Approved: 1-17-96
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chair Sandy Praeger at 10:00 a.m. on January 11, 1996 in Room 526-S of the Capitol.

All members were present except:

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

Others attending: See attached list

Conferees appearing before the committee:

Thelma Hunter Gordon, Secretary, Kansas Department on Aging
James J. O'Connell, Secretary, Kansas Department of Health and Environment

Kansas Department on Aging

Thelma Hunter Gordon, KDOA, introduced her staff and briefed the Committee on past, present and future activities of the Kansas Department on Aging. (Attachment 1) Secretary Gordon noted that a transition team composed of representatives from SRS, KDOA and the area agencies on Aging have finalized a plan to transfer long-term care programs for older Kansans from SRS to Aging. The transfer will consist of three programs: (1) the Income Eligible Home Care program, (2) the Home and Community Based Service program and (3) the Nursing Facility reimbursement program. These transfers should be completed on July 1, 1997.

Committee discussion related to proposed budget reduction in the department, transfer of SRS employees to Aging, privatization of services and inspection of nursing homes.

Introduction of bills

Secretary Gordon requested the introduction of two bills. One bill would transfer the administration of the Older Kansans Employment Program from Aging to Human Resources, and the second bill eliminates the interagency coordinating council for the Senior Care Act. If the Legislature approves the proposed transfer of programs from SRS to Aging, the coordinating council will be unnecessary.

Senator Hardenburger made a motion the Committee recommend introduction of the proposed legislation, seconded by Senator Jones. The motion carried.

Kansas Department of Health and Environment

James J. O'Connell, Secretary, Kansas Department of Health and Environment, briefed the Committee on organizational changes in the agency, as well as a brief overview of long term care services, Health Care Data Governing Board, health occupations, rural health initiatives and immunizations. (Attachment 2)

Committee discussion related to credentialing, nursing home surveys, rural health grants and clinics. The Chair noted that an update on rural health initiatives and a report regarding the Health Care Data Governing Board would be on the Committee's agenda next week.

Adjournment

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

The next meeting is scheduled for January 16, 1996.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 1-11-96

NAME	REPRESENTING
Bob Williams	Ks. Pharmacists Assoc.
myrle Myers	Johnson & Johnson
Elizabeth Maxwell	ECK Area Agency on Aging
Debra Zehr	KS Assn Of Homes & Services for Aging
David Till	Zeneca Inc.
Lynne Fisher Jones	Kansas Health Care Assn
Bill Cutler	KDOA
Steve Boston	KDHE
[illegible]	KDHE
Dan Daymenberg	SRS Adult Services
[illegible]	KDHE
Brenda Barta	DD Council
Thelma Hunter Gordon	KDOA
Jayne Cullwood	KDOA
Julie Hein	Hein, Ebert & Weir
Melissa Wangemann	"
Jim Haney	DOB
Jean Krahn	KS Gskip Program
Sandy Strand	Ks Advocates for Better Care

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: _____

NAME	REPRESENTING
Kim Gottlieb	Health Midwest
Tom Bevins	Allen & Assoc.
John Peterson	Ks Governtl Consulting
Bob Harder	—
John Federico	Pete McGill + Assoc
Mike Reid	Resource Center for Ind. Living

Testimony
Senate Public Health and Welfare
January 11, 1996

by
Thelma Hunter Gordon, Ed.S.
Kansas Department on Aging

Senator Praeger and committee members, I am pleased to report today on the activities of the Kansas Department on Aging (KDOA). I would also like to give you an update on the plan to transfer some programs from the Kansas Department of Social and Rehabilitation Services (SRS) to Aging.

Undoubtedly last week you read about furloughs in our Department. Also, two weeks ago, the Associated Press began a series of articles about the Department's budget and services provided through KDOA. Governor Graves last week prevented any disruption of services for now by calling us back to work. His proposed budget for FY 1997 will allow us to continue services efficiently and effectively next year.

1995 in Review

My first year as Secretary of Aging has been busy and productive.

Among the activities we initiated last year were consumer fraud seminars. We worked with the Attorney General and the Commissioner of Insurance to conduct eight seminars across the state. The seminars went well and educated many people who are often targets of fraudulent schemes.

One of my goals as secretary has been to increase public awareness and the seminars were an effective strategy for carrying out that goal.

Another goal has been to increase the capacity of the aging network to deliver services. To that end, I visited all eleven Area Agencies on Aging during 1995 and talked with providers and consumers about their delivery systems.

The Area Agencies on Aging took the initiative in December to convene a conference on managed long term care. The Department cosponsored the conference as one means to educate the aging network on best practices in service delivery systems.

The administration of the new CARE (Client Assessment, Referral and Evaluation) program has tested the capacity of the aging network during the last year. I have attached to this testimony copies of the executive summary of the first annual report on the CARE program. With good cooperation from hospitals and nursing facilities, SRS and KDHE, we succeeded in helping 12.96% of people state-wide who were seeking nursing facility care to find alternatives.

We encountered several barriers in implementing the computer system for tracking CARE programs. Resolving problems with this automated client tracking system is one of my top priorities. I have made this problem a priority for resolution.

On July 1, 1996, the Department plans to implement a new federal reporting system known as NAPIS (National Aging Program Information System). This system requires us to collect some

new data about consumers. The Department will be publicizing the new system as we get nearer to July 1.

Transfer

SRS Secretary Chronister and I, with the help of a transition team composed of representatives from SRS, KDOA and the area agencies on aging have finalized a plan to transfer long term care programs for older Kansans from SRS to Aging. We have developed this plan with the goal of simplifying customer accessibility to services and improving service delivery. In addition, we are concentrating our efforts on making this proposed transfer "invisible" to our customers.

A copy of our proposed transfer plan for the legislature's consideration is attached to my testimony. I would like to briefly highlight the main provisions.

First, we propose to transfer three programs: (1) the Income Eligible Home Care program, (2) the Home and Community Based Service program, and (3) the Nursing Facility reimbursement program. A description of each program is attached. We do not propose to change the responsibilities of KDHE; however, we are still discussing the appropriate location of Adult Protective Services.

Second, we propose to transfer all programs on July 1, 1997. We considered other alternatives such as transferring the programs area by area or program by program; but, we agreed that

transferring all programs simultaneously would reduce confusion for our customers and administrative complexity.

Third, we propose to transfer home care services only for older adults. Home care services for younger adults will remain the responsibility of SRS, which is in the process of writing a new Medicaid waiver to serve younger adults.

Fourth, we propose to privatize home care services in phases. State staff and supervisors currently provide SRS home care services. We plan to contract for these services; however, we will phase in the contracts so that service delivery is not disrupted. The SRS Commissioner of Adult Services and I are in the process of visiting the twelve SRS area offices to discuss the transfer with staff. We have conducted this tour to ensure a smooth transfer.

Secretary Chronister and I have worked with the Governor to draft a transfer bill for your consideration which should be introduced within the next week.

Other Legislation

Besides the transfer bill, I will be asking for the introduction of two other bills.

One bill transfers the administration of the Older Kansans Employment Program from Aging to Human Resources. This October, Governor Graves consolidated the administration of state employment programs in the Department of Human Resources (KDHR) through an interagency

agreement between KDOA and KDHR. So far this arrangement has worked very well and has succeeded in making access to employment programs simpler for our customers. This proposed legislation, with your approval, would make this transfer permanent.

The other bill eliminates the interagency coordinating council for the Senior Care Act. If the legislature approves the proposed transfer of programs from SRS to Aging the coordinating council will be unnecessary.

Conclusion

Congress has not yet reauthorized the Older Americans Act or passed the FY 1996 appropriations bill for the Older Americans Act so we are uncertain about authorization and appropriations for FFY 96 and 97.

The current debate in Washington indicates a probable outcome of more flexibility with less money. We will certainly keep you informed as we know more through the 1996 Legislative Session.

Again, I appreciate your invitation to provide an update on the activities of KDOA during the past year and our future goals. I will be happy to address any questions you may have.

CARE Program Executive Summary

The Kansas Department on Aging has always played an advocacy role for aging Kansans, and a role of facilitating a cohesive effort to begin to address problems and concerns facing the consumers and providers of long term care services in the state of Kansas. The CARE program (Client Assessment, Referral and Evaluation) is supported by diverse elements of government and the long term care industry, and has become the dynamic program intended by the legislature. (See Page 30)

The CARE Program was implemented statewide on January 1, 1995. It is administered by the Kansas Department on Aging through the 11 Area Agencies on Aging, hospitals and nursing facilities.

The overall outcomes of the CARE program are: (See Page 36 and 37)

1. A consumer-friendly assessment and referral program which has been instrumental in some cases in diverting individuals to community-based services rather than nursing facility entry.
2. A better-informed public and improved knowledge by professionals of long-term care options in Kansas.
3. Ways to measure the availability and need for community-based services.
4. Fewer persons with Mental Illness, Mental Retardation/Developmental Disabilities are entering nursing facilities when they need active treatment rather than nursing facility level of care.
5. Development of a strong working relationship between the Kansas Department on Aging, the Kansas Department of Health and Environment, and the Kansas Department of Social and Rehabilitation Services, Area Agencies on Aging, nursing facilities, hospitals and providers of community-based services.
6. A strongly-expressed interest and commitment by all entities to the development of community-based services and a long-term care system in Kansas.
7. Increased "advance planning" by individuals and families for long-term care for themselves and their loved ones. This has been documented by a significant increase in the number of information and assistance requests received at the Area Agencies on Aging.
8. An increased commitment to community outreach for the purposes of education to create awareness of the need for assessment prior to nursing home admission.

Background (See Page 2)

The U.S. Congress passed a law (called PASARR) in 1989 which ensures that individuals with severe mental illness, mental retardation/developmental disabilities who need active treatment receive appropriate targeted psychiatric services in appropriate care settings. Kansas responded to this law by requiring screening by the Kansas Department of Social and Rehabilitation Services, of all persons entering nursing facilities after January 1, 1989 for mental illness, mental retardation/developmental disabilities. In the spring of 1994, the Kansas Legislature adopted House Bill No. 2581, which repealed and replaced Section "1a" of K.S.A. 39-931, repealed K.S.A. 39-966 and established K.S.A. 39-968. H.B. 2581 created the CARE Program (Client Assessment, Referral and Evaluation) to be administered by the Kansas Department on Aging (KDOA) beginning January 1, 1995. (See Page 4)

Program Development

Development of the program included formation of the CARE Oversight Council, required by H.B. 2581, and coordination with the Health Care Data Governing Board of Kansas in the development of assessment forms for screening individuals contemplating entering a nursing facility. Reduction of the length of the assessment form was identified as a priority, along with the establishment of the goals of the program. The purposes of the program identified by the Legislature are "collection of data and individual assessment and referral to the community-based services and appropriate placement in long-term care facilities." (See Page 4)

Rules and Regulations, K.A.R. 26-9-1, were adopted by the Legislature effective January 1, 1995. Program training manuals for Level I and Level II processes, were written. Forms for reporting, release of information forms and the CARE Certificate were developed. The CARE Certificate, when completed by the Level I CARE Assessor, becomes the individual's "Proof of PASARR" establishing that they have had a Level I assessment and may enter the nursing facility of their choice if they do not require a Level II assessment. (See Page 12) If the individual is identified as mentally ill, mentally retarded or developmentally disabled, they are referred to Health Management Strategies International, Inc. (HMSI) for Level II Assessment prior to nursing facility entry. HMSI is the contractor for administration of Level II Assessments and Annual Resident Reviews.

Qualifications for a Level II assessment are a diagnosis of mental illness with more than one hospitalization in the past two years, or intense outpatient services; or a diagnosis of mental retardation with documentation of an IQ score of 70 or below or a related condition which limits "normal" life functions.

CARE Training Manuals - Level I and Level II (See Page 7 through 14)

Level I Training Manuals were written, reviewed and printed prior to initiation of the CARE Program assessor training. Sixteen training sessions for Level I assessors were conducted from September through December of 1994. An additional eleven trainings were conducted January through June.

Level II Training Manuals were completed in July of 1995 and training of 50 Level II assessors began in August, 1995.

Level I assessor trainings and pilot programs were initiated in September of 1994. Northeast Kansas Area Agency on Aging and Johnson County Area Agency on Aging agreed to pilot the Level I assessments and initiate use of the CARS data collection system. (See Page 15)

The Kansas Department on Aging created a team of trainers from KDOA, the Kansas Department of Health and Environment and the Department of Social and Rehabilitation Services who trained 1,242 CARE assessors between September and December of 1994. Ongoing assessor training has produced 478 additional assessors for a total of 1,720 Level I CARE assessors (September, 1994 through July, 1995) who are Area Agencies on Aging contractors, hospital discharge planners, nursing facility

licensed nurses/social workers, or SRS case workers. It is estimated that 41% of the Level I CARE assessments are performed by AAAs, 48% by hospital assessors, 8% by SRS workers and 3% or less by nursing facility personnel. It is projected that 13, 464 Level I CARE assessments will be completed in year one of the program.

Level II assessor training was initiated in August of 1995. Fifty assessors were trained in cooperation with HMSI (Health Management Strategies International, Inc.) There were 1,496 Level II assessments performed from January through September 1995, at an average cost of $104.81. This is a comparative saving of $20.19 per assessment or a potential saving of $46,467.50 per year. (See Page 38)

Level I Assessor training was expanded to include provision of two "UPDATE" CARE assessor trainings in each AAA area during year one. The additional two to three hour training was to enhance the level of knowledge about referrals to community based services available locally, and to increase the knowledge base of the Level I assessor regarding identification and referrals for persons with serious mental illness, mental retardation, or developmental disability.

An equitable and smooth-functioning internal procedure for the appeal process which allows individuals "due process" rights regarding Level I and Level II CARE determinations has been developed by KDOA.(See Page 32)

Data Analysis (See Page 38)

The first nine months of 1995, the cost of the CARE Level I and Level II program, including all training, administration, travel, rent for Docking State Office Building offices, salaries and benefits, and printing (excluding the ***Explore Your Options*** guide) was $819,964. Average cost per Level I assessment (approximate) $55 and a firm $125 for each Level II assessment, and $90 for each Annual Resident Review. Annual Resident Reviews of all previously identified individuals with mental illness, mental retardation or developmental disabilities are required by PASARR regulations. Of the 1,496 Level II assessments, there were 906 Annual Resident Reviews and 590 Level II Preadmission Assessments. The CARE program has seven full time employees. Total salaries and wages expended January 1 through September 30, 1995 was $101,438. KDOA and SRS have developed and signed an Interagency Agreement detailing responsibilities of each agency in the implementation of the CARE program.

Building Public/Private Partnerships (See Page 22-29)

Area Agencies on Aging (AAA) in Kansas are key players in the assessment and referral of individuals to community based services which will enable them to remain in their homes or to seek assisted living accommodations rather than entering a nursing facility. Kansas is divided into eleven Planning and Service Areas (PSA=AAA). Each AAA has a single point of contact person, the CARE Coordinator, who may be a full or part-time employee. The CARE Coordinator is responsible for receiving, assigning, review and oversight of all Level I CARE assessments performed in their AAA. Quarterly meetings of the CARE Coordinators, plus telephone conference calls (if needed) enhance the

communication between KDOA and the AAAs. A CARE Newsletter, "Partners for CARE," is published quarterly, and is a direct link to all CARE assessors and functions as a training/communication update for all CARE assessors. (See Page 26)

An activity initiated by the CARE Program is Community Outreach Seminars conducted in each Area Agency on Aging area during year one. These twenty-two meetings across the state were designed to inform and offer assistance and referral to individuals seeking information regarding long-term care services in their own home areas for themselves or for their loved ones.

Program Performance and Analysis (See Page 30)

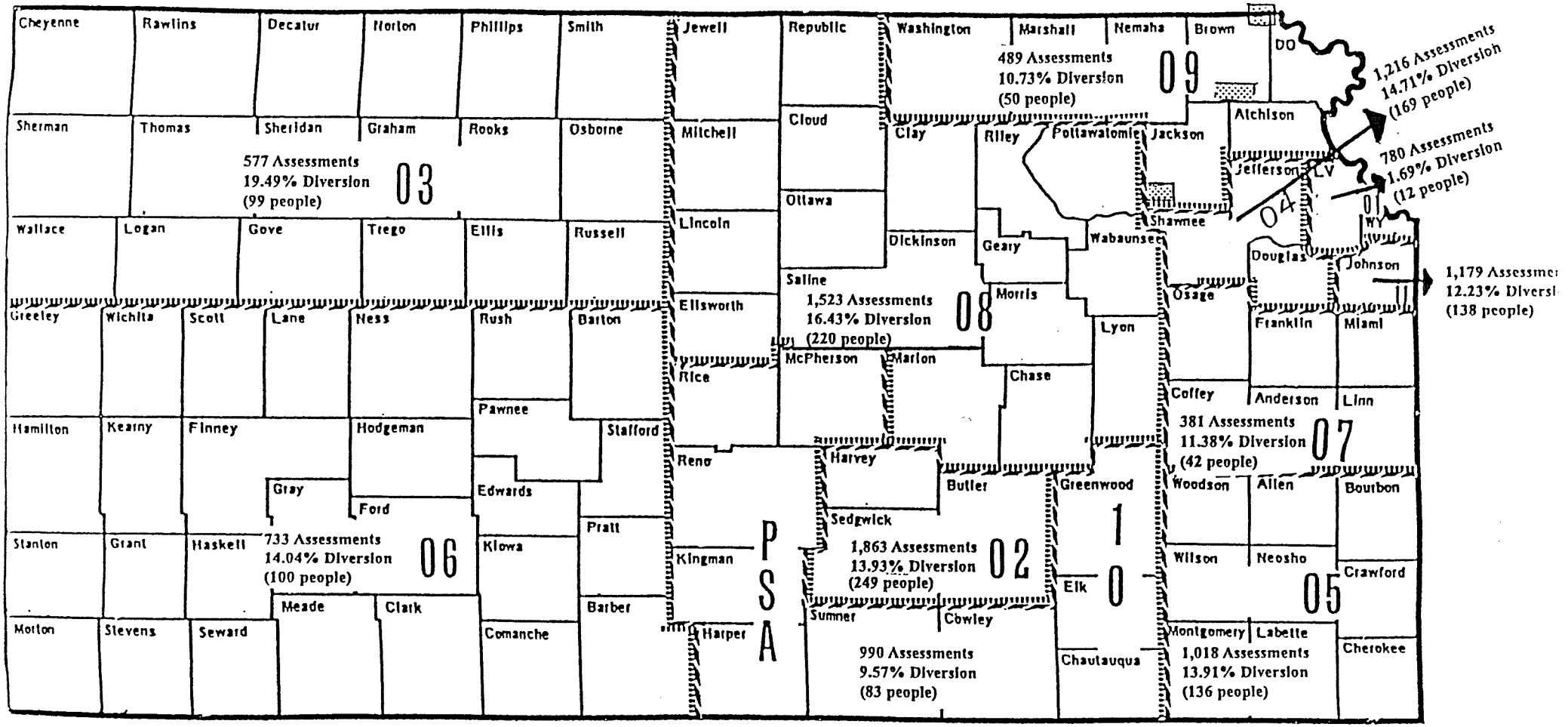
The CARE Program demonstrated a dynamic and flexible response to problem solving by initiating changes in processes, forms, manuals, training and communication procedures. Each problem was identified, addressed and analyzed by CARE Program staff. (See Page 30-35)

As one response to problem solving and program improvement, the CARE Coordinators and Area Agencies on Aging executive directors have participated in the development of a "Draft" CARE Quality Assurance Plan which will be finalized in January 1996. (See Page 35)

Future Directions

Future directions, in addition to ensuring appropriate placement of individuals and collecting data on unmet community-based services needs, includes continued emphasis on increasing public awareness of community-based long-term care options, creation of technical assistance packages to facilitate the development of community based long term care services by the private sector, and implementation of the CARE Quality Assurance Plan. (See Page 40)

CARE Program Diversion* Information
January 1 — September 30, 1995



PSA 01 — Wyandotte-Leavenworth County Area Agency on Aging
PSA 02 — Central Plains Area Agency on Aging
PSA 03 — Northwest Kansas Area Agency on Aging
PSA 04 — Jayhawk Area Agency on Aging
PSA 05 — Southeast Kansas Area Agency on Aging
PSA 06 — Southwest Kansas Area Agency on Aging
PSA 07 — East Central Kansas Area Agency on Aging
PSA 08 — North Central/Flint Hills Area Agency on Aging
PSA 09 — Northeast Kansas Area Agency on Aging
PSA 10 — South Central Kansas Area Agency on Aging
PSA 11 — Johnson County Area Agency on Aging

*Diversions are those who are in the community with services 30 days after the initial assessment. Diversion rate is calculated and based on completed follow-up calls. Diversion does not include those at home with no services.

INCOME ELIGIBLE HOME CARE PROGRAM
OVERVIEW

PURPOSE:

The SRS Income Eligible Home Care Program is designed to provide services to individuals 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 institutionalization. Recipients in this program have their needs assessed utilizing the Kansas Preadmission Assessment and Referral Instrument (KPARI) and must meet the program's financial guidelines. Individuals receiving services through this program may or may not be Medicaid-eligible.

SERVICES:

- Non-medical Attendant Care
- Case Management
- Homemaker

FUNDING:

Funding for the Income Eligible Home Care Program is entirely dependent upon Social Service Block Grant Funds (SSBG) and State General Funds (SGF). When shortfalls occur in the funding, waiting lists for services are created.

ELIGIBILITY CRITERIA:

- Personal and medical need
- Monthly income at or below 150% of poverty level
- Availability of service providers
- Budget constraints
- 18 years of age or older

Contact: Maryann Benoit
Manager, HCBS/NF and
Income Eligible
913-296-3981

MXB/dlt
12/16/94

HCBS
GENERAL OVERVIEW OF WAIVERS

PURPOSE OF THE WAIVER:

United States Congress has enacted Section 2176 of Public Law 97-35 of the Social Security Act, entitled the Omnibus Budget Reconciliation Act. Through this enactment certain statutory limitations have been waived in order to give states which have received approval from the Department of Health and Human Services the opportunity for innovation in providing cost-effective home and community-based services (HCBS) to eligible persons who would otherwise require institutionalization in a nursing facility (NF), hospital or intermediate care facility for the mentally retarded (ICF/MR). Kansas currently has approval to operate four such HCBS waivers.

DESCRIPTION OF WAIVERS:

* **HCBS/NF** - This waiver was designed to provide various community-based services to Medicaid-eligible individuals who have a medical need for nursing facility care. This waiver became effective in July of 1982. Recipients must be 16 years of age or older and disabled, or be 65 years of age or older. In FY 1994, 2468 persons were served on this waiver at an average monthly cost of $639.00 per month. Comparatively, the same individual in nursing facility care costs $1,135.00 per month.

Cost-effectiveness must be maintained in order to continue providing waived services. Rising acute care costs and serving individuals whose plans of care exceed the established cost cap of $1,445/month are creating concerns that the overall cost-effectiveness of the waiver may be jeopardized. Reducing reimbursement rates for acute care services such as pharmacy and medical and eliminating the availability of granting exceptions to the cost cap rule will have to be considered in any plans to increase the margin of cost-effectiveness between HCBS and institutional care.

* **HCBS/HI** - This waiver was designed to provide various community-based services to Medicaid-eligible individuals who have traumatically acquired, nondegenerative, structural brain damage resulting in residual deficits and disability, who without these services would require institutionalization in a head injury rehabilitation facility. This waiver became effective in July of 1991. Recipients must be 18 to 55 years of age. As of June 1994, 75 persons were being served on the waiver at an average monthly cost of $3,500 per month. Comparatively, the same individual in a rehabilitation facility costs $7,620 per month.

All recipients served by this waiver must utilize Transitional Living services and must show progress in Transitional Living Skills.

* **HCBS/TA** - This waiver was designed to provide various community-based services to Medicaid-eligible individuals who are ventilator-dependent, or require total parental

nutrition or a similar condition to sustain life and who without these services are at imminent risk of institutionalization in an acute care facility. This waiver became effective in March 1991. Recipients must be under 16 years of age. As of June 1994, 27 persons were being served on this waiver at an average monthly cost of $41,127 per year. Comparatively, the same individual in an acute care facility costs $92,671 per year.

* **HCBS/MRDD** - This waiver was designed to provide various community-based services to Medicaid-eligible individuals who, based on the outcome of the DDP screening process, meet the criteria for ICF/MR level of care and who without these services would be eligible for placement in an ICF/MR facility. This waiver became effective in July 1991. Recipients must be 5 years of age or older. As of June, 1994, 1497 persons are being served on this waiver at an average annual cost of $17,952. Comparatively, the same individual in an ICF/MR facility costs $49,310 per year.

MMZ:csl
12/16/94

NURSING FACILITY OVERVIEW

Purpose:

The purpose of nursing facilities (NF's) is to provide health care and related services to individuals requiring round-the-clock care in an institutional setting rather than in their own home. Individuals receiving services in a nursing facility require ongoing observation, treatment or care for long-term illness, disease or injury.

Services:

The services offered in a nursing facility may include, but are not limited to, skilled nursing care and related services, specialized rehabilitation services, therapy (to include physical, speech, occupational and psychological services), medically related social services, pharmacy services, dietician services, meaningful activities program, assistance with daily living skills, and home & community-based services; in some instances, such as respite, adult day health and day care.

Eligibility Criteria:

There were 12,747 consumers in a Medicaid participating facility beds in August, 1995 out of approximately 29,000 Medicaid-certified nursing facility beds. The criteria for an individual to be eligible for financial assistance in a Medicaid participating facility are:

- Medicaid/MediKan - (This determination of eligibility is made by SRS Economic Assistance staff through local SRS offices.);
- Require services listed above;
- Ongoing observation, treatment or care required; and,
- 16 years of age or older.

PASARR and C.A.R.E.:

Pre-Admission Screening and Annual Resident Review (PASARR) was a provision of OBRA '87, and requires pre-admission screening and annual review of the need for admitting or retaining individuals with mental illness or mental retardation in NF's that are certified for Medicaid. SRS is ensuring that all persons seeking admission to NF's are in compliance with the PASARR provisions, regardless of program eligibility or payment source by incorporating the PASARR questions in the Client Assessment and Referral Evaluation (CARE) instrument.

Kansas state law requires that "each individual prior to admission to an NF ... receive assessment and referral services." To achieve this, the CARE program "for the data collection and individual assessment and referral to community-based services and appropriate placement in long-term care facilities" was created. Implementation and oversight of the CARE program rests with the Kansas Department on Aging (KDOA).

Reimbursement:

The Kansas Department of Social and Rehabilitation Services (SRS) reimburses nursing facilities using a cost-based, facility-specific, prospective payment system. The allowance for health care costs is adjusted for the residents' characteristics as determined by a uniform assessment instrument called the minimum data set plus (MDS+). The August, 1995 postpay report indicates that the NF average daily rate was at $62.94 per day. A statewide average of 21.1% of that amount (or $13.25) is the responsibility of the Medicaid resident in the NF. Once the resident liability is backed out, the average daily rate paid from all-state dollars and federal financial participation dollars is $49.69 per day.

Case Mix Demonstration:

Kansas applied for and was selected to participate in the Multistate Case Mix Reimbursement and Quality Demonstration Project in July, 1989. The primary goal of the demonstration in Kansas has been to evaluate the impact of various components of a case mix payment system for the Kansas Nursing Facility Program on the quality of care of the residents.

Nursing Facility Services Are Provided By:

NF services are provided by facilities meeting Medicaid certification standards and offering the appropriate level of services. Currently there are only seven (7) freestanding nursing facilities in Kansas not participating in the medicaid program.

Survey and Certification Process:

Before SRS can enroll a nursing facility or nursing facility-mental health in the Medicaid program, it must be licensed and certified by KDH&E. Medicaid certification is based on meeting the federal standards of participation. There is currently an interagency agreement between the Department of Social and Rehabilitation Services (SRS) and Department of Health and Environment (KDH&E). Its purpose is to provide an active working relationship with the Adult & Medical Services Commission, and the Commission of Mental Health and Retardation Services (MH/RS) regarding the certification requirements of adult care homes for participation in the Medicaid program.

A key component of the agreement is that KDH&E will make on-site inspections with qualified personnel at flexible intervals not later than 15 months after the date of the previous survey with an annual statewide average of no more than 12 months. KDH&E is responsible for notifying SRS of the outcome of those surveys.

Currently K.A.R. 30-10-2(c) requires all licensed beds in a Medicaid participating facility to be certified. In other words, a facility that has 75 licensed NF beds would also be certified for 75 Medicaid beds.

CEM:csl--09/14/95

SRS/KDOA LTC TRANSITION PLAN
FINAL RECOMMENDATIONS

Opening Statement

Regarding the proposed "cost-neutral" transfer of programs providing services to the frail or vulnerable older adult citizens of Kansas from the auspices of Social and Rehabilitation Services to the Kansas Department on Aging, it is the goal of both agencies to minimize the impact of this transfer on current consumers (to make this transition "invisible" to clients and consumers of services provided for adults).

Sometime in the future, however, we envision the following changes:

*Creation of a single point-of-entry for services for adults, with support and guidance, rather than multiple assessments for multiple service needs.
*Improved access for consumers.
*Consolidation of funding sources to facilitate service delivery.
*The use of private and local services whenever possible rather than state agency as provider.
*Placing information and referral all in one program.
*Minimizing confusion about diversity of services and programs available.
*Eliminating duplication.
*Increasing consumer choice regarding how services are provided and what services are needed. Enhancing consumer autonomy.
*Basic restructuring of the service delivery model.
*Increasing an advocacy role and strengthening the Ombudsman role.
*On all levels, to re-create the system to better fit with and meet consumer needs.

This document presents a plan which reflects the work of a committee of staff representing our two agencies. The plan incorporates public input from both written comments and testimony presented in public hearings across the state. The Secretaries used the work of the committee and input from the public at large as a basis for further negotiations to resolve a variety of issues raised in the transfer of these important services from one department to the other.

General Agreements

The respective representatives have agreed:

1. That it is the stated goal of both SRS and KDOA that this transfer of programs and period of transition will be conducted in such a manner as to cause the least possible disruption to consumers (i.e. an "invisible" transfer from the consumer's perspective).

2. That a commitment will be made in this transfer process to maintain the expertise and experience of current service providers (i.e., SRS staff and Medicaid providers currently delivering services and managing programs,) by transferring that experience to the private sector to the extent possible.
3. That both agencies and the Area Agencies on Aging recognize and respect the high quality services provided by dedicated employees in these agencies. This valuable experience will be retained and utilized post-transition in the private sector to the greatest extent possible. The Secretary on Aging will have the authority to contract with AAA's or other agencies for delivery of services. Both SRS and KDOA will ensure that staff responsible for delivering services and administering programs will be adequately trained. KDOA will look first to available SRS staff affected by the transfer to meet service demand, and encourage their providers to do likewise.
4. That the Kansas Department of Social and Rehabilitation Services (SRS) and the Kansas Department on Aging (KDOA) will negotiate an interagency agreement as needed to insure continued Federal Financial Participation (FFP) related to the transition of Medicaid programs. SRS, as the single state agency, retains the ultimate authority and responsibility for the federal Medicaid funding expended on these programs, until such time as federal laws allow for other options. However, it shall be clear that KDOA is responsible for program and policy administration, and the fiscal responsibility of managing these programs. If changes in Federal law or allocation procedures were to be enacted, contracts between the two agencies would be renegotiated appropriately in light of the changes, maintaining the spirit of the transfer.
5. That the manner of service delivery will begin with privatization of service provision immediately. In this spirit, SRS has encouraged their direct service staff (LTC workers) to obtain certified nurse aide and home health aide certification in fiscal year 1996 to help ensure employability in the private sector.
6. That the transfer to KDOA from SRS of the Income Eligible Home Care Program (IE) for adults aged 60 and over, the Medicaid Home and Community Based Nursing Facility Waiver Program (HCBS/NF) for adults aged 65 and over, and the Medicaid Nursing Facility Program (NF) will be effective July 1, 1997. All programs will be transferred at the same time.
7. That resources (monetary and staff; staff determined as "full time equivalents or FTE's as determined by the REST study) will be fully available to transfer to KDOA at that time.
8. That SRS will continue to provide Medicaid operations (contracts, interagency agreements, state plan, etc.) support to KDOA until such time that resources are identified and transferred to KDOA or obtained by another means. SRS will continue to be responsible for and provide administrative hearing processes/services related to Medicaid appeals by both providers and consumers. If changes on the Federal level were to eliminate the requirement of a single state Medicaid agency, it might be possible to transfer some of this responsibility to KDOA. It is also agreed that Medicaid Management Information System (MMIS system) for Medicaid reimbursement that will be in place at the time of transfer within SRS will be utilized for all Medicaid claims payment. A KDOA liaison will be appointed to coordinate MMIS reporting needs and medical policy decisions

related to providers, and insure regulatory compliance. SRS will continue the existing contract.

9. That KDOA will create, prior to transfer, an ongoing communication mechanism between KDOA and the SRS Income Maintenance Policy Division at central office and local levels.
10. That prior to transfer, and no later than January 1, 1997, a plan for alignment and allocation of resources to be transferred from SRS to KDOA will be determined jointly by KDOA and SRS. Consideration will be given to existing caseloads; physical plant capacity; data processing and training capabilities; current location and housing of both KDOA/AAA and SRS programs, offices and staff. The Secretary of SRS shall announce all positions affected by the transition plan no later than February 1, 1997.

Program Specific Agreements

Income Eligible Home Care Program:

*To the extent that this funding is not merged with the HCBS/PD or HCBS-NF waiver programs, SRS transfers full responsibility for administration of the remaining income eligible program, full remaining resources of program, remaining caseload and waiting lists to KDOA without imposing any specific rules or regulations in regard to income. Upon transition, IE program services will be provided only to those individuals who would not be eligible for HCBS services under the proposed changes to the eligibility standards for both the HCBS/NF and HCBS/PD programs.

*KDOA will be responsible for developing and maintaining any necessary management reports and claims payment reports necessary for the administration of this program.

Home and Community Based Services/Nursing Facility Waiver Program (HCBS/NF):

*Prior to transition, the HCBS/NF waiver will be amended to exclude, to the extent that development and implementation of an HCBS/PD waiver will meet service needs, any individual under age 65. (Although Older American's Act and the Senior Care Act programs serve people 60 and older, current Medicaid regulations would require the HCBS/NF and HCBS/PD waivers to split at age 65.) **Note: Should the HCBS/PD waiver be denied as a result of current Medicaid rules or Medicaid reform (Medigrants), administration of programs and services for individuals under the age of 65 will remain in SRS.**

*That HCBS/NF service delivery will maintain the option of consumer directed attendant services through the Independent Living Centers.

*That after July 1, 1997, KDOA is responsible for development of all HCBS/NF waiver renewals, reviews, amendments, cost-effectiveness reports and/or applicable state plan changes, rules and regulations as applicable for people aged 65 and over. SRS will be responsible for timely submission of above to HCFA.

*With regard to client obligation: case managers will continue to collect HCBS obligations and deposit such payments to an identified state general fund account through established accounting procedures as designated by KDOA.

*If the Medicaid State Plan is amended to include targeted case management for the frail elderly, administration of this Medicaid service will be the responsibility of KDOA. Other Medicaid Primary and Acute Care services still remain within SRS administration and budget.

Nursing Facility Program (NF):

*That full administration, including promulgation of rules and regulations, and responsibility for the NF program is transferred, excluding Intermediate Care Facilities/Mentally Retarded ICF/MRs) and Nursing Facilities/Mental Health (NF/MHs) facilities.

*That KDOA will designate a liaison to develop necessary responsibilities for survey and certifications to be performed by the Kansas Department of Health and Environment (KDHE) with inter-agency agreement through SRS.

*That KDOA will assume responsibility for case-mix demonstration project and rate setting responsibilities, and any contracts and funding tied to these responsibilities.

*That existing NF litigation not resolved by July 1, 1997, will become the responsibility of KDOA, and SRS will ensure appropriate legal resources will be transferred.

Recommendations for Special Teams to be formed to report findings to the Long Term Transition Team:

*Resource Identification Team: To survey infrastructure support services to determine the total resources critical to successful transfer. Will include fiscal staff from both agencies. A preliminary report is due by February 15th, 1996. Coordinators: Karen Hawk and Alice Knatt.

*Legal Team: To study rules and regulations, policies and statutes that will be affected by or impact upon the transfer, and determine appropriate regulatory and statutory changes needed. Meetings for the Legal Team will begin immediately. A preliminary report is due Nov. 15th, 1995. Coordinators: Elaine Wells, John Badger, Jack Rickerson and Lyndon Drew.

*Financial Eligibility Team: To explore various models of financial eligibility processing and service authorization. The full spectrum of options will be considered by this team on an on-going basis, including post-transition. This team will begin meetings before July 1. Coordinators: Dennis Priest, Maryann Benoit and Bill Cutler.

*Data Processing Team: KDOA and SRS to jointly develop a final report before 4/1/96 on data processing capability capacity by county. Report will include details for CARS, SHARP,

MMIS, and other relevant systems. Coordinators: Alice Knatt, Sandra Hazlett, Tim Blevins and Tim Swietek.

*Allocation Team: To develop plan for alignment and allocation of resources to be transferred from SRS to KDOA, determined jointly by KDOA and SRS. Consideration given to existing caseload, physical plant capacity, data processing capabilities, current location and housing of SRS programs, offices and staff. A final report is due no later than January 1, 1997. Coordinators: O. D. Sperry, Dona Booe, Jack Rickerson, Alice Knatt and Denise Clemonds.

Service Systems Team: KDOA shall create a team which includes at a minimum representatives of AAA staff, Independent Living Centers and Home Health Agencies, that will establish and define the service delivery systems for July 1, 1997 and beyond. The proposed plan must be available for public comment by July 1, 1996. The team will begin to meet no later than February 1, 1996. Current SRS staff with knowledge and experience of the existing system will be utilized as a resource for this process. A subcommittee of this team (Denise Clemonds, Jayne Aylward and Elaine Wells) will identify an implementation plan for privatization. Coordinator: Lyndon Drew

*Interagency Agreement Team: SRS shall create a team to draft the necessary interagency agreement with KDOA to allow for the transfer of program administration. The interagency agreement will outline the administrative and fiscal responsibilities of both agencies in regard to the transition. The team will start meeting by no later than no later than March 1, 1996. Coordinators: Ann Koci, Sandra Hazlett, John Badger, Joe Kroll, and Jayne Aylward.

In presenting this report, the Secretaries of SRS and KDOA give special recognition to the Transfer Working Group Team who identified many of the policy issues raised in the transfer, and to members of the public who took the time to prepare comments or attend the public hearings.

Transfer Working Group Team:

SRS:	Dona Booe	KDOA & AAA:	Bill Cutler
	O.D. Sperry		Jayne Aylward
	Verlene Kunz		Lyndon Drew
	Julie Lemons		Denise Clemonds
	Bill McDaniels		Irene Hart
	Kip Lee		Jane Taul
	Dennis Priest		Mike Brooks
	Bill Pickering		Alice Knatt
	Elaine Wells		
		KDHE:	Joe Kroll

January 10, 1996

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State of Kansas

Bill Graves Governor

Department of Health and Environment
James J. O'Connell, Secretary

Testimony Presented to

Senate Public Health and Welfare Committee
by

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

OVERVIEW OF AGENCY

I appreciate your invitation to address the members of the Committee on behalf of the Department of Health and Environment. I want to first extend greetings to you on behalf of Dr. Steve Potsic, our Director of Health. Copies of the agency's Annual Report have recently been distributed to members of the legislature. I hope you find that it provides a concise, but useful, overview of the Department's activities. I won't take the limited time available today to review that material, but would prefer to focus on some specific areas where I think this committee and KDHE share interests and, perhaps, some concerns.

Organizational Changes in KDHE

The attached organization chart reflects some changes in staff support functions and some changes in the Division of Health. I'd like to focus on two of the latter changes:

1. Consolidation of the Bureau of Family Health with the Bureau of Children, Youth and Families. The Bureau of Family Health administered the Women, Infants and Children nutrition program. Consolidation has reduced the number of bureau directors by one and has allowed more effective use of management staff, without reducing services to program participants. Priorities in the WIC program now focus on expediting automation of the program for both local health agencies and vendors and on streamlining the contracting and documentation functions within KDHE and locally.

2. Dr. Potsic has advocated and I have supported establishment of an Epidemiologic Services staff function reporting to the Division Director and providing services throughout the Division. Under the direction of Dr. Pezzino, this function was developed using existing personnel resources. It is expected to better assist the Director in areas of internal quality assurance, epidemiologic studies, validation of protocols, and outbreak investigation. More effective and responsive coordination and communications with the Division of Environment can be achieved with epidemiologic services reporting directly to the Director of Health rather than a Bureau

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Director.

We are continuing to evaluate other organizational changes within the Division as well as throughout the agency.

Long Term Care Services

Assisted living regulations are in the final stages of development. The Bureau of Adult and Child Care has solicited and obtained a great deal of industry and consumer input to the regulations and the initial drafts have undergone a good deal of revision. The draft I reviewed last week seemed very much on target with the intent of Senate Bill 8, that is to develop a less costly alternative to nursing home care while assuring protection of the health and safety of the residents.

In a related area, we have already experienced significant reductions in HCFA funding for Medicare surveys. Despite these reductions HCFA had not been willing to act on requests for modifications in their survey priorities and requirements. The Bureau of Adult and Child Care was unable to adjust its assignment of resources and was also faced with a growing backlog of applications for initial Medicare surveys, including hospice services and rural health clinics. We have therefore revised our systems of prioritization and begun performing initial surveys, notifying HCFA of the change. No negative response from HCFA has yet occurred. This problem is significant because we do not expect HCFA funding of the Medicare contract for survey services to improve.

Though not directly related, we are working on revisions to the hospital licensure and risk management services to consolidate and streamline these services. Our goal is to try to regularize surveys of smaller non-accredited hospitals for both licensure and risk management. I believe that this can be achieved without assessing a fee to these approximately 80 small hospitals if funding that has supported the risk management program is maintained on a firm basis.

Facilities that are accredited by the Joint Commission on Accreditation of Health Care Organizations or the American Osteopathic Association are deemed qualified for licensure and this will continue. Therefore on-site licensure surveys are not required for these generally larger facilities.

The OBRA 1987 nursing home survey regulations became effective in July, 1995 and have presented major implementation difficulties nationwide. A great deal of agency staff time and provider staff time has been invested in training and attempting to work with the new system. Attempts by provider groups at the national level to have the regulations withdrawn for a major overhaul have not been successful. We look for some fine tuning but no major change by HCFA. The major problem with

the system is its restriction of the judgment and discretion of the professional nurse surveyors and the lock step approach to sanctions and remedies. For example a finding of substandard care currently requires a two year suspension of approval of the facility as a training site for CNAs, even if the deficiency is unrelated to training capability and even if the deficiencies are corrected within days after the survey. This certainly does not contribute to the ability of the nursing home providers to train the qualified people they need to provide good care. We have submitted proposed changes for our

programs in Kansas, but have not yet had a response. In the interim, we will grant exceptions to this exclusion where this facility develops an affiliation agreement as a clinical training site with a vocational-technical school, another nursing home with an approved program, or other approved education provider.

Health Care Data Governing Board

As chairman of this board, I'm pleased to report that the Board has set some very clear and important directions and is moving steadily toward significant accomplishments. The work of the board and the related KDHE staff have produced information for a health information resource directory available to educational and research institutions, businesses, the public and state government. Health occupations personnel have been inventoried, including specialties, distribution throughout Kansas and other relevant information. We plan to provide periodic reports and analyses to members of the legislature for the different health occupations and we are available to research health data needs for you.

Probably the most significant accomplishment in the past year has been the board's adoption of a strategy to identify and track specific health status indicators for Kansas. Great cooperation and support in this effort has come not only from board members, but also from the provider organizations--the Kansas Medical Society, Kansas Association of Osteopathic Medicine and the Kansas Hospital Association. Tracking these indicators over time can provide for analysis of the impact of health delivery and financing systems and the effects of health policy and legislation. In the longer term, this form of health care data analysis can be very useful in health policy revisions and new initiatives since it will allow for better prediction of results. I want to note here that this effort is separate from KDHE's work on the Insurance Statistical Data effort, which is separately funded and is intended to provide the Insurance Commissioner with information needed to carry out the Insurance Department's regulatory functions. While we hope to "spin off" some data for health status indicator purposes, this will have to have be done with proper safeguards against inappropriate disclosure and with careful separation of expenses, since these are not properly chargeable to the Insurance Statistical Data assessment funds.

Health Occupations

KDHE credentialing staff, under the leadership of Lesa Bray, is initiating a review, in conjunction with a number of other agencies dealing with health occupations, to review requirements for entry level training and the relationship to career ladder opportunities for persons at the entry level. We believe a review that includes input from educators, the professions and health occupations employers can help identify needs and barriers, can help eliminate the barriers and can encourage pursuit of health occupations as a career.

In a related area, discussions continued since the last session of the Legislature dealing with scope of practice changes. Dr. Potsic presented testimony to the Special Committee on Public Health and Welfare in September on this subject. We believe that scope of practice questions can and should be addressed through a mechanism different from KDHE's new occupations system. One that can be

more streamlined since it would deal with modifications to the scope of already established health occupations. If the Legislature feels it would assist their decision making, the concept of a broad based advisory group, with representation from licensing boards, practitioners, educational institutions with health occupations programs and members of the community should be considered. It could be employed when scope of practice related statutory and regulatory issues involve two or more professions. KDHE is ready to help professional organizations and the Legislature in this area whenever we may be called upon for assistance.

Rural Health

Governor Graves requested and the Legislature appropriated $200,000 in the current fiscal year for rural health initiatives. That action has permitted grants to 14 local communities to provide training and recruiting and retention services for primary care providers. In addition, it has allowed a grant to 7 rural counties for a major development of a Local Rural Health Cooperative. The goal of this effort is to support planning and implementation of shared management and shared services between the agencies, leading to improved services at efficient cost levels. The Governor's initiative and the Legislature's support were the key to our ability to leverage an additional $100,000 grant from the Kansas Health Foundation to assist local areas in completing community health assessments. A Request for Proposals has recently gone out for the health assessment assistance project.

Immunizations

Governor Graves noted in his State of the State that Kansas has achieved childhood immunization levels of over 82% and ranks 11th nationally. This level of success has been aided by state funding to supplement federal funds. We need to continue to encourage all parents to see that children receive needed immunizations on schedule and we need to continue to lower barriers such as was done with the immunization consent bill and first dollar insurance coverage in the last session. KDHE will be seeking legislation that will permit the ready sharing of immunization record information between providers so that records are less likely to be misplaced, will be more likely to be maintained on an up to date basis and will be more readily available for new providers to identify when immunizations are due.

On the more worrisome side of the immunization picture are the concerns that federal cuts will occur in the Vaccines for Children program and the possibility that federal vaccine purchasing contracts will no longer be maintained. We are watching these developments closely because they could mean a double-barreled impact of reduced funds and higher prices.

There are many more areas that are important to the health and safety of Kansas and the fact that I have not mentioned them today does not suggest they are less important. I would like to again thank you for this opportunity and I will be pleased to respond to any questions you may have.

Presented by: James J. O'Connell
Secretary of Health and Environment
January 11, 1996

January 1, 1996

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BILL GRAVES, GOVERNOR

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