Approved: 1-20-00
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chairperson Sandy Praeger at 10:00 a.m. on January 12, 2000 in Room 526-S of the Capitol.

All members were present except:

Committee staff present:

Norman Furse, Revisor of Statutes
Lisa Montgomery, Revisor of Statutes
Hank Avila, Legislative Research Department
JoAnn Bunten, Committee Secretary

Conferees appearing before the committee:

Janet Schalansky, Secretary, Kansas Department of Social and Rehabilitation Services

Others attending: See attached list

Introductions

Senator Praeger opened the Committee meeting with introduction of committee members and staff.

Briefing

Janet Schalansky, Secretary, SRS, briefed the Committee on the reorganization of the state's Social and Rehabilitation Services agency and the Medicaid program. Secretary Schalansky noted that highlights of the reorganization of SRS included a streamlined management structure and leadership team which now reflects the interconnections between service areas of SRS. She felt the changes would shift the focus of the agency from funding streams to supporting processes and functions within SRS, and that the new leadership structure would align agency management with the functions of service delivery, policy development, and operational support. She noted that one of the most notable organizational changes had been made within the Medical Policy/Medicaid Program. Formerly the Adult and Medical Services Commission, the program is now located within the Division of Health Care Policy. Secretary Schalansky also briefed the Committee on home and community based services waivers for the physically disabled and developmentally disabled, HealthWave - the state's version of the Children's Health Insurance Program, elimination of optional medical services for the medically needy, establishment of a task force to study the closure of the Rainbow Mental Health facility, and the need for children's services at the Larned Mental Health facility as noted in her written testimony. (Attachment 1) During Committee discussion, Secretary Schalansky outlined the eligibility requirement for children in the HealthWave program. She noted there are currently 15,222 children enrolled in the program which is credited to outreach efforts in the schools. An additional 17,092 new children are also on Medicaid.

Adjournment

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

The next meeting is scheduled for January 13, 2000.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 1-12-00

NAME	REPRESENTING
Sandy Barnett	KCSDV
Josie Torres	KCDD
Kevin Robertson	
Rick Guttman	Health Midwest
Tom Bell	Ks-Hosp. Assn.
Stan Pawon	KGC
Jeff Bottenberg	Merck
Kathy Damron	St Luke Shawnee Mission
Janet Schalansky	SRS
James Howard	SRS
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS
Kevin Barone	Hein & Wein Chtd
Mary Ellen Conlee	Via Christi
Barb Williams	Ks. Pharmacists Assoc
Yvonne Hirsch	Ks. Assoc. of the Medically Underserved
Paul Rubenstein	Kas Ass for the Medically Underserved
Kelly Tinsley	Ks. Public Health Assn.
Joyce Dolmut	Ks Assoc. Medically Underserved
Chris Beal	Eli Lilly & Co

Myrle Myers
LaRue Ann Lower

Johnson + Johnson
Ks Assoc of Health Plans

(over)

Jan. 12, 2000

Chip Wheelen, KS Assn of Osteo' Med.

State of Kansas Department of Social and Rehabilitation Services

Janet Schalansky, Secretary

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Senate Committee on Public Health and Welfare
January 12, 2000

Update on SRS Reorganization and Medicaid

Office of the Secretary
Janet Schalansky, Secretary
(785) 296-3271

Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

Senate Committee on Public Health and Welfare
January 12, 2000

Madam Chair and members of the Committee, thank you for the opportunity to appear before you today to provide this update on the department's recent reorganization and the Medicaid program.

Reorganization Overview

The purpose of the organizational changes I made effective October 4, 1999 is to provide the following benefits:

- Better services to our customers, through more integrated policy development and service delivery coordination, with an emphasis on effective, coordinated service delivery at the local level;
- Increased emphasis on organizational development and training, with a recognition that new and expanded competencies are required to operate effectively in this rapidly changing environment;
- A highly effective, high-powered organization healthy enough to meet the changing demands of the work we do every day;
- Expectations for staff to function in program units and in cross-functional teams to support the key functions of the agency;
- A focus on decision-making from the ground up, rather than from the top down; and
- A leaner administrative and management structure.

Highlights of the reorganization include a streamlined management structure and leadership team which reflects the interconnections between service areas. As the attached organization chart shows, six commissioners have been replaced by two deputy secretaries who have responsibility for issues across the agency and two assistant secretaries who have expanded policy responsibilities:

- Increased emphasis has been placed on service delivery through the creation of a Deputy Secretary for Service Delivery with responsibility for customer relations and all programs administered through field offices, including economic and employment support programs, rehabilitation services, and child support enforcement. The Deputy Secretary for Integrated Service Delivery is Candy Shively.
- Agency administrative operations have been consolidated under a Deputy Secretary, including dual reporting of operations directors and fiscal officers from the field and central office to the Deputy Secretary of Finance, Information Technology, and Administration. Diane Duffy is serving in this capacity.

- All policy development related to health care services has been consolidated under an Assistant Secretary for Health Care Policy, including health, mental health and substance abuse, services for persons with developmental disabilities, physical disabilities, and other individuals receiving Medicaid waiver services. Lyn Goering will be assuming these responsibilities from Interim Assistant Secretary and Chief of Staff Laura Howard on February 1.
- Child welfare and family development services have been consolidated under Assistant Secretary of Children and Family Policy Joyce Allegrucci.
- Separate executive functions have been consolidated under the leadership of Chief of Staff Laura Howard.
- We have reduced the number of area offices from 12 to 11 through the merger of the Salina and Manhattan Area Offices.

I am extremely proud of the strong team I have been able to assemble, and optimistic about our combined ability to move the organization forward.

The changes I have made in the organization are designed to shift the focus of our agency from funding streams to supporting processes and functions within our agency. The new leadership structure aligns agency management with the functions of service delivery, policy development, and operation support. Administrative support functions have also been realigned in keeping with the new structure, and several new cross-functional teams are being established to foster collaboration and coordinate key business processes.

These internal changes mirror the changes SRS has made in the way we deliver needed services to Kansans over the past several years. We have learned we can no longer provide effective services by working with consumers in an isolated fashion. The complexity of need, together with the coordination necessary to meet those needs, requires multiple interventions by many private and public partners.

In every division of the agency - within Health Care Policy, Children and Family Policy, or Integrated Service Delivery – we have become a partnering agency.

Child Welfare is an example of the need for coordination between public and private entities. We know that safety and permanency for children cannot be accomplished by the public child welfare agency alone. We have learned we can provide better services – better protection for children and quicker permanency for children - by emphasizing coordinated service delivery with other agencies at the local level. The new organizational structure reflects an effort to apply those lessons to our internal operations as well.

Medical Policy / Medicaid Program

Overview. One of the most notable organizational changes has been within the Medical Policy/Medicaid Program. Formerly the Adult and Medical Services Commission, the program is now located within the Division of Health Care Policy. To allow the program autonomy in administering the Medicaid program and focus on medical policy, the HCBS waivers (Physical Disabilities, Head Injured and Technology Assisted Children) were transferred to the program of Community Supports and Services. In addition, certain field functions such as Adult Protective Services were transferred to the Integrated Services Division.

I mention this because it highlights our desire to move the Medical Policy/Medicaid program in a direction that focuses on health care policy for the medically needy and undeserved. We must recognize the critical role this program plays in the overall health care picture in Kansas. When you combine HealthWave, the children's health insurance, and Medicaid programs, the State of Kansas is the single largest purchaser of health care for children in the state. Medicaid pays for nearly one in every three births in the state. In fact, this program is the third largest purchaser of health care in the state behind Blue Cross/ Blue Shield and Medicare.

So we can better discuss our plans for the future, I would like to provide you with an update on the current status of the program.

Current Program Status. The Medical Policy/Medicaid program has been reorganized to reflect its emphasis on value-based purchasing of health insurance for Medicaid and HealthWave eligible beneficiaries. The program has been divided into two branches: "Purchasing and Contracting" and "Benefits and Medical Policy." The goal of this reorganization is to make Medical Policy more compatible with the business partners from whom it purchases services.

As you know, the Medicaid program provides services under three types of payment arrangements: traditional fee-for-service; Primary Care Case Management (PCCM), known as HealthConnect; and capitated managed care, known as PrimeCare.

In the past, we have found it difficult to stabilize our capitated managed care program. The most recent example was in May 1999, when the sole provider of PrimeCare and one of the main Managed Care Organizations (MCOs) in HealthWave, Horizon Health, was placed under the direction of the Kansas Insurance Department and a new MCO, FirstGuard, took over the direction of both programs. It was estimated that Horizon had outstanding provider claims of almost $10 million. During the summer and early fall, SRS has resolved its obligation to Horizon based on additional claims data filed by the company and through a recalculation of prior recoupments. This resolution led to a total payment of nearly $3.8 million to Horizon.

Just recently, SRS extended its contract with FirstGuard as both a HealthWave contractor and the sole MCO participating in PrimeCare and Family Health Partners, the other MCO in HealthWave, through June of this year. We are currently working with our PrimeCare contractor to ensure a more stable and predictable future for the program. Having been assured of the financial viability of FirstGuard, we now are working collaboratively to expand its customer base, because we know that an MCO is financially more viable if it can spread its risk across a larger customer base. In addition, we anticipate that as of next week, a system will be in place so that Medicaid beneficiaries who do not choose between HealthConnect or PrimeCare will be defaulted to PrimeCare. The rationale for this action is quite simple. It is our belief that for Medicaid beneficiaries, capitated managed care is likely to lead to better health care services – especially since the incentives are placed on preventive care rather than illness management. The second action being taken to strengthen PrimeCare is program implementation in Sedgwick County.

Future Initiatives. In planning for the future, we have made some basic assumptions which we believe must be the foundation of our decision making. The first assumption is recognizing that 60 percent of Medicaid participants are poverty-level women and children. We believe this population, which accounts for less than 30 percent of the State's Medicaid expenditures, is best served in a truly managed system of care. Second, we want these individuals to have a medical home with a primary care provider who can provide for continuity of care. Third, we need to be sure that dollars spent on health care are purchasing medical services that are compatible with our assumptions, while at the same time assuring maximum benefit from each dollar that is spent. Finally, we believe it's in the State's best interest to have as healthy a population as possible.

Our goals for the future are as follows:

Having stabilized our managed care market for the short term, we are intent on developing methodologies that make the Medicaid program more closely resemble the Children's Health Insurance Program as represented by HealthWave. It is also our intention to move away from our dependence on the PCCM program and expand our capitated managed care market to cover as many eligible poverty-level women and children as possible. This will require Health Care Finance Administration (HCFA) approval for alternative methodologies of determining the Upper Payment Limit (UPL) that may be used to create the rates under capitated managed care. We informally have been assured by HCFA that they are going to propose allowing states greater flexibility in determining the UPL. This lack of flexibility has made it difficult to provide adequate reimbursement for capitated managed care without increasing the entire cost of all health care by increasing all fee-for-service rates.

In addition to expansion of MCOs as managers of care, we intend to move forward in combining, at least from the perspective of the consumer, our Managed Care Medicaid and HealthWave programs. Our goal is that, to the degree possible, they will appear as

a single insurance program. Currently it is possible for a family to have children enrolled in two different programs and in turn to have separate medical homes. Bringing the two together will not be a simple task given the regulatory differences that govern these two programs. However, we continue to believe that creating a single "look-alike" program is critical to providing quality healthcare to the citizens of Kansas. We have set January 2001 as a target date for issuing an RFP that combines these programs. Our goal for providing consumers a choice between at least two capitated managed care plans is the beginning of FY 2002.

We also have as a short range goal the delinking of Medicaid from our welfare programs. Although we have in theory delinked these programs when welfare reform was introduced, we continue to encounter unanticipated systems issues that do not support the philosophy of delinking. Successful uncoupling of welfare and health benefits will facilitate the creation of a single insurance plan as noted above and reduce the stigma currently experienced by many Poverty Level Eligible (PLE) beneficiaries.

As a part of our desire to reexamine our health care policies, we are beginning a thorough review of our current benefits and the pricing structures that support them. The question we need to ask ourselves is: What services do we think are critical to the provision of quality health care and how much do they cost? We do not have an unlimited budget and we need to purchase wisely if we are to provide good stewardship of public monies. As an example, we are looking at two areas of increasing medical costs: non-emergency transportation and pharmaceutical costs. In regard to transportation, we are preparing an RFP that will use a private transportation broker to manage non-emergency transportation. Pharmacy costs, increasing at more than 15 percent each year, are another area of concern. We currently are exploring options that would slow the growth in these expenditures.

We also remain concerned about the need to provide better oral health to our Medicaid beneficiaries. We anticipate an expenditure of approximately $9.8 million this fiscal year for oral health. We currently are developing data on the number of dentists available to provide Medicaid services. Additionally we are reviewing our claims data to determine past utilization and compare it to utilization by the commercial population.

Finally, the Medical Policy/Medicaid program will increase its efforts to work with other state and local health related agencies to coordinate our efforts and to assure that we do not duplicate efforts. This will involve working collaboratively with KDHE, KDOA, Department of Education and local health care agencies. We also have talked with the Kansas Health Institute about the possible joint sponsorship of a health care policy forum that would involve key policy makers in a discussion about the future of health care in Kansas.

Other Health Updates.

As you recall, the Home and Community Based Waiver programs were designed to provide alternatives to institutional services. They have been successful in reducing the demand for hospital beds and reducing our reliance on nursing homes. But, clearly, there has been rapid growth and increased popularity of these programs in the last few years. As the Governor indicated in his message, there are public policy issues that must be fully debated regarding the waiver programs. The following sections describe the status of each of the department's waiting lists and waivers.

Home and Community Based Services Waiver for the Physically Disabled (PD). Subsequent to the 1999 session, in an effort to remain within budgeted appropriations for the HCBS-PD waiver, the department instituted a waiting list. The number of persons on the waiting list grew to 334 by October 15, 1999. At that time, the Governor recommended that persons on the waiting list at that time receive services. We moved aggressively to place people on the waiting list into services. Currently, the agency is serving all persons who apply and are eligible for the waiver, and there is now no waiting list. The department has taken a number of steps to reduce expenditure growth for the program, including:

- Increasing the long-term care threshold score for new applicants from 15 to 26 to equal the score required (level of care) for nursing facility placement (effective 11/1/99);
- Changing the method assessments are done by assessing consumers on their "typical" day as opposed to their "worst day" (effective 1/1/00); and
- Changing the amount of services requested on the plan of care to be based on the "typical" day as opposed to the "worst day" (effective 1/1/00).

However, the demand for services continues to exceed available resources, even with supplemental funding recommended by the Governor in FY 2000. The rapid and consistent growth in all our waiver programs requires that we develop better methods to adjust growth in the number of persons needing services and the resources required; that we develop needs assessment protocols and processes that help us to target resources to needs; and that we develop effective, efficient, and practical methods to manage within available resources while targeting resources to the most vulnerable populations. We look forward to policy discussions with the Legislature regarding this and other waiver programs during this session.

Home and Community-Based Services Waiver for the Developmentally Disabled (DD). The 1999 Legislature authorized new funding of $10.8 million for the DD waiver in FY 2000, including $5 million for provider rate increases and $5.8 million to reduce the number of unserved persons on the waiting list. During the session, and particular by this Committee, there were a number of concerns expressed regarding management practices and accountability of Community Developmental Disability Organizations (CDDOs). In response to these concerns, we made several changes in the contract

between SRS and CDDOs for FY 2000. First, the current contract requires CDDOs to mange access to the waiver so that the amount spent does not exceed the CDDO allocation. CDDOs are required under the contract to move persons off the waiting list in a timely manner, while not committing the state to additional expenditures in a subsequent year. Adjustments were also made to provide equity of services across the state. The agency has been meeting monthly with the budget director, and with representatives of InterHab, the Kansas Council on Developmental Disabilities, and CDDO representatives to monitor expenditure patterns and waiting list movement. Based on this regular reporting, issues specific to single CDDOs are then addressed.

The following summarizes movement on the DD waiting list since the beginning of the fiscal year:

Waiting List July 1, 1999	333
Persons removed from the waiting list since July 1, 1999	212
New persons added to the waiting list since July 1, 1999	172
Number waiting on January 4, 2000	293

Of the 293 persons on the waiting list, 125 are adults and 168 are children. Further, 52 of them have been waiting for fewer than 60 days.

Other HCBS Waivers. SRS administers two other HCBS waivers - Technology Assisted Children and Head Injury. The Technology Assisted waiver has a waiting list of two and currently serves 40 children. This is the total number authorized under this model waiver.

The HCBS Head Injury waiver currently serves 90 consumers with 110 persons on the waiting list. The average length of time on the waiting list is 18 months. In an effort to reduce time spent on the waiting list and serve consumers more quickly, efficiently and cost-effectively, SRS has recently instituted some policy changes to assist in identifying consumers who are ready to transition from the Head Injury waiver to other services, such as the PD waiver.

Home and Community Based Services Income Standard. The department is proposing to modify the income standard used to determine eligibility and the amount of cost sharing in the state's Home and Community Based Services (HCBS) waivers. Waivers affected by this proposal include those serving the frail elderly, physically disabled, and developmentally disabled.

The income standard for HCBS has been set higher than others to provide an additional benefit to these clients. In the current economic environment, considering the difficult decisions that must be made, changing those standards seems to be appropriate. Although some individuals will have their support reduced as a result of these changes, the most vulnerable will still be protected.

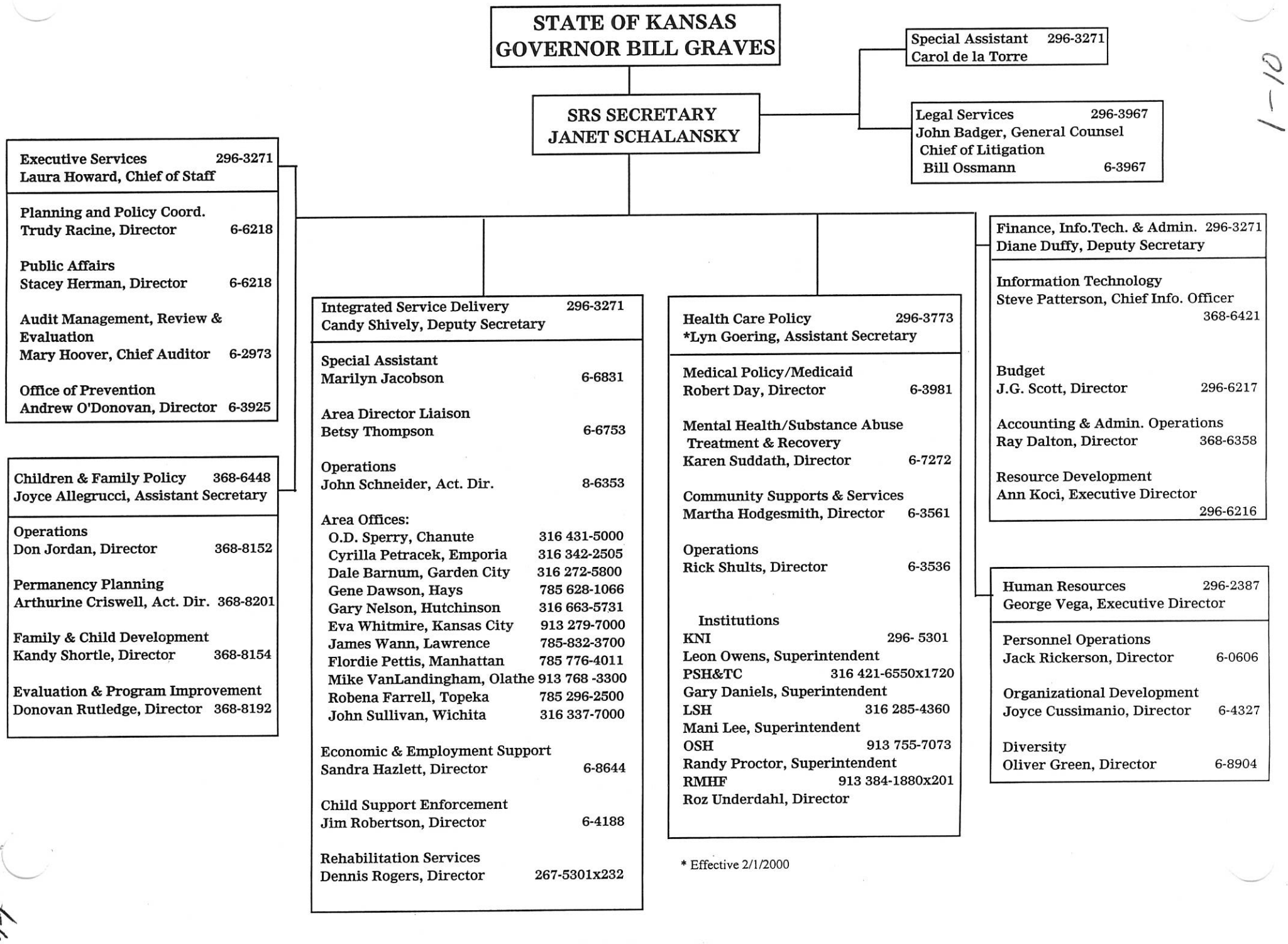
HealthWave Program. HealthWave, the Kansas version of the State Children's Health Insurance Program, celebrated its first birthday on January 1, 2000. There are currently 15,222 children enrolled in the HealthWave program, and an additional 17,092 new children on Medicaid, largely a result of the outreach and marketing for HealthWave. In total, more than 32,000 children today have health coverage who didn't have such coverage one year ago. We are very pleased with the success of this program and the outreach efforts, although we have been surprised at the proportion of new children who are Medicaid eligible. These additional children are reflected in the increased caseload estimates for regular medical assistance. Over the next few months we will be monitoring enrollment numbers closely as children reach their 12th month of continuous eligibility in HealthWave or Medicaid. We'll be looking at how many children remain eligible for their current program, how many change programs, how many lose eligibility, and how many choose not to reapply for services.

Eliminating Optional Medical Services for the Medically Needy. The medically needy are individuals who otherwise meet the criteria for Supplemental Security Income (SSI) or Temporary Assistance to Families (TAF), but whose income is too great. Such individuals qualify for Medicaid, but must meet a spend-down; that is, they must devote a portion of their income to medical expenses. To curb the rising costs in Regular Medical Assistance that were discussed earlier, the Governor has recommended the elimination of optional services, such as dental, vision, and chiropractic care, to the medically needy population. This change will reduce medical costs by $6.2 million in FY 2001. The recommendation exempts mental health coverage, and full funding is provided for services delivered by the community mental health centers.

Rainbow Mental Health Facility and Children's State Hospital Beds. As the Committee is aware, we have been discussing the future of the Rainbow Mental Health Facility, acute care services for adults with severe and persistent mental illness and the appropriateness of state hospital placement for children. The state has made considerable investment in community-based options for children, specifically the HCBS waiver for children with Serious Emotional Disturbances (SED), and most recently the Family Centered System of Care funded by the 1999 Legislature. The census of children in state hospitals has declined considerably in recent years. Last year, only 21 hospital beds for children were in use at any given time at the two facilities. For adults, access to acute care services close to home is vital for persons to maintain ties with their families, employment, and community. In mid-December 1999, Governor Graves and I announced the establishment of a task force to review the proposed closure of Rainbow and the need for children's beds at Larned Mental Health Facility. I intend to appoint that task force this month. The Governor's FY 2001 budget continues funding for Rainbow Mental Health Facility and children's services at Larned State Hospital.

I thank you for the opportunity to discuss these issues with you today. I'll be happy to stand for questions.

SRS Central Office Organization Chart 1/2000



* Effective 2/1/2000

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