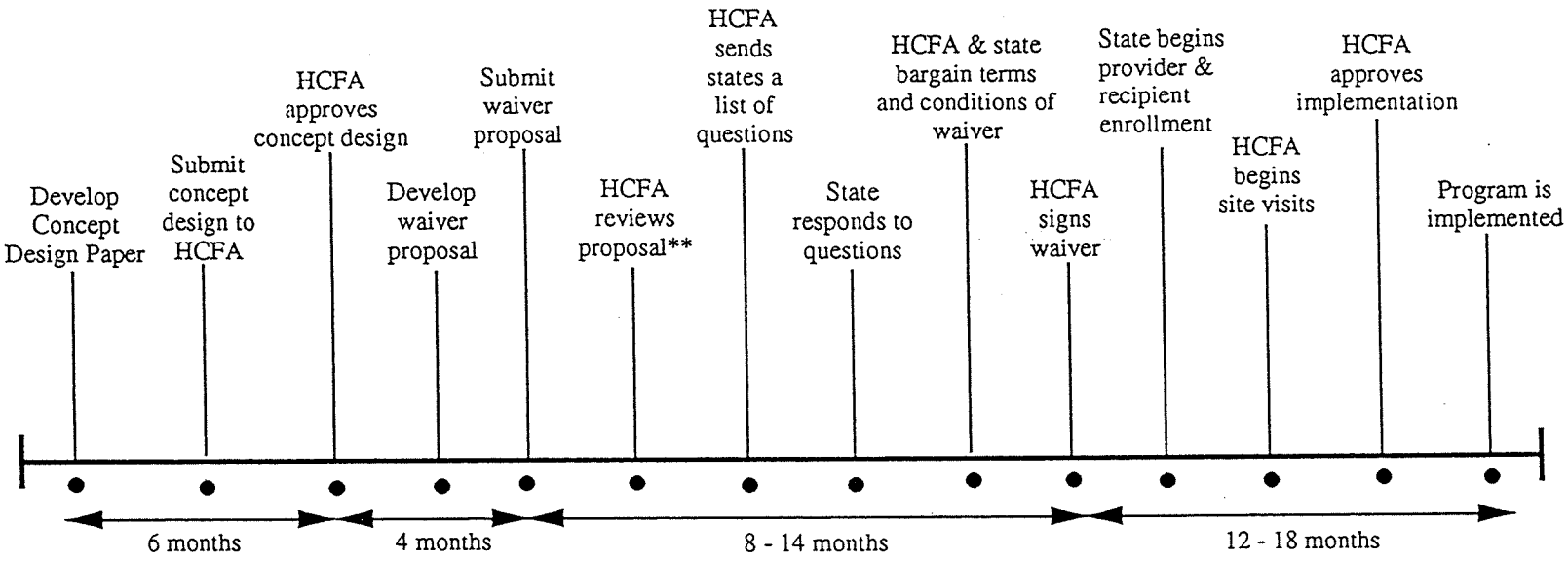
1115 Waiver
Managed Care Timeline for Sedgwick County*



*This timeline is based upon the projected Missouri 1115 demonstration waiver process.

**Length of HCFA review will vary depending upon the number of 1115 waivers already submitted. Currently, there are 12 1115 waivers that have been submitted. Several states are also currently writing 1115 waivers which will be submitted within the next six months.

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E-B

SUMMARY OF KEY FEDERAL WELFARE REFORM LEGISLATION

President Clinton's Work and Responsibility Act

- Mandates completion of an employability plan and case management services for each applicant, including teen parents. Employable adults would be expected to participate in JOBS program. States may qualify for an enhanced match rate for JOBS expenditures.

- Limits adults to 24 cumulative months of AFDC benefits unless working 20-30 hours per week.

- Requires States to operate a WORK program for adults who have reached the 24 month limit of AFDC benefits but have not found a job. Several options for the WORK program exist, including wage subsidies to for-profit employers and public service employment in communities.

- Includes teen pregnancy prevention initiative grants for primary prevention and case management programs, requires minors to live at home, and allows states to adopt a family cap.

- Increases child support enforcement efforts including simplified processes for paternity establishment and support collection, paternity outreach in hospitals, requiring parents to cooperate in paternity establishment before receiving AFDC benefits, state centralized payment center and a national child support registry.

- Coordinates more closely AFDC and Food Stamp program rules for simplification.

House Republican's Personal Responsibility Act

- Proposes deep cuts in a broad range of programs for low-income households and eliminates entitlement status of most major programs, including AFDC, Food Stamps, SSI, Child Support Enforcement, At-Risk Child Care, and low-income housing programs.

- Denies AFDC and housing benefits to children of young adult unmarried mothers for their entire childhood unless the mother marries the biological father or marries a man who adopts the child. Savings will be diverted to pay for orphanages. In addition, children whose paternity is not legally established will be denied assistance even if the mother is fully cooperating with Child Support Enforcement.

- Terminates all eligibility for AFDC after five years regardless of a family's circumstances. Limit could be two years at state option. While receiving benefits, recipients must participate at least 35 hours per week in a work program.

- Merges all food programs, such as food stamps, WIC, and the school lunch program, into one block grant with funding ceiling to be set below current funding levels.

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- Makes legal immigrants ineligible for about 60 federally-funded health, education, job training, housing, social service, and income security programs. Allows legal immigrants emergency medical care only.

Senator Kassebaum's Welfare and Medicaid Responsibility Exchange Act of 1995

- Beginning October 1, 1996, AFDC, food stamps, and WIC would be terminated, and the obligation to furnish cash and non-cash assistance would pass to the states with a maintenance of effort requirement. For five years, the federal dollars saved by the turnover of these three programs would be returned to states for use as enhanced federal match for Medicaid.

- At the end of the five year period, the federal government would assume full responsibility for Medicaid, including what had been the state's share, and no federal dollars would flow to the states for cash, food, or medical assistance programs.

- Programs maintain entitlement status for FY 1997-2001 with increases for inflation and caseload growth. Federal mandate for states to continue cash and food assistance ceases after 2001.