Approved: January 20, 1998

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES.

The meeting was called to order by Chairperson Carlos Mayans, at 1:30 p.m. on January 15, 1998 in Room 423-S-of the State Capitol.

All members were present except: Representative Judy Showalter - excused

Committee staff present: Emalene Correll, Legislative Research Department
Robin Kemp, Legislative Research Department
Norman Furse, Revisor of Statutes
Lois Hedrick, Committee Secretary

Conferees appearing before the committee:
Sandra Strand, Legislative Coordinator, Kansas Advocates for Better Care
Larry Buening, Jr., Executive Director, Kansas State Board of Healing Arts
Rochelle Chronister, Secretary, Kansas Department of Social and Rehabilitation Services
Ann Koci, Commissioner, SRS Adult and Medicaid Services
Shannon Manzanares SRS Division of Children and Family

Others attending: See Guest List (Attachment 1)

Chairperson Mayans noted that **HB 2622 -** Dental services for dentally indigent persons has been assigned to the committee.

The Chairperson then introduced Sandra Strand, Legislative Coordinator for Kansas Advocates for Better Care, who requested legislation to amend K.S.A. 39-1409 to require that complaints of abuse, neglect or exploitation of care home residents be investigated by investigators of the Kansas Department of Health and Environment or SRS. (See testimony, Attachment 2.) After discussion, upon motion of Representative Morrison, seconded by Representative Hutchins, the committee approved introduction of such legislation.

Larry Buening, Executive Director of the Kansas Board of Healing Arts, recommended that a bill (similar to **SB 248** - Board of healing arts regulation of licensees) be introduced to amend the board's authority to respond to complaints of impairment of licensees. Mr. Buening also requested that another bill be introduced to amend the manner of issuing subpoenas as some of the current law is unconstitutional. (See Attachment 3 for suggested changes.) After discussion, upon motion of Representative Hutchins, seconded by Representative Horst, the committee approved introduction of these two bills.

Chairperson Mayans then introduced Rochelle Chronister, Secretary of the Department of Social and Rehabilitation Services. Secretary Chronister stated that federal legislation of the uninsured children's program and the adoption program will be reviewed by two SRS staff members. Secretary Chronister noted that if the federal programs are understood, then the state's programs will be understandable.

Ann Koci, Commissioner, SRS Adult and Medicaid Services, provided an overview of the federal children's health insurance legislation (Title XXI) and the various options available to the state to extend coverage to all uninsured children. (See testimony, Attachment 4.) Commissioner Koci noted that two state task forces (the Insurance Commissioner's and SRS) came to the same conclusions that are encompassed in the federal program. Commissioner Koci also provided a summary of programs presented at the Bi-Regional Conference held in Kansas City on January 9 (see Attachment 5).

Shannon Manzanares, SRS Division of Children and Family Services, discussed the federal Adoption and Safe Families Act" and the Kansas Initiative for Decision Support (KIDS) (see testimony, Attachment 6). Ms. Manzanares expressed belief that these programs will improve services to children and families by focusing on the safety and permanency for children.

Chairperson Mayans thanked the conferees for their information. He then advised that the agenda for Tuesday, January 20, is being changed as **HB 2607** - State long-term care ombudsman, attached to the department of administration, prescribing powers, duties and functions will be rescheduled for a later meeting. **SCR 1613 -** Establishing a task force on long-term care services will be heard on Tuesday. The Chairperson also noted that any member planning to participate in the Fort Riley tour scheduled for next Wednesday to please advise his office.

The meeting was adjourned at 2:45 p.m.

The next meeting is scheduled for January 20, 1998

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

HOUSE COMMITTEE ON
HEALTH AND HUMAN SERVICES
GUEST LIST
JANUARY 15 , 1998

NAME	REPRESENTING
Pam Scott	Ks Funeral Directors Assn
Darin Conklin	Ks. Pharmacists Assn.
Doug Bowman	KS Interagency Coord. Council
Lisa Area	KAPS
KEITH R LANDIS	CHRISTIAN SCIENCE COMM. ON PUBLICATION FOR KS
Carolyn Middendorf	Ks St Ns Assn
Ann Koci	SRS
Rochelle Chronister	SRS
Carolyn Duwe	KDHE
Sandra Strand	Ks Advocates for Better Care
Carrie Reese	Smoot
Danielle Noe	Governors Office
Dori Hiros	The Hiros Group
Keith Quitania	Health Midwest
Julie Thomas	D.O.B.
Larry Buening	Bd of Healing Arts
Sharon Manzanares	SRS CFS
Judy Eyerly	KS Assn. for Medically Underserved

HOUSE HHS COMMITTEE
Attachment 1-1
1 - 15 - 98

HOUSE COMMITTEE ON
HEALTH AND HUMAN SERVICES
GUEST LIST
JANUARY 15 , 1998

NAME	REPRESENTING
Mike Meacham	N/A
Cheryl Allard	HealthNet
Michelle Peterson	Peterson Public Affairs Group
Gary Robbins	KS Dept of Ag
Tom Bell	KHA

HOUSE COMMITTEE ON
HEALTH AND HUMAN SERVICES
GUEST LIST
JANUARY 15 , 1998

NAME	REPRESENTING
Mary Ellen Conlee	Via Christi Health Sys

KANSAS ADVOCATES FOR BETTER CARE

913 Tennesee, Suite 2 • Lawrence, Kansas 66044-6904 • (913) 842-3088

TO: House Committee on Health and Human Services

FROM: Sandra Strand, Legislative Coordinator

DATE: January 15, 1998

SUBJECT: Request for Bill Introduction

In January 1996, the Kansas Department of Health and Environment changed its policy on the investigation of complaints received by the Adult Care Home Program. We had hoped the change was a temporary response to a budget shortfall, but in fact it has become standard practice.

If a complaint is self-reported by a nursing facility or if it is anonymous, KDHE may allow the facility to investigate the complaint internally, and to submit a written report. In many cases, KDHE investigative staff take no further action on these complaints. KDHE even permits these internal investigations of complaints of abuse, neglect, and exploitation which do not involve immediate jeopardy to residents.

Examples of this type of complaint can include:
- A resident with a black eye, the cause of which is unknown;
- Staff verbally abusing a resident;
- A resident wandering out of the facility, falling and breaking a hip;
- Three residents with broken ribs in the past three weeks;
- A staff member making sexual remarks to a resident and touching her breasts;

(Source: Legislative Division of Post Audit)

The members of KABC, as well as the general public, consider this practice the equivalent of allowing the fox to guard the hen house, and believe it places vulnerable people at unnecessary risk. In August 1996, The Legislative Division of Post Audit concluded that the practice of delegating complaint investigations "may not be in the best interests of nursing home residents," and commented further that a facility's self-investigation "is an internal management tool for the facility, and shouldn't be substituted for the external oversight that a regulatory agency can and should provide through an independent investigation of the facts."

We are requesting legislation which will put an end to this practice, by requiring that any internal investigations conducted by care providers should not replace investigations of complaints by KDHE or SRS investigative staff.

Thank you.

HOUSE HHS COMMITTEE
Attachment 2-1
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Statute # 39-1409
Chapter 39 - MENTALLY ILL, INCAPACITATED AND DEPENDENT PERSONS; SOCIAL WELFARE
Article 14 - REPORTING ABUSE, NEGLECT OR EXPLOITATION OF CERTAIN PERSONS
Same; assistance of appropriate public or private agencies, groups or individuals.

K.S.A. 39-1409 is hereby amended to read as follows: 39-1409. Same; assistance of appropriate public or private agencies, groups, or individuals. In performing the duties set forth in this act, the secretary of social and rehabilitation services or the secretary of health and environment may request the assistance of the staffs and resources of all appropriate state departments, agencies and commissions and local health departments and may utilize any other public or private agency, group or individual who is appropriate and who may be available to assist such department in the investigation and determination of whether a resident is being, or has been, abused, neglected or exploited or is in a condition which is a result of such abuse, neglect or exploitation, *except that any internal investigation conducted by any caretaker under investigation shall not serve in lieu of, but shall be in addition to, an independent investigation by the department of health and environment or the department of social and rehabilitation services.*

KANSAS BOARD OF HEALING ARTS

BILL GRAVES
Governor

235 S. Topeka Blvd.
Topeka, KS 66603-3068
(785) 296-7413
FAX # (785) 296-0852
(785) 368-7102

MEMORANDUM

TO: All Members of the House Health and Human Services Committee

FROM: Lawrence T. Buening, Jr.
Executive Director

DATE: January 15, 1998

RE: **PROPOSED BILLS REQUESTED FOR INTRODUCTION**

Attached to this memorandum are two proposed drafts of bills which are requested to be introduced through your committee. Thank you for your consideration of this request.

LAWRENCE T. BUENING, JR.
EXECUTIVE DIRECTOR

MEMBERS OF THE BOARD
JOHN P. GRAVINO, D.O., PRESIDENT
LAWRENCE
RONALD J. ZOELLER, D.C., VICE-PRESIDENT
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DONALD B. BLETZ, M.D., OVERLAND PARK
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JANA D. JONES, M.D., LANSING
LANCE MALMSTROM, D.C., TOPEKA

LAUREL H. RICKARD, MEDICINE LODGE
CHRISTOPHER P. RODGERS, M.D., HUTCHINSON
HAROLD J. SAUDER, D.P.M., INDEPENDENCE
EMILY TAYLOR, LAWRENCE
HAI K. TRUONG, D.O., WICHITA
ROGER D. WARREN, M.D., HANOVER

HOUSE HHS COMMITTEE
Attachment 3-1
1-15-98

HOUSE BILL NO. _____

AN ACT concerning the Kansas healing arts act; amending K.S.A. 65-2842 and K.S.A. 1997 Supp. 65-2836 and repealing existing sections.

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

Section 1. K.S.A. Supp. 65-2836 is hereby amended to read as follows: 65-2836. A licensee's license may be revoked, suspended or limited, or the licensee may be publicly or privately censured, or an application for a license or for reinstatement of a license may be denied upon a finding of the existence of any of the following grounds: (a) The licensee has committed fraud or misrepresentation in applying for or securing an original, renewal or reinstated license.

(b) The licensee has committed an act of unprofessional or dishonorable conduct or professional incompetency.

(c) The licensee has been convicted of a felony or class A misdemeanor, whether or not related to the practice of the healing arts.

(d) The licensee has used fraudulent or false advertisements.

(e) The licensee is addicted to or has distributed intoxicating liquors or drugs for any other than lawful purposes.

(f) The licensee has willfully or repeatedly violated this act, the pharmacy act of the state of Kansas or the uniform controlled substances act, or any rules and

regulations adopted pursuant thereto, or any rules and regulations of the secretary of health and environment which are relevant to the practice of the healing arts.

(g) The licensee has unlawfully invaded the field of practice of any branch of the healing arts in which the licensee is not licensed to practice.

(h) The licensee has engaged in the practice of the healing arts under a false or assumed name, or the impersonation of another practitioner. The provisions of this subsection relating to an assumed name shall not apply to licensees practicing under a professional corporation or other legal entity duly authorized to provide such professional services in the state of Kansas.

(i) The licensee has the inability to practice the ~~branch of the~~ healing arts ~~for which the licensee is licensed~~ with reasonable skill and safety to patients by reason of physical or mental illness or condition, ~~alcoholism, excessive~~ or use of alcohol or drugs~~, controlled~~ or any other chemicals or substances~~, chemical or any other type of material or as a result of any mental or physical condition~~. In determining whether or not such inability exists, the board, upon reasonable suspicion of such inability and following the procedures prescribed in K.S.A. 65-2842 and amendments thereto, shall have authority to compel a licensee to submit to mental or physical examination or drug screen, or any combination thereof, by such persons as the board may designate. ~~To determine whether reasonable suspicion of such~~

~~inability exists, the investigative information shall be presented to the board as a whole, to a review committee of professional peers of the licensee established pursuant to K.S.A. 65-2840c and amendments thereto or to a committee consisting of the officers of the board elected pursuant to K.S.A. 65-2818 and amendments thereto and the executive director appointed pursuant to K.S.A. 65-2878 and amendments thereto, and the determination shall be made by a majority vote of the entity which reviewed the investigative information. Information submitted to the board as a whole or a review committee of peers or a committee of the officers and executive director of the board and all reports, findings and other records shall be confidential and not subject to discovery by or release to any person or entity. The licensee shall submit to the board a release of information authorizing the board to obtain a report of such examination or drug screen, or both. A person affected by this subsection shall be offered, at reasonable intervals, an opportunity to demonstrate that such person can resume the competent practice of the healing arts with reasonable skill and safety to patients. For the purpose of this subsection, every person licensed to practice the healing arts and who shall accept the privilege to practice the healing arts in this state by so practicing or by the making and filing of an annual renewal to practice the healing arts in this state shall be deemed to have consented to submit to a mental or physical examination or a drug screen, or~~

~~any combination thereof, when directed in writing by the board and further to have waived all objections to the admissibility of the testimony, drug screen or examination report of the person conducting such examination or drug screen, or both, at any proceeding or hearing before the board on the ground that such testimony or examination or drug screen report constitutes a privileged communication. In any proceeding by the board pursuant to the provisions of this subsection, the record of such board proceedings involving the mental and physical examination or drug screen, or any combination thereof, shall not be used in any other administrative or judicial proceeding.~~

(j) The licensee has had a license to practice the healing arts revoked, suspended or limited, has been censured or has had other disciplinary action taken, or an application for a license denied, by the proper licensing authority of another state, territory, District of Columbia, or other country, a certified copy of the record of the action of the other jurisdiction being conclusive evidence thereof.

(k) The licensee has violated any lawful rule and regulation promulgated by the board or violated any lawful order or directive of the board previously entered by the board.

(l) The licensee has failed to report or reveal the knowledge required to be reported or revealed under K.S.A. 65-28,122 and amendments thereto.

(m) The licensee, if licensed to practice medicine and surgery, has failed to inform a patient suffering from any form of abnormality of the breast tissue for which surgery is a recommended form of treatment, of alternative methods of treatment ~~specified in the standardized summary supplied by the board. The standardized summary shall be given to each patient specified herein as soon as practical and medically indicated following diagnosis, and this shall constitute compliance with the requirements of this subsection. The board shall develop and distribute to persons licensed to practice medicine and surgery a standardized summary of the alternative methods of treatment known to the board at the time of distribution of the standardized summary, including surgical, radiological or chemotherapeutic treatments or combinations of treatments and the risks associated with each of these methods. Nothing in this subsection shall be construed or operate to empower or authorize the board to restrict in any manner the right of a person licensed to practice medicine and surgery to recommend a method of treatment or to restrict in any manner a patient's right to select a method of treatment. The standardized summary shall not be construed as a recommendation by the board of any method of treatment. The preceding sentence or words having the same meaning shall be printed as a part of the standardized summary. The provisions of this subsection shall not be effective until the standardized written summary provided for~~

~~in this subsection is developed and printed and made available by the board to persons licensed by the board to practice medicine and surgery~~ recognized by licensees of the same profession in the same or similar communities as being acceptable under like conditions and circumstances.

(n) The licensee has cheated on or attempted to subvert the validity of the examination for a license.

(o) The licensee has been found to be mentally ill, disabled, not guilty by reason of insanity, not guilty because the licensee suffers from a mental disease or defect or incompetent to stand trial by a court of competent jurisdiction

(p) The licensee has prescribed, sold, administered, distributed or given a controlled substance to any person for other than medically accepted or lawful purposes.

(q) The licensee has violated a federal law or regulation relating to controlled substances.

(r) The licensee has failed to furnish the board, or its investigators or representatives, any information legally requested by the board.

(s) Sanctions or disciplinary actions have been taken against the licensee by a peer review committee, health care facility, a governmental agency or department or a professional association or society for acts or conduct similar to acts or conduct

which would constitute grounds for disciplinary action under this section.

(t) The licensee has failed to report to the board any adverse action taken against the licensee by another state or licensing jurisdiction, a peer review body, a health care facility, a professional association or society, a governmental agency, by a law enforcement agency or a court for acts or conduct similar to acts or conduct which would constitute grounds for disciplinary action under this section.

(u) The licensee has surrendered a license or authorization to practice the healing arts in another state or jurisdiction, has surrendered the authority to utilize controlled substances issued by any state or federal agency, has agreed to a limitation to or restriction of privileges at any medical care facility or has surrendered the licensee's membership on any professional staff or in any professional association or society while under investigation for acts or conduct similar to acts or conduct which would constitute grounds for disciplinary action under this section.

(v) The licensee has failed to report to the board surrender of the licensee's license or authorization to practice the healing arts in another state or jurisdiction or surrender of the licensee's membership on any professional staff or in any professional association or society while under investigation for acts or conduct similar to acts or conduct which would constitute grounds for disciplinary action

under this section.

(w) The licensee has an adverse judgment, award or settlement against the licensee resulting from a medical liability claim related to acts or conduct similar to acts or conduct which would constitute grounds for disciplinary action under this section.

(x) The licensee has failed to report to the board any adverse judgment, settlement or award against the licensee resulting from a medical malpractice liability claim related to acts or conduct similar to acts or conduct which would constitute grounds for disciplinary action under this section.

(y) The licensee has failed to maintain a policy of professional liability insurance as required by K.S.A. 40-3402 or 40-3403a and amendments thereto.

(z) The licensee has failed to pay the annual premium surcharge as required by K.S.A. 40-3404 and amendments thereto.

(aa) The licensee has knowingly submitted any misleading, deceptive, untrue or fraudulent representation on a claim form, bill or statement.

(bb) The licensee as the responsible physician for a physician's assistant has failed to adequately direct and supervise the physician's assistant in accordance with K.S.A. 65-2896 to 65-2897a, inclusive, and amendments thereto, or rules and regulations adopted under such statutes.

Sec. 2. K.S.A. 65-2842 is hereby amended to read as follows: 65-2842. ~~Whenever the board directs, pursuant to subsection (i) of K.S.A. 65-2836 and amendments thereto, that a licenses submit to a mental or physical examination or drug screen, or any combination thereof, the time from the date of the board's directive until the submission to the board of the report of the examination or drug screen, or both, shall not be included in the computation of the time limit for hearing prescribed by the Kansas administrative procedure act.~~ (a) Every person licensed to practice the healing arts, by so practicing or by filing an application for an original, renewal or reinstated license shall be deemed to have consented to submit to a mental or physical examination or drug screen, or any combination thereof, when ordered by the board pursuant to this section upon a finding of reasonable suspicion that such person has the inability to practice the healing arts with reasonable skill and safety to patients by reason of physical or mental illness or condition, or use of alcohol or drugs or any other chemicals or substances, and further to have waived all claims to any privilege or objections to the admissibility of the testimony, drug screen or examination report of the person conducting such examination or drug screen at any proceeding or hearing before the board.

(b) The Board may order a person to submit to a mental or physical examination or drug screen, or any combination thereof, only after giving such

person notice and an opportunity for hearing under the provisions of the Kansas administrative procedure act. A proceeding for examination or drug screen may be commenced as part of an investigation by the board, during discovery in an administrative proceeding, or in response to an application for an original renewal or reinstated license. This section action as necessary to suspend or temporarily limit a license pursuant to K.S.A. 65-2838 and amendments thereto.

(c) The board shall hold any hearing under this section in closed session, except that the board shall cause the proceeding to be recorded.

(d) All orders, reports, records, memoranda, pleadings, exhibits and transcripts of proceedings related to an application for an order under this section shall be privileged and confidential, and shall not be subject to discovery, subpoena or other means of legal compulsion for their release to any person or entity and shall not be admissible in any civil or administrative action other than a disciplinary proceeding by the board, except that such information may be disclosed in the same manner authorized by K.S.A. 65-2898a and amendments thereto.

Sec. 3. K.S.A. 65-2842 and K.S.A. 1997 Supp. 65-2836 are hereby repealed.

Sec. 4. This act shall take effect and be in force from and after its publication in the statute book.

HOUSE BILL NO. _____

AN ACT concerning the Kansas healing arts act; amending K.S.A. 65-2839a and repealing existing section.

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

Section 1. K.S.A. 65-2839a is hereby amended to read as follows: 65-2839a. (a) In connection with any investigation by the board, the board or its duly authorized agents or employees shall at all reasonable times have access to, for the purpose of examination, and the right to copy any document, report, record or other physical evidence of any person being investigated, or any document, report, record or other evidence maintained by and in possession of any clinic, office of a practitioner of the healing arts, laboratory, pharmacy, medical care facility or other public or private agency *or office* if such document, report, record or evidence relates to ~~medical~~ *professional* competence, unprofessional conduct*, authority to engage in the practice of the healing arts,* or the mental or physical ability of a ~~licensee~~ *person to* safely ~~to~~ practice ~~the healing arts~~ *any profession for which an individual is licensed or registered by the board.*

(b) For the purpose of all investigations and proceedings conducted by the board:

(1) The board may issue subpoenas compelling the attendance and *sworn*

testimony of witnesses or the production for examination or copying of documents or any other physical evidence if such evidence relates to ~~medical~~ *professional* competence, unprofessional conduct, *authority to engage in practice,* or the mental or physical ability of a ~~licensee~~ *person to* safely ~~to~~ practice ~~the healing arts~~ *any profession for which an individual is licensed or registered by the board.* Within five days after the service of the subpoena on any person requiring the production of any evidence in the person's possession or under the person's control *or compelling the attendance and sworn testimony of any person,* such person may petition the board ~~to revoke, limit or modify the subpoena~~ *for a protective order.* The board ~~shall revoke, limit or modify~~ *may issue a protective order revoking, limiting or modifying* such subpoena if in its opinion the evidence required ~~does not relate to practices which may be grounds for disciplinary action~~ *is not within the authority of the board as provided by this section,* is not relevant to the ~~charge which is the~~ subject matter of the proceeding or investigation, or does not describe with sufficient particularity the physical evidence which is required to be produced. Any member of the board, or any agent designated by the board, may administer oaths or affirmations, examine witnesses and receive such evidence.

(2) Any person appearing before the board shall have the right to be represented by counsel.

~~(3) The district court, upon application by the board or by the person subpoenaed, shall have jurisdiction to issue an order:~~

~~(A) Requiring such person to appear before the board or the board's duly authorized agent to produce evidence relating to the matter under investigation; or~~

~~(B) revoking, limiting, or modifying the subpoena if in the court's opinion the evidence demanded does not relate to practices which may be grounds for disciplinary action, is not relevant to the charge which is the subject matter of the hearing or investigation or does not describe with sufficient particularity the evidence which is required to be produced.~~ *A subpoena pursuant to this section to compel the testimony of any person not licensed, registered, or seeking to be licensed or registered shall be accompanied by witness and mileage fees as established by of K.S.A. 28-125(a)(1) and amendments thereto.*

(c) The board may receive from the Kansas bureau of investigation or other criminal justice agencies such criminal history record information (including arrest and nonconviction data), criminal intelligence information and information relating to criminal and background investigations as necessary for the purpose of determining initial and continuing qualifications of licensees and registrants and applicants for licensure and registration by the board. Disclosure or use of any such information received by the board or of any record containing such information, for

any purpose other than that provided by this subsection is a class A misdemeanor and shall constitute grounds for removal from office, termination of employment or denial, revocation or suspension of any license or registration issued under this act. Nothing in this subsection shall be construed to make unlawful the *lawful* disclosure of any such information by the board in *the course of or at* a hearing held pursuant to this act.

(d) Patient records, including clinical records, medical reports, laboratory statements and reports, files, films, other reports or oral statements relating to diagnostic findings or treatment of patients, information from which a patient or a patient's family might be identified, peer review or risk management record or information received and *all other* records kept by the board as a result of the investigation procedure outlined in this section shall be confidential *and privileged* and shall not be disclosed *and shall not be subject to discovery, subpoena, or other means of legal compulsion for their release to any person or entity, and shall not be admissible in any civil or administrative action other than a proceeding by the board.*

(e) Nothing in this section or any other provision of law making communications between a physician and the physician's patient a privileged communication shall apply to investigations or proceedings conducted pursuant to

this section. The board and its employees, agents and representatives shall keep in confidence the names of any patients whose records are reviewed during the course of investigations and proceedings pursuant to this section.

Sec. 2. K.S.A. 65-2840a is hereby repealed.

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

State of Kansas
Department of Social & Rehabilitation Services

Rochelle Chronister, Secretary
Janet Schalansky, Deputy Secretary

For additional information, contact:

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House Health and Human Services
Thursday, January 15, 1998

Testimony: Children's Health Initiative

Adult and Medical Services
Ann Koci, Commissioner

HOUSE HHS COMMITTEE
Attachment 4-1
1-15-98

STATE OF KANSAS

BILL GRAVES, *Governor*
State Capitol, 2nd Floor
Topeka, Kansas 66612-1590

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OFFICE OF THE GOVERNOR

MEMORANDUM

TO: HHS Bi-Regional Conference Participants

FROM: Danielle Noe, Legislative Liaison

DATE: December 22, 1997

SUBJECT: Children's Health Insurance Program

Thank you for the opportunity to update you on Kansas' plans for the Children's Health Insurance Program. At this time, Kansas is continuing to seek advice about the best way to provide insurance coverage to the estimated 60,000 children who are eligible for Title XXI benefits.

Like other states, Kansas has received much input on this program. Last fall, two different task forces began to study the issue. Together. they made a recommendation which includes a Medicaid expansion with the possibility of private sector initiatives.

The Governor is particularly interested in obtaining more information about potential private partnerships. He expects to have enough information to make a recommendation to the Legislature in early to mid January

Presented by Debbie Chang, Director
Office of Legislation, Health Care Financing Administration
Co-Chair, U.S. Department of Health and Human Services CHIP Steering Committee

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

- **BASIC PROGRAM DESIGN**
- **SETTING ELIGIBILITY LEVELS**
- **ALLOTMENTS**
- **OUTREACH/ENROLLMENT AND ADMINISTRATION**
- **FINANCING AND MAINTENANCE OF EFFORT**

BASIC PROGRAM DESIGN

- **States can choose to provide child health assistance to low-income, uninsured children through:**
  - **a separate insurance program;**
  - **a Medicaid expansion; or**
  - **a combination of these two approaches.**

BASIC PROGRAM DESIGN

- **For States that choose a separate program, they have four benefit options:**
  - **benchmark coverage (BCBS PPO, HMO, State employee plan);**
  - **benchmark-equivalent coverage;**
  - **existing comprehensive State-Based coverage (FL, NY, PA); and**
  - **Secretary-approved coverage.**

BASIC PROGRAM DESIGN

*Separate program continued

- **Cost-Sharing:**
  - **At or below 150% of poverty, it must be at Medicaid medically needy levels (inflation adjustment permitted for cost-sharing);**
  - **Above 150% of poverty, it cannot exceed 5% of family income for all children in the family;**
  - **No cost-sharing is permitted for well-baby, well-child care, including immunizations.**
  - **Cannot favor higher-income children over lower-income children.**

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BASIC PROGRAM DESIGN

- For States that choose to expand Medicaid, they must:
  - use full Medicaid benefits;
  - meet all Medicaid rules; and
  - comply with Medicaid cost-sharing rules (i.e., no cost-sharing for children).

SETTING ELIGIBILITY LEVELS

- A "targeted low income child" is one who:
  - meets the State eligibility standards;
  - has a family income at or below 200% of poverty or 50% points above Medicaid limit;
  - is not eligible for Medicaid or other insurance (except State-only coverage in effect 7/1/97);
  - is not an inmate of a public institution;
  - is not a patient in an IMD; and
  - is not in a family eligible for State employee health plan.

SETTING ELIGIBILITY LEVELS

- For States that choose Medicaid, the following categories can be a "targeted low-income child:"
  - child receiving inpatient psychiatric care; and
  - child in a family eligible for a State employee health plan.
- States that choose to accelerate coverage of 15 through 18 year olds under 100% of poverty will get enhanced match (until they age in).

SETTING ELIGIBILITY LIMITS

- Immigrants: Under an 8/97 proposed rule, legal immigrant children who arrive after 8/22/96 will not be eligible for 5 years. States may cover those who arrive before 8/22/96. Under Medicaid, undocumented persons can only receive emergency care.
- Native Americans: Non-duplication rules do not apply to IHS programs.
- Crowd out: States must describe how this does not substitute for group coverage.

4-6

OUTREACH/ENROLLMENT AND ADMINISTRATION

- New options under the BBA:
  - Presumptive eligibility for children;
  - 12 month continuous eligibility for children
- Current authority to conduct outreach:
  - shortened and simplified eligibility forms;
  - combined form for both Medicaid and CHIP;
  - outstationing eligibility workers

OUTREACH/ENROLLMENT AND ADMINISTRATION

- Under CHIP, 10 percent of Federal expenditures may be used for total costs of:
  - outreach;
  - administration;
  - direct services to children; and
  - other child health assistance.
- The Secretary may waive the 10 % limit for coverage that is cost-effective and is provided through a community-based health delivery system.

ALLOTMENTS

- A State must have an approved State plan for the Federal fiscal year (FY) in order to receive an allotment that year.
  - For example, to receive an allotment for a FY98, a State must have an approved plan by 9/30/98.
- The child health plan is not required to use the full allotment in a FY. Allotments are available to States for up to 3 years.

FINANCING AND MAINTENANCE OF EFFORT

- States will receive enhanced match for child health assistance.
  - For States that create a separate program, Federal funds, premiums and other cost-sharing cannot be used for the State matching requirements.
  - Medicaid provider taxes and donations rules apply.
  - Intergovernmental transfers can be used for State matching requirements.

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FINANCING AND MAINTENANCE OF EFFORT

- Maintenance of effort rules:
  - States cannot adopt more restrictive income and resource standards and methodologies for Medicaid than those in effect on 6/1/97.
  - New York, Pennsylvania and Florida must maintain State children's health spending at least at the 1996 levels.

CHILDREN'S HEALTH INSURANCE PROGRAM

Bi-Regional Conference

Kansas City, Missouri

January 9, 1998

Children's Health Insurance Program
State Summaries

HOUSE HHS COMMITTEE
Attachment 5-1
1 - 15 - 98

ILLINOIS CHILDREN'S HEALTH INITIATIVE

In response to the federal Balanced Budget Act of 1997 the Governor has authorized the expansion of Medicaid coverage for children and pregnant women and formed a bipartisan task force, in cooperation with the Illinois General Assembly, to address further coverage of children under Title XXI of the Social Security Act.

MEDICAID EXPANSION

Expansion Highlights

- Effective January, 1998, expand Medicaid to 133% of federal poverty level (FPL) for children under age 19 and to 200% of FPL for pregnant women and their newborns
- Approximately 700,000 children are currently enrolled in Medicaid
- The expansion is projected to cover 40,000 additional children and 2,900 additional pregnant women
- Expanded community-based outreach efforts will also target children who are eligible for Medicaid, but not currently enrolled
- Enhanced outreach will include a shortened application form and expanded enrollment sites

Expansion Goals

1) Improve the health status of Illinois children

2) Extend health benefits coverage to optional targeted, low income children

3) Improve access to quality health care for optional targeted low income children enrolled in Title XXI program

4) Assure appropriate health care utilization by optional targeted low income children enrolled in Title XXI program

5) Implement statewide outrach and public awareness campaign regarding the importance of preventive and primary care for well children and the availability of health benefits coverage through Title XXI

TASK FORCE

The Governor and the General Assembly have established a Children's Health Insurance Task Force to collaborate on the development of a State plan to implement Title XXI of the federal Social Security Act. The task force will study methods to extend health care coverabge to uninsured children and make recommendations to the Governor for presentation to the General Assembly. The task force is comprised of child health experts and advocates, representatives of appropriate State agencies, General Assembly members, and health care providers and insurers.

Indiana
Children's Health Insurance Program

PURPOSE

A bipartisan panel was appointed by the Governor for the purpose of reviewing and recommending short- and long-term options to implement the Children's Health Insurance Program for Indiana children.

FUNCTION

I. The Panel will review the federal requirements for this program including eligibility, outreach, plan design, coordination with private sector benefits, fiscal impact, etc.

2. The Panel will evaluate the relationship with the current Medicaid program and make recommendations on the coordination of these two programs.

3. The Panel will evaluate other state and federal block grant programs and make recommendations on the coordination of program efforts. (e.g.. Children with special health care needs, Maternal and Child Health, Immunization, etc.)

4. The Panel will review and make recommendations on plan design and plan coverage for implementation of the program.

5. The Panel will solicit and evaluate public input on the blueprint for program implementation.

6. The Panel will review and make final recommendations on the blueprint for implementing the Children's Health Insurance Program including the fiscal impact, outreach, administrative structure and evaluation component.

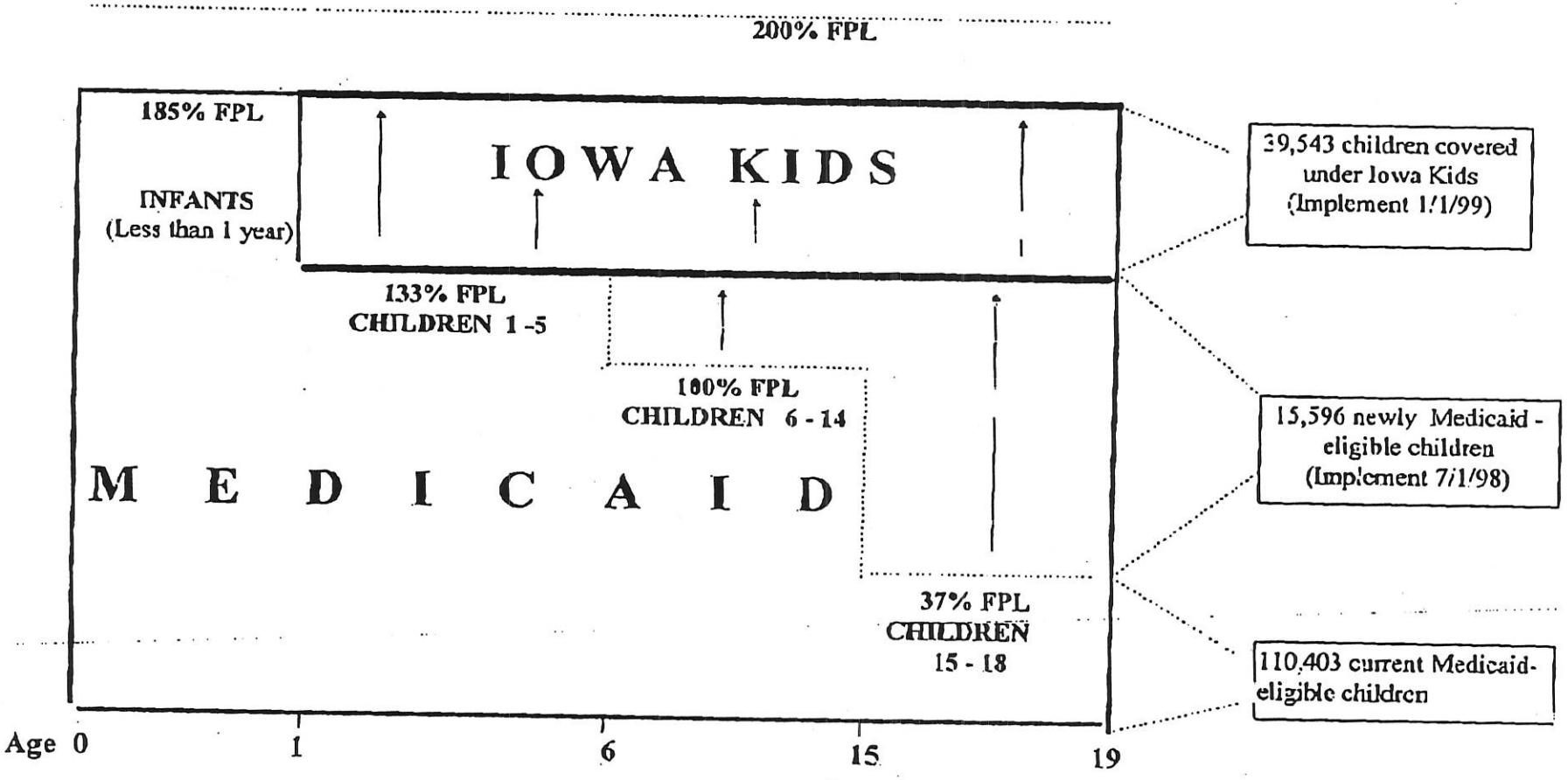
TIMEFRAME

It is anticipated that the Indiana General Assembly will focus on the Children's Health Insurance Program during their upcoming session. It is further anticipated that a long term plan will be considered during their long biennial budget session in 1999.

IOWA

Governor's Proposal to the Legislature

COMBINATION MEDICAID EXPANSION AND NEW IOWA KIDS PROGRAM



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STATE OF KANSAS

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OFFICE OF THE GOVERNOR

MEMORANDUM

TO: HHS Bi-Regional Conference Participants

FROM: Danielle Noe, Legislative Liaison

DATE: December 22, 1997

SUBJECT: Children's Health Insurance Program

Thank you for the opportunity to update you on Kansas' plans for the Children's Health Insurance Program. At this time, Kansas is continuing to seek advice about the best way to provide insurance coverage to the estimated 60,000 children who are eligible for Title XXI benefits.

Like other states, Kansas has received much input on this program. Last fall, two different task forces began to study the issue. Together. they made a recommendation which includes a Medicaid expansion with the possibility of private sector initiatives.

The Governor is particularly interested in obtaining more information about potential private partnerships. He expects to have enough information to make a recommendation to the Legislature in early to mid January

HELPING MICHIGAN'S UNINSURED CHILDREN

Michigan Children's Health Plan - MIChild

Michigan is a national leader in providing insurance for all age groups and ranks among the top eight states with the lowest number of uninsured children. Michigan's new Child Health Insurance Program, "MIChild" (pronounced My Child) will provide public funds to help insure 156,000 children of working low and moderate-income families that do not qualify for Medicaid or have private insurance. On December 23, 1997, Michigan submitted its state plan to the Secretary of Health and Human Services detailing how the state intends to use the funds.

- **Affordable Health Insurance for the Children of Michigan's Working Families.** This new program aims to subsidize health insurance for children of working low or moderate-income families who do not qualify for Medicaid. It will cost a family just $8 per month or $96 per year to insure a child. The annual maximum for any family would be the cost of insuring two children, or $192 per year.
- **A Comprehensive, Child-Focused Benefits Package.** Children with a medical home are more likely to receive preventive services and health education, less likely to miss school because of illnesses, and less likely to use the emergency room.
- **Partnering with Local Communities and Interest Groups to Reach Our Children.** We will continue to partner with providers who have supported the health and well-being of our children.
- **Using the Pooled Purchasing Power of State.** The State's purchasing power will assure competitive pricing and affordability for families.
- **Private Sector Participation and Flexibility.** This new state program is public/private partnership, remaining flexible to meet the needs of the children without committing taxpayer funds beyond available resources.
- **Individual Responsibility and Dignity.** The stigma associated with welfare has been a barrier to enrollment of children in Medicaid. The use of private-market health plans, combined with cost-sharing, will give families personal responsibility and choices in managing the health of their children.
- **Simplicity and Accountability.** The enrollment process aims to be easy. A short mail-in application form will be used to enroll children in this program.

Eligibility

To qualify for participation in **MIChild**, a family must meet the following eligibility requirements:

- Family income must be less than twice the Federal Poverty Level (FPL) - a family of four with income up to $32,000 per year would be eligible. There will be no asset test.
- Children eligible for Medicaid will be enrolled in the Medicaid program.
- To encourage the use of available employer insurance, a family must wait six months if they had access to employer paid insurance or if the employer eliminates dependent coverage in the six months prior to application.
- Must not be currently insured through private insurance.

Benefits Package
Michigan plans to use the state employees health plan as its benchmark benefit package. Services include, but are not limited to:

1. Well Child Visits and Immunizations
2. Hearing Screening and Diagnostic Services
3. Vision Screening and Diagnostic Services
4. Primary Care and Specialty Physician Services
5. Diagnostic Services
6. Hospital Services (Inpatient/Outpatient)
7. Emergency Services and Transportation
8. Durable Medical Equipment
9. Mental Health Services
10. Dental Services
11. Prescription Drugs

Enrollment and Cost-Sharing
To avoid the stigma of applying for health benefits at the welfare office, the Michigan Children's Health Plan will use a short mail-in application form to determine eligibility. A central processing center will receive all applications and make eligibility determinations.

When fully implemented, the Michigan Children's Health Insurance Plan will conduct open enrollment in January and September of every year. Qualifying children will be enrolled in a health plan for a 12 month period. Families are required to report any changes during the 12 month period which may cause ineligibility.

The Michigan Children's Health Insurance Plan encourages parental responsibility for the care of their children by sharing insurance costs. The program is administratively simple and very affordable for families. Families above 150 percent of FPL will participate in cost sharing with the state based on an $8 premium per child per month basis ($96 a year). The maximum a family will be required to pay is a $16 premium per month ($192 a year). A $5 copay will be required for eye glass prescriptions, crowns, and prescription drugs not included in a plan's formulary. For families with income below 150 percent of the FPL, there will be no cost sharing on premiums or copays.

Partnering with Local Communities
In partnership with various children's advocacy organizations, Michigan held five community-based forums throughout the state to gather information on community needs and goals for the program. Michigan used comments from these forums to draft its state plan.

The state will continue to work with the public and private sector to market the **MIChild** program, coordinate outreach activities, and perform eligibility, and enrollment activities. The state will also continue to work with local communities and established local multipurpose collaboratives in every county that includes health, education, human service agencies, and consumer representatives to develop outreach plans to identify uninsured children and assist with enrollment.

Minnesota Department of **Human Services**

KidCare: State Children's Health Insurance Program

Minnesota's Response: October 14, 1997

Current Title XIX Coverage in Minnesota. Minnesota currently covers approximately 54,000 otherwise uninsured children through MinnesotaCare (1115 waiver expansion) and approximately 230,000 children through Medical Assistance (traditional Medicaid program), as follows:

	Medical Assistance (MA)	MinnesotaCare
Income Standard	Children 0-1 275% FPG Children 1-5 133% FPG Children 6-14+ 100% FPG Children 0-20 @60% FPG	Children 0-21 275% FPG
Asset Standard	Effective 7/1/97: $3,000 Household of 1 $6,000 Household of 2 + 200 Each add'l person	Effective upon federal approval of 1115 waiver amendment: $15,000 Household of 1 $30,000 Household of 2 or more
Insurance Status	Not relevant to eligibility, but other health coverage is primary payer.	Children <150% FPG: Underinsured. Others: Uninsured for past 4 months and no access to employer-subsidized coverage for past 18 months. Employer-subsidized coverage is defined as coverage for which an employer pays at least 50% of the cost of the coverage.
Coverage	Medicaid benefit set under the state plan.	Medicaid benefit set under the state plan.
Federal Funding Authority	State Medicaid plan, including provision under §1902(r)(2).	§1115 Medicaid waiver amendment approved effective 7/1/95.

MinnesotaCare successful. According to the Bureau of the Census, Minnesota has the lowest average annual percentage of children uninsured of any state in the nation.[1] A recent study published in the Journal of the American Medical Association indicates that while the rate of uninsurance increased nationally, Minnesota's remained stable and low at six percent between 1990 and 1995.[2] The proportion of children uninsured for 12 months or more fell by nearly 40

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1 CRS analysis of data from the Bureau of the Census for 1993 to 1995.

2 Kathleen Thiedo Call, PhD; Nicole Lurie, MD, MSPH; Yvonne Jonk; Roger Feldman, PhD; Michael D. Finch, PhD; "Who is Still Uninsured in Minnesota? Lessons From State Reform Efforts," Journal of the American Medical Association, Vol. 278, No. 14, October 8, 1997.

percent, from 5.2 percent in 1990 to 3.1 percent in 1995, "suggesting that state initiatives targeting this group were effective." In addition, according to the study, "[t]here is little evidence that the MinnesotaCare program has resulted in significant erosion from the private market." In spite of this effort, however, federal CPS[3] statistics estimate Minnesota has approximately 81,111 children still uninsured.

Current activity in response to enactment of KidCare. The Minnesota Department of Human Services (state Medicaid agency) is working cooperatively with the Minnesota Department of Health to develop a proposal for the Minnesota Legislature in response to the new funding available under the Balanced Budget Act of 1997. One meeting has been held with advocates for children's health and other stakeholders to identify barriers to access under the current programs and to explore any opportunities the new legislation may hold for addressing those barriers. Additional meetings with advocates are planned.

Initial analysis, however, appears to limit Minnesota's access to the new funding without doing expansion that could exceed the state's median income. The departments are exploring whether there may be opportunities under S1115 to waive the restrictions in the new title XXI that prevent states that have already undertaken significant effort for children. However, the Health Care Financing Administration's initial response to inquiries about S1115 waivers of Title XXI has not been encouraging.

In addition, the Department of Human Services has issued a request for proposals to expand and better target outreach efforts. While this may have little effect in terms of accessing funding under the new legislation, we are hopeful that this will improve access for uninsured children and increase enrollment in the current programs.

Additional information. For additional information concerning Minnesota's planning in response to the new federal program, you may contact any of the following staff at the Minnesota Department of Human Services, 444 Lafayette Road, St. Paul, Minnesota 55155:

- Mary Kennedy
  Medicaid Director & Assistant Commissioner for Health Care
  Phone: (612)292-9921

- Kathleen Henry
  Director of Health Care for Families with Children
  Phone: (612)296-8818

- Kathy McDonough
  Eligibility Policy for Families with Children
  Phone (612)297-7721

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3 Average calculated arithmetic average of number of uninsured children in 1993, 1994, and 1995 as estimated by the March 1994, March 1995, and March 1996 supplements to the Current Population Survey (CPS) of the Bureau of the Census.

MISSOURI'S TARGETED WAIVER INITIATIVE UNDER MC+

Missouri is seeking an amendment to its Medicaid waiver which was submitted in 1994 and is still pending with the federal government. This amendment will build on our very successful MC+ program by focusing on children and adults leaving welfare for work. This waiver:

- Expands MC+ coverage to 90,300 eligible low income children, helping ensure the health of future generations and allowing their parents to remain in the workforce.

- Uninsured children with family income up to 300% of the federal poverty level will be eligible ($39,990 per year for a family of three).

- Coordinates outreach activities for children with schools and local programs like Caring Communities.

- Supports families moving from welfare into jobs and supports working families by providing MC+ coverage to 76,000 eligible low income uninsured parents.

- Adults leaving welfare for work without available health insurance will be eligible for MC+ with a commercially oriented benefit package and participation premiums. Non-custodial parents will have to be paying child support and current on all payments.

- Extends family planning coverage for 44,000 eligible low income new mothers.

- Funding will include existing resources and the new federal children's health initiative program. The total cost is $180 million of which $119 million is federal funding. The state share comes from welfare caseload declines, disproportionate share funding, managed care savings, and Medicaid funding changes under the new federal law.

RECOMMENDATIONS FOR NEBRASKA'S CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

January 7, 1998

1. **The Medicaid eligibility level should be expanded to 185% of Federal Poverty Level for all children age 0 through 18.**

2. **Twelve month continuous eligibility should be implemented for all Title XXI and XIX recipients through age 18.**

   Advantages:
   - Improve the access and continuity of care for Medicaid recipients.
   - Establish a consistent Medical Home that focuses on preventive care.
   - Increase provider willingness to accept Medicaid recipients by lessening administrative burden.

   Disadvantages:
   - Initial cost of expanded coverage for 12 months.
   - Minor systems changes required.

3. **The existing Medicaid eligibility system needs to be expanded to incorporate the following:**

   - Presumptive eligibility for children through 18.
     a. Physician Clinics
     b. Nebraska Hospitals
     c. Rural Health Clinics/FQHCs
     d. County Health Departments

     Advantages:
     - Improves the ease of access fro prospective Medicaid recipients to obtain care.
     - Provides for earlier coverage.
     - Lessens the administrative load of eligibility for local HHS offices.
     - Decreases the amount of uncompensated care for Nebraska physicians and other providers.
     - Improves Medicaid's goal of easier and faster eligibility process.
     - Allows for enhanced federal match for services for children who are later found ineligible for Medicaid

     Disadvantages:
     - Cost of presumptive eligibility.
     - Requests provider locations to assume increased administrative burden.

- Increased administrative cost for staff to support these efforts.

- **Expand HHS office hours to some evening and weekend hours.**

- **Set up telephone interviews upon request.**

- **The existing School Nurse programs as local points of contact and information.**

- **Mail-in eligibility forms for Head Start and WIC providers.**

  Advantages:
  - Increase ease of applying for Medicaid coverage.
  - Improves Access to coverage for health care services.
  - Decreases uncompensated care for providers and cost of local governments for care to the medically indigent.

  Disadvantages:
  - Decreases face-to-face contact with the local office case workers.
  - Increases costs related to providing computer support, security, staff.

4. The Children's Health Insurance Program should be administered through Title XIX of the Social Security Act with emphasis being on expansion of coverage for children(0-18).

5. The CHIP program will be called "Kids Connection ...Reaching for a Healthy Future:" and will target low income children with the new name of "Kids Connection".

Executive Summary
Ohio's Children's Health Insurance Program State Plan

During the past several years, Ohio, under Governor George Voinovich's leadership, has deepened its commitment to assisting families achieve success--in reaching self sufficiency; in leading productive lives; and in caring for their children. The Governor's Family and Children First Initiative is one example of how Ohio is improving its approach to serving families. At the same time, Ohio has worked hard to revitalize its economy in order to provide job opportunities for parents taking personal responsibility for the care of their children Ohio has been a leader in reforming its welfare system by removing disincentives to self sufficiency. And Ohio has been re-tooling its approach to purchasing health care, seeking to become a value purchaser in its management of the Medicaid program by focusing on consumers, performance, and information.

The State Children's Health Insurance Program (CHIP) represents an opportunity for the State of Ohio both to support and to build upon all of this work on behalf of Ohio families. Increasing access to quality health care for children helps to support working families whose employers may be unable to offer family health care benefits. Healthy children will be better ready to learn and should perform better in school. Families seeking to avoid going on public assistance programs will not be forced to do so in order to gain access to health care for their children. As transitional Medicaid benefits expire, parents can continue working, confident that their children have coverage through CHIP. Providing a well-rounded package of health care benefits is an investment in preventive and primary care, the health care children most often need and sometimes have difficulty getting. Expanding and simplifying eligibility for health care coverage should result in a more family-friendly system for all children, making it easier to reach out to families whose children may be eligible for health care insurance.

For all of these reasons, Ohio's children's health insurance initiative will have a two-pronged strategy aimed at providing health care coverage to Ohio's most vulnerable lower-income children. First, beginning January 1, 1998, Ohio will implement two new co-existing health insurance coverage options for children in families with income at or below 150% of FPL. This model extends Ohio's current Healthy Start program and concurrently implements phase one of Ohio's CHIP plan. This co-existing model allows Ohio to offer a health insurance package which provides comprehensive health care coverage for children. This health insurance eligibility expansion is the result of both legislative and public processes that have identified health insurance coverage for children as a key priority. Through the state biennial budget process, the Ohio Department of Human Services requested the funding and authority to do a Medicaid eligibility expansion for children up to age 19 in families with incomes at or below 150% of FPL. This initiative was included in Ohio's Biennial Budget (H.B.215) and signed by Governor Voinovich in late June, 1997. Following the passage in August of the federal Balanced Budget Act, part of which created Title XXI, CHIP, Ohio assessed its expansion strategy for inclusion in the State's initial CHIP plan and has decided to coordinate its Medicaid eligibility expansion with the first phase of the State CHIP Plan. By the end of Ohio's current biennium approximately 133,000 children are expected to be insured (with an average monthly enrollment of 103,000 in year two of the biennium). These new children are not eligible for Medicaid today.

Ohio's second strategy is to intensify outreach efforts to find children who are eligible for the State's children's health insurance plan. These outreach activities will help the State provide health care coverage to children in families who are striving toward self sufficiency and may not know that health care coverage is today available for their children. Providing health insurance for children can remove significant barriers for families moving from welfare to work. In Ohio there are approximately 323,000 children chronically without health insurance. Half of these children are in families with incomes at or below 150% of FPL and will now be eligible for health insurance coverage. Some of these children may be eligible for health insurance coverage through Medicaid today, and others will be made eligible by the health insurance expansion for children. Outreach efforts to find all of these children are being coordinated by state agencies and communities.

Ohio will improve access to health insurance coverage for children through this expansion of health insurance initially by building on the same administrative processes which support Ohio's current Healthy Start Program. Using a Medicaid expansion provides an administrative mechanism for extending coverage to more children quickly, offering a well rounded package of benefits, at a reasonable cost. Implementation is under way and on schedule. Ohio's goal is to create a seamless system for consumers, whereby distinctions between traditional Medicaid eligibility financing and delivery systems, and CHIP eligibility financing and delivery systems, are invisible to families. A streamlined application process will be used. The majority of children will also benefit from a relationship with a primary care physician through managed care arrangements once capitation rates for health maintenance organizations, HMOs, have been examined and a decision is made to begin enrolling children made eligible by the expansion into HMOs.

Two Medicaid State Plan Amendments will co-exist to effect Ohio's Medicaid eligibility expansion. The first amendment is Medicaid State Plan Amendment 97-029, based on a HCFA draft dated October 10, 1997, which will expand Medicaid eligibility, as authorized by 1902(a)(l0)(A), from its levels as of October 1, 1997, to children up to age 19 in families with incomes at or below 150% FPL for optional targeted low-income children. The state is submitting an additional Medicaid State Plan Amendment, 97-028 to co-exist with 97-029, so that children who do not meet the definition of 'optional targeted low-income children' can still be found Medicaid eligible through the second State Plan Amendment. The 97-028 Medicaid State Plan Amendment, as authorized by 1903 (accelerated SOBRA) and 1902(r)(2), will allow the state to provide Medicaid coverage to children who meet the income requirements for the eligibility expansion but who have creditable coverage.

Wisconsin
BadgerCare Program

Summary. BadgerCare ensures access to health care for all children and parents in uninsured families with income below 185% of the federal poverty level (FPL). Once enrolled, families may remain in BadgerCare until family income exceeds 200% of the FPL. BadgerCare fills gaps between Medicaid and private insurance without supplanting or "crowding out" private insurance

Additional Children and Families Covered. BadgerCare is projected to cover an additional *48,800* uninsured, low-income Wisconsin residents, including 22,700 children and 26,100 parents. A family of three, which is the average BadgerCare family size, would;

- Have no premium with income under 150% of the FPL ($20.000 annually/$10 per hour)
- Pay a premium of $60 per month at 180% of the FPL ($24~000 annually/$12 per hour)
- Be ineligible for BadgerCare with income in excess of 200% of the FPL ($27,000 annually/$13.50 per hour)

- **Cost Sharing.** Families with income over 150% of the FPL pay a monthly premium of 3% to 3.5% of family income.
- Premium Collection. BadgerCare prerniums will be collected through wage withholding or an alternative, automated system
- **Crowd-Out of Private Insurance.** Families with access to insurance where the employer pays at least 80% of the cost of family coverage are not eligible for BadgerCare. Other options under review to minimize the "crowd-out" of private insurance include the purchase of employer plans where cost-effective, and a maximum three-month retrospective check for private insurance
- **Health Care Benefits/Delivery System.** BadgerCare benefits are identical to the comprehensive package of benefits and services covered by Wisconsin Medicaid. The existing Wisconsin Medicaid HMO managed care system, including provisions for quality assurance and improved health outcomes, will be used for BadgeCare

Goals. Badgercare provides access to affordable health care for low-income families with children. In particular, BadgerCare:

- Provides a safeguard against unintentionally increasing the nurnber of uninsured children and parents through welfare reforn.
- Complements Wisconsin Works (W-2) bv elimiating barriers to successful employment.
- Assures access to health care for all low-income families who do not have employer insurance.
- Integrates employer health insurance and Medicaid, while building on the health care system that is a reality to working families.
- Promotes personal responsibility through cost sharing.
- Improves health outcomes and reduces uncompensated health care costs by establishing a "medical home" for all low-income famifies with children.
- Streamlines eligibility procedures and HMO enrollment for health care.

Waiver/Funding. Federal waivers are required to implement BadgerCare. The program creates a non-entitlement block grant under recently-enacted Title XXI (State Chidren's Health Insurance Program) and expands Medicaid coverage under Title XIX. Expanded Medicaid coverage uses premium cost sharing as the state match for federal funds. The total amount of funding is $69.0 million - $47.6 million in federal, $16.6 million in state, and $4.8 million in premium revenue. To fund the change to premium cost sharing at 150% of the FPL for BadgCare, the Department will request the release of additional funding now set aside in the Joint Committee on Finance supplemental appropriation.

State of Kansas
Department of Social & Rehabilitation Services

Rochelle Chronister, Secretary
Janet Schalansky, Deputy Secretary

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House Health and Human Services
January 15, 1998

Testimony: Adoption and Safe Families Act and KIDS

Children and Family Services
Teresa Markowitz, Commissioner

HOUSE HHS COMMITTEE
Attachment 6-1
1 - 15 - 98

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Rochelle Chronister, Secretary

House Health and Human Services

January 15, 1998

Mr. Chairman and Members of the committee, thank you for the opportunity to appear before you today on behalf of Secretary Chronister. I am here today to talk with you about two very exciting things that we believe will improve services to children and families by focusing on the safety and permanency for children.

Adoption and Safe Families Act

First, congress has passed and the president has signed the Adoption Support and Safe Families Act - P.L. 105-89. This amends Titles IV-B and IV-E of the social security act related to child welfare, foster care and adoption assistance. The Adoption Support and Safe Families Act emphasizes that child safety is paramount, clarifies that re-unification efforts are not always reasonable and recognizes the urgency of making decisions related to children timely. It sends a clear message to all the players in the system - families, social services, prosecutors, judges - that it is no longer acceptable to dawdle along in an adult sense of time when a childs future is at stake. For a long time we have talked the talk about the importance of permanency for children. This legislation is now asking us to walk the walk. In Kansas many of the provisions of the act are already in state law and we can be proud that once again Kansas has set the pace for the federal initiatives. In your packet you will find a summary of the Adoption and Safe Families Act.

Briefly the Adoption and Safe Families Act has four Titles.

Title I - Reasonable Efforts and Child Safety provisions:

- Child health and safety is paramount.
- Reasonable efforts to preserve and reunify families - when a court finds re-unification is not a reasonable goal the court must conduct a permanency hearing within 30 days. Efforts to re-unify are not required when a child has been subjected to torture, chronic abuse or sexual abuse, the child has been abandoned, a parent has assaulted this child or another child, the parents have killed a child, or parental rights to a sibling has been involuntarily terminated.
- Efforts to adopt - the state must concurrently make reasonable efforts to recruit and approve qualified families and must document efforts to place children in a permanent home (adoption or guardianship).
- Termination of Parental rights - states are required to file a petition to terminate parental rights when the court has determined a child has been in out-of-home placement 15 of the last 22 months or when the court finds reunification is not viable for the reasons listed above.

Title II - Adoption Promotion Provisions

Adoption incentive payments of $4000.00 per child will be paid to the state for all foster children adopted over a base line number. For children with special needs, an additional $2,000.00 will be paid.

States must provide medical care for foster children who receive adoption support. Kansas does that now.

A child's eligibility for adoption support will continue if an adoption dissolves due to the death of adoptive parent or for any other reason.

States are not to deny or delay inter-state adoptions.

Title III - System Accountability and Reform Provisions

Permanency Hearing - States must have a permanency hearing within 12 months of date of entry into foster care (current Kansas law) to determine if child should:

- return home;
- be placed for adoption (state must have termination hearing within 30 days); or
- be referred for legal guardianship or other permanency plan.

HHS will develop performance outcomes by which the state will be measured.

The number of demonstration grants to states is increased to 10.

Title IV - Additional Provisions

The act re-authorizes the Family Preservation and Family Support Act (IV-B part 2) with additional funding for time limited re-integration services and adoption services. It also re-authorizes the funding for the court improvement project.

The act authorizes:

- a Kinship Care study,
- child welfare agencies to use the federal parental locator services to locate absent parents,
- a study of the relationship of substance abuse to child abuse
- increases to $5000.00 the amount of savings a youth with an independent living plan can conserve.

Additionally it suggests states should consider standby guardianship provisions for chronically ill parents.

This is a major step forward for children. We are proud that the federal statutes reflect many of the provisions in current Kansas law. The Department will be introducing legislation related to those provisions not already in Kansas law.

KIDS - Kansas Initiative for Decision Support

Secondly, we want to tell you about a new initiative which was begun to improve the handling of reports of children in need of care and the making of critical decisions related to those reports. Over the last ten years there has been considerable research around assessments of risk and safety. Several states have successfully standardized and validated tools and protocols to assist staff in making those important initial decisions concerning the immediate safety of a child and the risk of future harm. During the past year we have been researching the state of the art. With the help of the University of Kansas School of Social Welfare we held a symposium at which we heard from leading experts in the field of risk assessment and decision support systems. Two staff attended the national round table on risk assessment and staff went to Rhode Island and Michigan (two states which are leaders in the field) to learn about the operational aspects of decision support systems.

Decision support systems are a cohesive set of case work methods that guide critical case decisions. The components of a decision support system include structured, research based assessment tools or protocols to assess the risk of the likelihood of future harm, immediate safety of the child, and the strengths and needs of the family and child which can mitigate risk and safety issues. It also establishes services standards and interventions that are based on the assessments. In addition to the support provided to the social worker who must make life alerting decisions the support system will also provide information for work load management by translating services standards into resource requirements and will assist the agency in deploying resources equitably throughout the system.

Improving assessment skills and decision making is the most important task we have to undertake and will result in overall better services to children and families. We owe it to Kansas families, our staff and communities to use the most up to date technology and methodology.

Based on what we learned, it was decided to create a decision support system that fits the unique needs of Kansas. The Kansas Initiative for Decision Support-- KIDS--is the name given to this initiative. The implementation of KIDS will have a positive impact in the following ways:

- greater consistency in decision making from worker to worker and from one part of the state to another;
- enhanced child safety through the use of empirically validated assessment of risk of future harm;
- produce better client outcomes;
- supports case decision making at major crossroads such as case opening, service level (i.e. family preservation, foster care), case review, and closure and reunification;
- assists workers in the identification of needs and strengths to best target service interventions (most helpful to new and inexperienced workers); and
- provides useful information to managers and policy makers in determining resource needs, allocation of resources, workload analysis, and service gaps.

Decision support systems have primarily been applied to child abuse and neglect cases and juvenile offender cases. Kansas has the challenge to apply the methodology to youth who come to the attention of the agency as the result of their behavior such as truancy, runaway, out of control behaviors. Roughly a third of the child in need of care case load is comprised of these youth.

In your packet you have a two page summary of the KIDS initiative and a one page general overview of decision support systems which will provide you more detail.

Thank you for the opportunity to talk with you about these major opportunities to improve the safety and permanency for children.

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Children and Family Services

For: Rochelle Chronister
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ADOPTION AND SAFE FAMILIES ACT OF 1997

Summary	Action Needed
Title I: Reasonable Efforts and Child Safety Provisions	
Child Health and Safety Paramount: In making decisions the child's health and safety must be paramount.	Implement actions below
Reasonable Efforts to Preserve and Reunify Families: When the court finds that reunification is not reasonable, based on specified facts such as: aggravated circumstances defined in state law including abandonment, torture, chronic abuse and sexual abuse; parent has killed another child or has assaulted this child or another of their children; or parent's rights to a sibling has been involuntarily terminated, The court must conduct a permanency hearing within 30 days of the finding that reunification is not reasonable and the state must make reasonable efforts for adoption or guardianship.	Amend K.S.A. 38-1563, 1565
Reunification and adoption efforts may be concurrent.	Train foster care and adoption contractors
Documentation of Efforts to Adopt: When permanency plan is adoption the state must document steps taken to: find an adoptive home or relative home; make a permanent placement; and finalize the adoption/guardianship. Additionally the state must document child specific recruitment plans.	Specify in the IV-B state plan and policy how the state will document steps taken. Modify the Case Planning Document. The adoption contractor is currently required to develop a child specific recruitment plan if an adoptive home is not identified within 90 days of the referral..
Termination of Parental Rights: States are required to file a petition or join a petition to terminate parental rights when: a child has been in foster care for 15 of most recent 22 months; court has determined abandonment; court has determined that a parent assaulted the child or killed or assaulted another of their children.	Amend the Kansas Code for Care of Children to provide court must make finding of fact that the child was abused or neglected and petition for termination of parental rights must be filed within 30 days. Training for prosecutors on the act.
Concurrently state is to identify, recruit, process and approve a qualified adoptive family unless: the child is cared for by a relative;	Adoption contract covers the identification, recruitment of qualified families and is in place.
the state has documented to the court compelling reasons a petition is not in the best interest of the child;	Through policy establish guidelines for compelling reasons a petition is not in the best interest of a specific child.
the state has failed to provide services deemed necessary for reunification when reasonable efforts to reunify are required.	Case planning documents currently provide documentation of services offered\provided.

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ADOPTION AND SAFE FAMILIES ACT OF 1997

Summary	Action Needed
Termination of parental Rights: - Continued	
For children who enter foster care after the date of enactment (November 1997) states are required to comply with the 15 of 22 months rule within three months of the end of the states first regular legislative session. (For Kansas July, 1998)	Ensure that information system can identify children related to the 15/22 rule. Develop policy related to Administrative Reviews. Train foster care contractors. Develop procedures for requesting motion by county/district attorney.
For children in foster care at the time of enactment states must comply in three phases: 1/3 of the children with in 6 months of the close of the legislative session (Oct. 1998); 1/3 within 12 months (April, 1999); and full compliance by Oct, 1999.	Training for county/district attorneys and courts on the requirements.
Criminal Record Checks: State must do CRC prior to approval for foster and adoptive families for children eligible for IV-E foster care and adoption support. Foster or adoptive parent cannot be approved if there is a felony conviction for: child abuse/neglect; spousal abuse; crimes against children, including child pornography; or crimes of violence, rape, sexual assault or homicide. Also, parent cannot be approved if in the last 5 years there has been a felony conviction for physical assault, battery or a drug related offence. The Governor or legislature can opt out of this requirement.	Amend statutes to add adoptive families to the statues requiring the K.B.I. to do criminal background checks child care providers. Or, opt out of the requirement.
Quality Standard of Care: By Jan. 1999 states must implement standards to ensure foster children receive quality services.	No Action required Foster Care outcomes are in place Foster parents are required to have MAPP training and annual training.

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ADOPTION AND SAFE FAMILIES ACT OF 1997

Summary	Action Needed
Title II Adoption Promotion Provisions	
Adoption Incentive Payments: States are eligible for incentive payments when: the number of children placed in FY 1998 exceed the average number for FY's 1995-1997; in FY 1999 and subsequently, when adoptions are higher than in any previous FY after 1996.	Determine baseline data
Incentive payment is $4,000 for each child above the base number plus an additional $2,000 for foster children with special needs.	Develop policy about sharing the incentive payments with the adoption contractor.
To be eligible for incentive payments in FY 2001 and 2002 states must provide heath insurance for any special needs child receiving adoption assistance.	Kansas would be required to provide a medical card for children in Kansas from states which are not ICMA reciprocal.
Technical Assistance to Promote Adoption: HHS will provide T.A. to states for: guidelines for expediting TPR; concurrent planning; specialized units to more toward adoption; tools for determining risk of harm if child is returned home; fast tracking children under 1; and legal risk adoption.	No action required
Eligibility for Adoption Assistance in Cases of Dissolved Adoptions: Federal adoption assistance follows a child to a new adoptive placement.	Revise the eligibly and payment manual to reflect this change. Include in state plan
Health Care for Adopted Children with Special Needs: States must provide medical care for adoption assistance children.	No action required. Provision currently in place
Interjurisdictional Adoption: States could lose IV-E eligibility if the Secretary finds a state has denied or delayed placement when an approved family was eligible in another jurisdiction.	Adoption contractor is required to conduct a national search when no Kansas resource is immediately available. Out comes in place to ensure no delays.

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ADOPTION AND SAFE FAMILIES ACT OF 1997

Summary	Action Needed
Title III: System Accountability and Reform Provisions	
Permanency Hearings: Must have permanency hearing within 12 months form date of entry into foster care. Entry into foster care is defined as: date of first judicial finding of child abuse/neglect, or 60 days after a child's removal from the home.	Amend Kansas Code for Care of Children to provide hearing must be "permanency" hearing. Amend Kansas Code for Care of Children to require court finding of fact regarding CA\N.
The purpose of the permanency hearing is to determine permanent plan for the child and includes time table for: 1. returning home; 2. placement for adoption/state filing of TPR; 3. referral for legal guardianship; or 4. other permanent plan based on compelling reason 1,2, or 3 are not options.	Training for contractors, court and prosecutors. Amend Kansas Code for Care of Children.
Participation in Case Reviews/Hearings: Foster parents, pre adoptive parents and relatives providing care of a child must be given notice of hearing and have a right to be heard. Receiving notice does not equal being a party to the action.	Amend Kansas Code for Care of Children Develop policy and procedure to provide up to date information to the court for proper notices.
Performance Measures for State Child Welfare Programs: HHS with assistance from states and advocates must develop outcome measures for states and report to Congress by May, 1999.	Outcome measures are in place. Volunteer to participate with HHS in establishing outcome measures.
Measures are to be developed from AFCARS, in as much as possible and measure: length of stay in foster care; number of foster care placements; number of adoptions.	No action required. Outcome measures are currently in place Determine if FACTS\SACWIS can provide the data
Additionally HHS, with assistance from states and advocates must study and make recommendations to Congress for performance based incentive funding for IV-B and IV-E. Feasibility study due by May 1999.	No action required
Child Welfare Demonstrations: HHS may approve 10 demonstration programs for FY 1998-2002. Demonstrations must consider and address: barriers resulting in delays in adoption; identify and address parental substance abuse problems that endanger children and result in foster care placement; address kinship care.	Plan to submit a project. Preliminary work begun.

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ADOPTION AND SAFE FAMILIES ACT OF 1997

Summary	Action Needed
Title IV: Additional Provisions	
Reauthorization and Expansion of Family Preservation Program:..IV-B, part 2, FP and FS and Court Improvements Projects is re-authorized. Part 2 is expanded and must include: community based family support services; family preservation; time-limited reunification services (no more than 15 months); adoption promotion support services (pre and post adoption services, activities designed to expedite the adoption process)	Update state plan to include the additional services and add an assurance that safety of the child is paramount. Develop policy and procedure
State plan must assure that the safety of the child is the paramount concern.	Add documentation of the assurances to case planning document.
Kinship Care Report: HHS to convene an advisory panel on the extent to which foster care children are placed with relatives. HHS is to report to the panel by 6-98, panel reviews and submits comments by 10-98. HHS to submit final report to Committees on Ways and Means and Finance by 6-99.	No action required. Foster Care and Adoption contractors currently utilize Kinship Care
Federal Parent Locator Service: Child welfare agencies are authorized to use FPLS to locate absent parents.	Current practice in many areas. Ensure that CSE is aware of the federal authorization.
Coordination of Substance Abuse and CPS: HHS is to report to the committees on Ways and Means and Finance on the out comes of substance abuse by November 1998.	No action required. Enhance effort to coordinate and exchange information with ADAS.
Eligibility for Independent Living Services: Revised to include children no longer eligible for IV-E because of assets up to $5000.	Develop policy changes. Coordinate with IM/EPS to ensure policy change does not render the child ineligible for a medical card.
Standby Guardianship: States should (not mandatory) have laws/procedures permitting chronically ill or near death parents to designate a standby guardian to take effect upon parents death/incapacity.	Can do under Kansas current laws. Training concerning the option is needed.
Purchase of American Made Equipment: To the extent possible equipment and products purchased under ASFA should be American made.	Inform purchasing
Preservation of Reasonable Parenting: Nothing in this legislation is intended to disrupt or intrude on the family unnecessarily or prohibit reasonable methods of parental discipline or prescribe a particular method of parenting.	No action required

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ADOPTION AND SAFE FAMILIES ACT OF 1997

Summary	Action Needed
Use of AFCARS Data:..To the extent possible information required by this act would be supplied through AFCARS. *Temporary Reduction of Contingency Fund:* $40 million will be taken from the $2 billion TANF contingency fund. **Title V: Effective Date** Provision are effective on the date of enactment except for: provisions dealing with termination of parental rights, and legislation required by states to comply with state plan requirements (the first quarter following the end of the next state legislative session).	Determine availability of data in FACTS\SACWIS

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KANSAS INITIATIVE FOR DECISION SUPPORT
"KIDS"

With the privatization of direct foster care, adoption and family preservation services well underway, attention is turned to improving our ability to accurately assess the needs of children and families. And to target to those needs the services which will enable children to be safe and secure in their own families. Or, when that is not possible, to quickly become a permanent member of another family. Child safety is paramount both in terms of immediate harm as well as the likelihood of future harm. We need to ensure that we are utilizing state of the art methodology as we make the critical decisions which have life long effect on families.

Three activities over the past year helped to shape the direction we are moving in the search for methods to improve assessment and decision making. First, was the client assessment symposium co-sponsored by the KU School of Social Welfare and SRS Children and Family Services. We heard from leading experts in the field of risk assessment and decision support. Secondly, a four person delegation was sent to Rhode Island and Michigan (two states which are leaders in field) to learn about the operational aspects of decision support systems. Thirdly, two staff persons attended the national round table on risk assessment to learn more about what is going on across the country in this area.

Based on what we learned we concluded decision support systems have beneficial impact in the following ways:

- greater consistency in decision making from worker to worker and from one part of the state to another;
- enhanced child safety through the use of empirically validated assessment of risk of future harm;
- produce better client outcomes;
- supports case decision making at major crossroads such as case opening, service level (i.e. family preservation, foster care), case review, and closure and reunification;
- assists workers in the identification of needs and strengths to best target service interventions (most helpful to new and inexperienced workers); and
- provides useful information to managers and policy makers in determining resource needs, allocation of resources workload analysis, and service gaps.

The determination was made to create a decision support system that fits the needs of our unique service system in Kansas and better serves the needs of Kansas children and families. The Kansas Initiative for Decision Support (KIDS) is the name given to this initiative. Decision support systems have primarily been applied to child abuse and neglect cases and juvenile offender cases. Kansas has the challenge to apply the decision support methodology to youth who come to the attention of the agency as the result of their behaviors such as truancy, runaway, conflict with home school and community. Roughly a third of the child in need of care case load is comprised of these youth.

Planning for the development and implementation of KIDS is based on:

- taking advantage of the research and development completed in other states;
- building upon the work methods and policies already in place that are working well;
- making improvements in the tools and work methods employed in other states;
- taking into consideration the new roles and responsibilities under privatization, Kansas laws, and the "settlement agreement" requirements" and
- making maximum use of field level involvement in both design and implementation.

SRS area staff, supplemented by some staff from CFS, the KU School of Social Welfare and contractors were appointed to develop KIDS. They will identify the major decision points and recommend policy and practice in the following phases of a case.

Child Protection Response: Screening and intake--the decision point of whether to investigate and how quickly. Included will be an exploration of any benefits that might be derived from a statewide centralized screening process.

Service Response: Decisions related to whether services should be provided, and at what level (i.e. Family Services, Family Preservation, or Foster Care.) These decisions are made during and immediately after investigations of child abuse/neglect and are supported by risk and safety assessments. Decision making for non-abuse neglect will also be addressed.

Assessment for Case Planning: Attention is focused on decision points following the initial assessment and throughout the case life to support decisions in case planning and case management, including assessment of case progress and re-assessment of risk for the purpose of case closure.

A steering committee oversees and directs the work of the group. The steering committee is chaired by Commissioner of Children and Family Services and is comprised the CFS Executive Management Team; a representative of the KU School of Social Welfare; an Area Director; a CEO representing the foster care contractors, a children's advocacy representative, and work group chair persons.

The work group will complete their policy development and implementation planning by mid spring. CFS will coordinate data needs with the development of the next phase of AWISP, the child welfare information system.

Overview of Decision Support Systems

Decision support systems are a cohesive set of case work methods (assessment tools and protocols) that guide critical case decisions. The following are the major features of decision support systems:

1. **Assessment tools** A series of structured assessment tools (i.e. risk assessment, safety assessment, and caretaker and child needs and strengths assessment) administered at critical decision points (i.e. case opening, service planning, case review, and re-unification) in the life of a child welfare case.

2. **Service standards** Service standards defining specific number of case contacts based on the risk and need scores.

3. **Case planning** Case planning protocols that tie client assessment to case outcomes through a service plan of action.

4. **Information System** A comprehensive information system to provide case documentation and information for the worker as well as information to support management functions such as supervision, monitoring, planning, and evaluation (including validation and refinement of the risk assessment tool).

5. **Workload Management** A workload accounting and budgeting system that translates service standards into resource requirements and helps deploy resources equitably throughout the system.

The Major Assessment Tool Types Are:

Risk - The risk assessment is an empirically validated instrument that provides information on the likelihood of future maltreatment. The resulting score is translated into a classification of Low, Medium, High, or Intense for both abuse and neglect. A risk assessment instrument is less of a clinical diagnostic tool that a method of sorting cases for differential response.

Safety - The safety assessment is a consensus based tool intended to identify factors that offset risk. The safety assessment identifies the factors associated with a child being in danger of serious harm and the safety factors that might help to keep the child safe (i.e. other family resources, use of other community agencies, perpetrator leaving, non-maltreating caregiver and child move to safe environment, out-of-home placement, or other).

Family Needs and Strengths - Family needs and strength assessment instruments are consensus developed and are designed to identify caretaker attributes that are the contributing factors leading to the abuse or neglect. Examples include characteristics such as emotional stability, parenting skills, substance abuse, domestic relations, and social supports. These factors are scored and needs are classified as low, medium or high need. This information is sometimes used with risk scores to determine service intensity levels. More importantly, these identified factors serve as the starting point for the service plan. This assessment is also used to monitor progress at case reviews and make decisions on re-unification.

Child Needs and Strengths - A child needs assessment is a consensus based tool that is intended to identify child needs and general functioning. Ten areas are assessed including: family relationships, substance abuse, mental health, intellectuality ability, school functioning, life skills, health, victimization, sexual adjustment, and support system/peers. Like the family assessment, factors are scored and needs categorized as low, medium or high. This information is used with risk scores to determine service intensity levels.

Decision support systems have primarily been applied to child abuse and neglect cases and juvenile offender cases. Roughly a third of the child in need of care cases in Kansas come to the attention of the agency because of their behaviors such as truancy, runaway, conflict with home, school and community. In developing a Kansas system, we need to apply decision support methodology to this different group of cases.