Approved: March 29, 2002
Date

MINUTES OF THE SENATE COMMITTEE ON WAYS AND MEANS.

The meeting was called to order by Chairperson Stephen Morris at 10:40 a.m. on February 20, 2002 in Room 123-S of the Capitol.

All members were present except: All Present

Committee staff present:
Alan Conroy, Chief Fiscal Analyst, Kansas Legislative Research Department
Deb Hollon, Kansas Legislative Research Department
Martha Dorsey, Kansas Legislative Research Department
Becky Krahl, Kansas Legislative Research Department
Norman Furse, Revisor of Statutes
Michael Corrigan, Assistant Revisor of Statutes
Judy Bromich, Assistant to the Chairman
Mary Shaw, Committee Secretary

Conferees appearing before the committee:
Senator Greta Goodwin
Bill Medley, Retired Superintendent of Schools
Laura Howard, Assistant Secretary, Health Care Policy, Department of Social and Rehabilitation Services
Ron Hammock, Executive Director, Creative Community Living
Sharon Bird, President, Creative Community Living
Candace Shively, Deputy Secretary, Integrated Service Delivery, Department of Social and Rehabilitation Services
Pam Scott, Executive Director, Kansas Funeral Directors and Embalmers Association

Others attending: See attached list

Subcommittee report on:

Kansas Guardianship Program (Attachment 1)

Subcommittee Chairman Huelskamp reported that the Subcommittee concurs with the Governor's recommendations for FY 2002.

Subcommittee Chairman Huelskamp reported that the Subcommittee concurs with the Governor's recommendations for FY 2003 with notation as listed in the subcommittee budget report.

Senator Huelskamp moved, with a second by Senator Feleciano, to adopt the subcommittee budget report on the Kansas Guardianship Program for the FY 2002 and FY 2003 budget. Motion carried on a voice vote.

Chairman Morris opened the public hearing on:

SB 557 --Community developmental disability services federal financial participation

Staff briefed the Committee on the bill.

Senator Greta Goodwin testified in favor of **SB 557** (Attachment 2). Senator Goodwin explained that at the very last minute in 2001 a last minute amendment to **HB 2067** was ill conceived and created severe penalties for those providers who have stepped up to care for medically fragile citizens of Kansas, many of whom are former Winfield State Hospital residents. The Senator mentioned that through **SB 557** she is correcting the disparity in funding which now exists due to the passage of the amendment of last session. Senator Goodwin urged passage of **SB 557** to correct a grave funding injustice which the state made to the developmental disabled community.

Bill Medley, retired Superintendent of Schools and treasurer/member of the Board of Directors of Creative Community Living of South Central Kansas, who testified in favor of **SB 557** (Attachment 3). Mr. Medley mentioned that he was asked to join a few parents and guardians of residents of the Winfield State Hospital to help form a not-for-profit corporation to provide housing and care for individuals with severe developmental disabilities. He explained that when **HB 2067** was passed in the last few hours of the 2001 session, it did not recognize the funding of the special tier rates. Mr. Medley urged consideration of **SB 557** as a vehicle to correct an inequity.

Laura Howard, Assistant Secretary, Health Care Policy, Department of Social and Rehabilitation Services, spoke regarding **SB 557** (Attachment 4). Ms. Howard explained that **SB 557** amends KSA 201 Supp 39-1811 to modify the allowable usage of revenue derived from the maximization of federal financial participation (FFP) in the Medicaid program for community developmental disability services. She expressed concern regarding the policy choices inherent in deleting section (d) (2) are akin to those contemplated by the stakeholder design team last fall. Ms. Howard noted that non-waiver eligible persons could lose funding; the gain in maximization would be off-set by administrative disruption and cost; and there would be a loss of service flexibility and responsiveness to local need. She mentioned that enacting the proposed change in section (d) (1), along with retaining the language in section (d) (2) will offer the state of Kansas the maximum flexibility to meet the service needs of Kansans with developmental disabilities, while continuing to maximize the dollars in the system as much as possible.

Ron Hammock, Executive Director, Creative Community Living, spoke in favor of **SB 557** (Attachment 5). Mr. Hammock expressed concern regarding Creative Community Living, and other similar agencies who work with individuals with severe disabilities, and a pattern of adverse decisions and proposed changes related to the continuation of adequate funding for those with severe disabilities. Specifically, he noted the continuation of an inadequate allocation at the beginning of each fiscal year, the micro management of special tier rates, proposed changes to reimbursement for targeted case management, and the unfair distribution of potential rate increases gained from maximization efforts accomplished by matching programs which draw down additional Federal dollars. Mr. Hammock mentioned that the eleventh hour passage of **HB 2067** during last year's session with inferences that suggest special tiers do not need to be adjusted upward when additional funding is available in the future. Mr. Hammock noted that **SB 557** deletes those features of **HB 2067** which allow for direct or indirect attacks on funding for people with severe disabilities.

Sharon Bird, President, Creative Community Living, spoke in favor of **SB 557** (Attachment 6). Ms. Bird noted in her testimony that when **HB 2067** was passed last year, it was a measure that would leave their children out of the money flow simply because they are the most severely handicapped and costly people served in a community setting. She mentioned that **SB 557** would put all the people served in a community setting on the same level.

Committee questions and discussion followed. There was discussion regarding the use of formulas and use of actual records of costs. SRS will look into the comments and will get documentation back to the committee. There being no further conferees to come before the Committee, the Chairman closed the public hearing on **SB 557**.

The Chairman opened the public hearing on:

SB 513--After death of recipients of medicaid requiring certain moneys to be recouped and repaid to secretary of social and rehabilitation services

Staff briefed the Committee on the bill.

Candace Shively, Deputy Director, Integrated Service Delivery, testified in favor of **SB 513** (Attachment 7). Ms. Shively explained that **SB 513** would permit recoveries of excess funds remaining in funeral agreements and is a part of a package of bills developed by the Department to improve the effectiveness of and amount of recoveries for the Estate Recovery program in Kansas. She offered an amendment to the originally proposed bill which was developed in collaboration with the Kansas Funeral Directors Association who also support the changes (Attachment 8).

Pam Scott, Executive Director, Kansas Funeral Directors and Embalmers Association (KFDA), testified in favor of **SB 513** (Attachment 9). Ms. Scott mentioned that **SB 513** allows for the recovery, by the Kansas Department of Social and Rehabilitation Services (SRS), of any excess balance remaining in prepaid funeral agreements after the payment of funeral and burial expenses. She noted that while KFDA supports the intent of **SB 513**, they did not believe the current language of the bill was the best way to accomplish the goal of returning excess funds to SRS. Ms. Scott explained that KFDA met with representatives of SRS and came up with substitute language and offered that language as an amendment (Attachment 10).

Committee questions and discussion followed. Chairman Morris asked if both the languages were the same in the proposed amendments and the responses were that the languages are the same.

Senator Schodorf moved, with a second by Senator Huelskamp, to amend **SB 513** with the proposed amendments by SRS and the KFDA. Motion carried on a voice vote.

The meeting was adjourned at 12:00 noon. The next meeting is scheduled for February 21, 2002.

SENATE WAYS AND MEANS COMMITTEE
GUEST LIST
DATE February 20, 2002

NAME	REPRESENTING
Candy Shively	SRS
Brian Jazwinski	SRS
Roger A. VanEtten	SRS
Martha Hunt	SRS
Lana Howard	SRS
John Badger	SRS
Patrick A Sell	cerebral Palsy Research
Ron Hammack	Creative Comm't Living
Sharon T Bird	CCL - Creative Community Living
Elaine Hermes	LWV Wichita-Metro
Sharon Schlieger	LWV Wichita-Metro
MaryLou Warren	LWV Great Bend
Josie Torrez	KCDD
Trudy Racine	SRS
Bill Medley	Creative Community Living
Jason Moon	KU Pharmacy Student
Dolores Furtado	League of Women Voters-City Johnson
Jeanie McCracken	League of Women Voters
Bill Peterson	AARP
Mike Hatfield	Alliance for Kansans w/ Dev. Disabilities
Jean Kiaka	KCP
MATT FLETCHER	INTERHAB
Mary Lou Taylor	Creative Community Living

Senate Subcommittee Report

Agency: Kansas Guardianship Program **Bill No.** **Bill Sec.**

Analyst: Krahl **Analysis Pg. No.** Vol. I - 720 **Budget Page No.**175

Expenditure Summary	Agency Estimate FY 02	Governor's Recommendation FY 02	Subcommittee Adjustments
State Operations			
State General Fund	$ 1,130,350	$ 1,110,350	$ 0
Employee Positions*	13.0	13.0	0.0

* Employees of the Kansas Guardianship Program are not state employees, but are listed for informational purposes.

Agency Estimate/Governor's Recommendation

The agency estimates expenditures for FY 2002 of $1,130,350, which is an increase of $50,913 (4.7 percent) from the FY 2002 approved budget. This increase is to be funded through KSIP funds. The request includes $523,559 for salaries and wages, $556,363 for contractual services, $14,515, for commodities, and $35,913 for capital outlay.

The Governor recommends expenditures for FY 2002 of $1,110,350 which is an increase of $30,913 (2.9 percent) from the FY 2002 approved budget. The Governor recommends a $20,000 volunteer stipends reduction. The recommendation includes $523,559 for salaries and wages, $536,363 for contractual services, $14,515 for commodities, and $35,913 for capital outlay.

Senate Subcommittee Recommendation

The Senate Subcommittee concurs with the Governor's recommendation.

Senator Tim Huelskamp, Chairperson

Senator Paul Feleciano

35864(2/19/2{9:20AM })

Senate Ways and Means
2-20-02
Attachment 1

Senate Subcommittee Report

Agency: Kansas Guardianship Program **Bill No.** **Bill Sec.**

Analyst: Krahl **Analysis Pg. No.** Vol. I - 720 **Budget Page No.** 175

Expenditure Summary	Agency Request FY 03	Governor's Recommendation FY 03	Subcommittee Adjustments
State Operations			
State General Fund	$ 1,177,134	$ 1,073,050	$ 0
Employee Positions*	15.0	13.0	0.0

* Employees of the Kansas Guardianship Program are not state employees, but are listed for informational purposes.

Agency Request/Governor's Recommendation

The agency request expenditures for FY 2003 of $1,177,134 which is an increase of $46,784 (4.1 percent) from the FY 2002 agency estimate. The request includes $599,764 for salaries and wages, $554,389 for contractual services, $15,981 for commodities, and $7,000 for capital outlay. The request includes an enhancement package for two recruiter/facilitator positions ($69,328) and related operating expenses ($24,000).

The Governor recommends expenditures for FY 2003 of $1,073,050 which is a decrease of $37,300 (3.4 percent) from the FY 2002 recommendation. The recommendation includes $539,680 for salaries and wages, $518,389 for contractual services, and $14,981 for commodities. The Governor does not recommend the enhancement.

Senate Subcommittee Recommendation

The Senate Subcommittee concurs with the Governor's recommendation with the following notation:

1. The Subcommittee notes that liability protection is a concern for many of the agency's guardians and/or conservators who have volunteered become legally and morally responsible for the well-being of their neighbors in need and have no liability protection.

2. The Subcommittee notes that every year many Kansans are declared legally unable to manage their lives and financial affairs. Most people have family members or other community supporters who are appointed by the courts to serves as guardians. There are, however, a significant number of adults who are served by the many volunteers of the Kansas Guardianship Program. The Kansas Guardianship Program provides qualified, caring, and trained persons to serve as court appointed guardians and/or conservators to the numerous persons

who are Medicaid eligible and have families unable, unwilling, or inappropriate to provide the necessary care involved in guardianship/conservatorship.

3. The Subcommittee notes that during the fiscal year 2001, the Kansas Guardianship Program volunteers provided guardianship/conservatorship services to 1,666 wards and conservatees. As of June 30, 2001, approximately 815 volunteers were serving in the program and over the years, over 2,840 Kansans have been recruited to serve as volunteers in the program.

Senator Tim Huelskamp, Chairperson

Senator Paul Feleciano

35866(2/19/2{9:25AM })

STATE OF KANSAS

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SENATOR, 32ND DISTRICT
COWLEY AND SUMNER COUNTIES

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TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNMENTS
RANKING MINORITY MEMBER:
JUDICIARY
CORRECTIONS/JUVENILE JUSTICE
STATE BUILDING CONSTRUCTION

MEMBER: ASSESSMENT AND TAXATION
TRANSPORTATION
CONFIRMATION OVERSIGHT
KANSAS SENTENCING COMMISSION
STATE CAPITOL RESTORATION
HEALTH CARE STABILIZATION FUND
LEGISLATIVE OVERSIGHT
JUDICIAL COUNCIL JUVENILE OFFENDER/
CHILD IN NEED OF CARE ADVISORY
JUDICIAL COUNCIL PROBATE LAW
ADVISORY

SENATE WAYS AND MEANS COMMITTEE
TESTIMONY IN SUPPORT OF SENATE BILL 557
February 19, 2002

Chairman Morris and Members of the Committee:

I appreciate the opportunity to testify in support of the passage of Senate Bill 557. I would like to give some background information on why the passage of this legislation is so important to not only the South Central area of our state, but to all of the state of Kansas.

In January, 1992 a legislative task force filed a report recommending the reduction of Kansas' three mental retardation state hospitals which ultimately became the first step leading to the closure of the Winfield State Hospital and Training Center located in Winfield, a mental retardation hospital in existence since 1887. This hospital cared for and continued to care for the most severely disabled Kansas citizens for over 100 years until the state ordered it to be closed. In March, 1998 the doors were closed.

Upon the decision to close our hospital, all parents and guardians were told that they would be the ones, and the only ones, to choose where their loved one/ward would get the same services as received at our hospital. There were no comparable services in place in our state for those severely disabled persons at that time. As a result, the parents and guardians organized and created their own organization, Creative Community Living, to care for their loved ones. They are the largest of the four providers in the Cowley/Butler County area. That organization is represented here today.

Upon closure of our hospital our medically fragile residents were moved into the community all over the state of Kansas, but many stayed in the Cowley/Butler County area to be cared for by their same care takers as they were when living at the hospital. The decision brought much controversy to certain people in the Topeka area. Then Secretary of SRS, Rochelle Chronister, found that the state's most severely disabled residents of the hospital being placed in the community-based homes did not fit into any of the regular tier criteria for funding. Therefore, after several meetings with providers and myself, Secretary Chronister created special-tier reimbursement rates for people who needed more services at a much higher cost than any other disabled residents of our state.

With that background, I come to the need for this legislation. As the 2001 session was winding down several meetings were held by a conference committee on HB 2067 which originally concerned only employees of adult care homes and home health agencies. At the last meeting of the conference committee held on the last night of session, a member of the House requested the conference committee to add a section which a lobbyist had brought forward that created a new statute. The new amendment requires that moneys raised by a taxing subdivision for developmental disability services to be used as a certifiable match for federal financial

Senate Ways and Means
2-20-02
Attachment 2

participation to the extent feasible and that money derived from maximizing federal funds is to be used only for the purposes set out in the new section. The new section called for the federal funds to be used (1) exclusively to increase the regular nonspecialized tier reimbursement rate above the ... or (2) for other Medicaid reimbursable services for persons with developmental disabilities based upon an agreement entered into by the secretary and community developmental disability organizations by written contract.

This amendment intentionally eliminated proportionate special tier funding to be made to those providers who care for the most severely disabled in our state. You might hear the argument today that provision (2) would allow **some** money to flow to those providers. As to whether or not super-tier adjustments will be made according to (2) depends on SRS and the CDDOs reaching an agreement per this amendment which became law. There are many CDDOs in our state who have no persons eligible for special tier reimbursement. I do not perceive a majority, or perhaps any, CDDO willing to give up their funding to fund someone else's more severely disabled clients. The cost of service to the developmentally disabled is a very hot topic in our state just like the school finance issue being debated this year. All CDDOs will be protecting their own budgets just as schools are fighting for resources for their budgets.

This very last minute amendment was ill conceived and created severe penalties for those providers who have stepped up to care for our medically fragile citizens of Kansas, many of whom are former Winfield State Hospital residents. Through Senate Bill 557 I am correcting the disparity in funding which now exists due to the passage of the amendment of last session.

I urge the passage of Senate Bill No. 557 to correct a grave funding injustice which our state made to the developmental disable community.

Thank you for the opportunity to appear before you this morning. I am here to urge your consideration of Senate Bill 557.

I am Bill Medley, treasurer and a member of the board of directors of Creative Community Living of South Central Kansas. I retired as superintendent of Winfield USD 465 in 1994. Soon thereafter, I was asked to join a few parents and guardians of residents of the Winfield State Hospital to help form a not-for-profit corporation to provide housing and care for individuals with severe developmental disabilities. There was one other non- "parent/guardian" on the original board of directors. The result of the efforts of this group and others is Creative Community Living as it now exists. Our bylaws require that the membership of the board of directors has at least fifty-one per cent parents or guardians of those served by the organization. The members of the board of directors receive no material benefits or fees.

From the beginning, it has been the desire of the board of directors and the staff of CCL that the former residents of the Winfield State Hospital receive the same or better services when they were placed in the community.
Although it has been a challenge, we take pride in the accomplishments of CCL. The special tier rates set up and approved by SRS recognized that many of the people moving from the Winfield State Hospital to the community had the greatest needs. It is obvious that people who require services 24 hours a day will require more funding than those who receive services only a few hours a day or a week. When House Bill 2067 was passed in the last few hours of the 2001 Legislative Session, it did not recognize the funding of the special tier rates.

We hope that this was not the intent of those who proposed the legislation or of those who voted for HB 2067. We consider SB 557 as a vehicle to correct an inequity and we encourage your affirmative vote.

Thanks for the consideration that you give to this request.

Bill Medley
1314 East Ninth Avenue
Winfield, KS 67156
620-221-9180

Senate Ways and Means
2-20-02
Attachment 3

Kansas Department of Social and Rehabilitation Services

Janet Schalansky, Secretary

Docking State Office Building
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Senate Ways and Means Committee
February 20, 2002 - 10:30 AM

Testimony Regarding Senate Bill 557

Health Care Policy
Laura Howard, Assistant Secretary
785.296.3274

Senate Ways and Means
2-20-02
Attachment 4

Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

Senate Ways and Means Committee - Room 123-S
February 20, 2002 - 10:30 AM

Testimony Regarding Senate Bill 557

Mr. Chairman and members of the Committee, thank you for the opportunity to appear on Senate Bill 557. This bill amends K.S.A. 2001 Supp. 39-1811 to modify the allowable usage of revenue derived from the maximization of federal financial participation (FFP) in the Medicaid program for community developmental disability services.

Background

During the 2001 Kansas Legislative Session, considerable discussion occurred on workforce challenges and rates paid for developmental disabilities services. SRS rate studies and those of private providers showed shortfalls in meeting competitive salaries for direct service workers. To address part of the workforce issues, the Legislature passed H.B. 2067, an amendment to the 1995 Developmental Disabilities Reform Act. A key mandate in H.B. 2067 is a requirement that the Secretary assure annually that federal financial participation is maximized in the developmental disabilities system.

Maximizing FFP - Progress To-Date

The Secretary, on January 28, 2002, submitted a Report to the Legislature - Plans for Maximizing Federal Financial Participation and Community Capacity Building Plans. That report is attached to this testimony. The report goes into detail about the collaborative processes that were undertaken last summer and fall to implement the legislative mandate. In short, the first stage of this maximization effort has resulted in the addition of $6.8 million in new federal Medicaid funds in the developmental disabilities service system in FY 2002.

Specifically, based on the recommendations of a design team made up of CDDOs and community service providers and the feedback received from a broader group of stakeholders, SRS and the CDDOs reached an agreement last December to increase the amount SRS pays CDDOs for administering the developmental disabilities system. Raising these payments using existing state funds as match allowed significant increased federal funding, approximately $6.8 million, to be paid for community DD services in FY 2002. Under the terms of a contract amendment, CDDOs will distribute this funding throughout the community service provider system to address workforce issues.

In addition to this maximization of funds achieved in FY 2002, a work group made up of CDDOs and community service providers from the state's metropolitan statistical area (MSA) counties

(urban areas) is currently working with SRS to implement rate increases for services provided through the Home and Community Based Services waiver for persons with developmental disabilities. Nine counties, identified by the Office of Management and Budget as high cost areas in Kansas, serve 50% of the persons in the community developmental disabilities system and are experiencing the most serious workforce challenges. This work group's goal is to implement these higher HCBS rates by the beginning of FY 2003, using local unmatched funds as the state match for these higher Medicaid rates.

As a result of the first phase of the process, only $8.7 million in state and local funds remain unmatched in the developmental disabilities system. This amount will be reduced further with implementation of MSA rates in the urban areas.

During the collaborative processes during the summer and fall, a number of different models were explored, including models that would match each unmatched dollar with federal Medicaid funds. The report goes into detail about the concerns voiced by most developmental disabilities stakeholders about the outcomes and ramifications of following through with plans to maximize all state dollars in the system:

1. Maximizing federal funds to a greater degree means moving towards a solely Medicaid-funded system.
2. Non-waiver-eligible persons would lose services in an all-Medicaid-funded system.
3. Differential HCBS waiver rates across the state not tied to cost differences would be a natural outcome.
4. The gain in maximization would be offset by administrative disruption, cost and service loss.
5. There would be a loss of service delivery flexibility and ability to be responsive to local need.

Impact of Proposed Changes in S.B. 557

The proposed change at section (d) (1) expands the flexibility of this law. Currently this subsection requires that SRS use the revenue derived from FFP maximization to increase regular HCBS rates only. By lifting this requirement, SRS would gain the ability to use dollars generated from FFP maximization to raise the special rates paid for services for people with extraordinary needs. The agency supports this proposed change in public policy.

The proposed deletion of section (d) (2), however, decreases the flexibility of this law. If passed, the law would require that funds derived from maximization in the community DD system be used solely to raise the reimbursement rates for HCBS services. The current language allows SRS the flexibility to use revenue derived from the maximization of FFP to fund non-HCBS Medicaid services. Many people in the community DD system are Medicaid eligible, but require less intensive services than are provided through the HCBS waiver program. This second provision in section (d) allows SRS and CDDOs to fund existing or new Medicaid services for people with disabilities.

The policy choices inherent in deleting section (d) (2) are akin to those contemplated by the stakeholder design team last fall. That is, non-waiver eligible persons could lose funding; the gain in maximization would be off-set by administrative disruption and cost; and there would be a loss of service flexibility and responsiveness to local need. Another important goal, namely decreased dependence on publicly-funded services, could also be jeopardized if this section of the law is deleted. People who are currently served with SGF dollars or who are on the HCBS waiver, but have relatively few service needs, could be left with no service options but the HCBS waiver. Such persons could also benefit from non-HCBS Medicaid services, such as minimal personal assistance services. It is good public policy to allow people to have the option to access services like these and to encourage their increased independence. In addition, it would appear that the maximization efforts achieved in the current fiscal year could not be continued in subsequent years.

Attached is a chart from the "State of the States in Developmental Disabilities: 2002 Summary" that shows how many state funds are potentially available in each state to match for additional federal Medicaid funding. As you will note, Kansas is in the top ten states that are highly maximized. At the time this study was conducted, only 5% of Kansas community developmental disability dollars were unmatched. On page two of the attached "Report to Legislature," you will note that 26% of Kansans who receive community developmental disabilities services receive services funded with state-only dollars. This mere 5% of community DD funds generates a high return on investment by serving a quarter of the people in the Kansas DD system. Maintaining the flexibility inherent in section (d) (2) of K.S.A. 2001 Supp. 39-1811 would guarantee Kansas can continue to realize this high return on investment for many Kansans with developmental disabilities.

Enacting the proposed change in section (d) (1), along with retaining the language in section (d) (2) will offer the state of Kansas the maximum flexibility to meet the service needs of Kansans with developmental disabilities, while continuing to maximize the dollars in the system as much as possible.

I would be happy to answer any questions you might have.

Attachment A

Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

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Report to Legislature

Plans for Maximizing Federal Financial Participation and Community Capacity Building Plans

Health Care Policy
Laura Howard, Assistant Secretary

Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

Report to Legislature
PLANS FOR MAXIMIZING FEDERAL FINANCIAL PARTICIPATION AND COMMUNITY CAPACITY BUILDING PLANS

During the 2001 Kansas Legislature, considerable discussion occurred on work force challenges and rates paid for developmental disabilities services. SRS rate studies and those of private providers showed shortfalls in meeting competitive salaries for direct service workers. To address part of the work force issues, the legislature passed HB 2067, an amendment to the 1995 Developmental Disabilities Reform Act. In part, this amendment requires the Secretary of SRS:

1) To ensure annually the maximum feasible use of available state and local taxing subdivision (county) funds as match or certified match for federal Medicaid funds. Revenue derived from maximization shall be applied to increase HCBS waiver rates for persons with developmental disabilities (MRDD waiver) or upon agreement with the community developmental disability organizations (CDDOs), for other Medicaid reimbursable services.

2) To require Councils of Community Members (CCMs) within CDDOs to annually develop and implement community capacity building plans to improve the quality and efficiency of service delivery. The capacity building plans shall:

- Identify strengths within the local service area, including natural and community supports;
- Identify barriers to meeting the independence, productivity, integration and inclusion goals of the developmental disabilities reform act; and

3)Report to the 2002 Legislature and each subsequent Legislature on the results of plans to maximize federal financial participation and on the results of community capacity building plans.

Financing in the Developmental Disabilities System

A key mandate in H.B. 2067 is a requirement that the Secretary assure annually that federal financial participation is maximized in the developmental disabilities system. Even prior to the implementation efforts summarized in this report, the developmental disabilities system in Kansas has relied substantially on federal Medicaid funds. Making maximum use of federal Medicaid funds was a key premise in the establishment and expansion of the Home and Community Based Services (HCBS) Medicaid waiver for persons with developmental disabilities. In fact, prior to current

maximization efforts:

- 83% of state general fund and country funds dedicated to developmental disability services were matched with federal funds;

- Only $18.4 million out of $105.8 million in state general and county funds are unmatched by federal Medicaid dollars, for total system funding of $240.3 million

Persons with developmental disabilities are supported in the community from Medicaid funding, from state only funding, and from local county funds:

- As of December 31, 2001, 8,766 Kansans with developmental disabilities received community-based services

- 68.5% of these Kansans were funded through the HCBS MRDD Medicaid waiver;

- 26% of these Kansans received services funded only with state general fund dollars (SGF); and

- 5.5% of these Kansans are supported by other funding sources.

Although the maximization efforts undertaken in accordance with H.B. 2067, did not generate increases in revenue of a magnitude to fully fill the direct care salary gaps identified in the rate studies, additional federal funds have been generated for investment in the developmental disabilities system. Specifically:

- The amount of unmatched state and county funds is reduced from $18.4 million to $8.7 million in the first phase of maximization -- leaving virtually no state funds and only limited county funding unmatched;

- Additional federal funds of $6.8 million are generated in these maximization efforts in FY 2002 for distribution to community service providers;

- A second phase of maximization will increase reimbursement rates for the HCBS-DD waiver in urban high cost areas, using local county funds as match for new federal funds– this second phase will reduce even further the level of unmatched funds in the system;

The remaining pages of this report provide additional detail on the rules surrounding federal financial participation, the collaborative process to implement H.B. 2067, the

system impacts of certain maximization choices, summarize the federal rules that must be followed in claiming Medicaid funds, detail the FY 2002 maximization efforts and future plans, and summarize issues related to community capacity building.

MAXIMIZING FEDERAL FINANCIAL PARTICIPATION

The Rules of Federal Financial Participation (FFP)

The goal of HB 2067, the 2001 Amendment to the DD Reform Act, is to match Federal Financial Participation (FFP) to the greatest extent feasible for use in addressing work force issues impacting on the capacity of the DD service system to delivery quality services.

State policy and federal funding rules dictate the extent to which state and local funds can be matched with FFP. The Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration, is the federal agency responsible for financial and programmatic oversight of the Medicaid program. Federal laws and regulations govern what can be matched, and how match can be certified:

- Medicaid authorizes the state match of 40% to be provided by either "hard" cash match from the state or by a certified match of either state or local funds.

- Funds can only be certified by public agencies. At the local level, the CDDO, as a quasi-governmental agency, is the only entity that can certify match for Medicaid services.

- The federal government requires that each entity certifying match (in this case, each CDDO), have sufficient funds available to certify match for Medicaid payments for the consumers served in their region.

Current Use and Distribution of Unmatched Funds

The $18.4 million in unmatched state and local funds are distributed across the state, and only provided to CDDOs.

- They are distributed unevenly across the state, based on the formula for the distribution of various state funding sources or according to the level of local county mill levy;

- The unmatched state and county funds are used for a wide variety of purposes that meet needs not met by Medicaid funding (i.e. infant/toddler programs, transportation, housing assistance) and directly support 26% of persons receiving

community DD services.

Implementing HB 2067 - Collaborative Teamwork

To accomplish the objectives of HB 2067, SRS convened meetings with various stakeholders from June through December 2001. At the Health Care Policy meeting with CDDOs on August 23, 2001, it was agreed to develop a Federal Financial Participation (FFP) System Design Team.

The purpose of this team was to review the fiscal and administrative issues related to the matching of state and local funds to increase HCBS/MRDD Waiver reimbursement rates. Meetings of the Design Team were held on September 11 and 25, October 2, 3, 16 and 17. A sub-group of the Design Team met on September 18. Members of a Resource Team participated in the meetings on September 11 and October 3. The design team included representatives of community developmental disability organizations and community service providers. In addition, the Resource Team had consumer and advocacy representation.

Analyzing System Impacts of Enhanced Maximization of Federal Funds

The FFP System Design Team worked through an analysis of federal CMS (HCFA) requirements and the current structure of financing and services delivery in the DD services system. The Design Team concluded that there were several factors impacting the maximization goals and a number of system, policy or funding distribution ramifications from certain maximization models:

Factors that Impact Proposed Maximization Goals

- Medicaid rules, the existing DD system infrastructure and local financing methodology impact the ability to achieve maximization as initially envisioned.
- HB 2067 specified, and stakeholders agreed, that services funded with state general funds only (SGF) or with county funds are to be disrupted as little as possible in the maximization effort.
- State aid and County funding not matched to Medicaid are distributed unevenly across the state.
- Currently, Medicaid payments are made directly to hundreds of Community Services Providers (CSPs) and not paid through CDDOs.

Major Systems and Policy Change

- Medicaid allows the state match of 40% to be provided by either "hard" cash match from the state or by a certified match of either state or local funds. Funds can only be certified by public agencies. At the local

level, the CDDO as a quasi-governmental agency is the only entity that can certify match for Medicaid services.

- In a certified match scenario, there must be a Medicaid expenditure - the match must "touch" the federal funds. So, a Medicaid service must be provided to an eligible person by a qualified Medicaid provider.
- To satisfy Medicaid requirements, all Medicaid payments would have to be made to the CDDO as the qualified Medicaid provider and not to individual community service providers.
- Payment to community service providers would have to be made by the CDDOs and not directly to CSPs from SRS.

Major Adjustments in Funding Distribution

- Federal Medicaid rules require that each entity certifying match–in this case, each CDDO, have sufficient funds available to certify match for Medicaid payments. As noted earlier, the current distribution of state funds that would be used to certify match is uneven. Also, counties levy different amounts of county funds for DD services. In order to meet this requirement, one or more of the following impacts would result:

  - **Rates Would Vary**
    MRDD waiver rate increases would vary from place to place depending only on how unmatched state and county funds are currently distributed to each CDDO; or

  - **State Funding Would Be Redistributed**
    State funding would have to be redistributed based on how much Medicaid can be matched. This would move funding from CDDOs that are using it for non-Medicaid services.

  - **State Law Conflicts with Federal Requirements**
    HB 2067 directs the use of county funds to be used to match Medicaid funding, but it prohibits SRS from directing how county funding would be used. To satisfy Medicaid requirements, expert consultants have reported CMS requires specific steps be taken when using county funds to match Medicaid funding.

Enhanced Federal Scrutiny of Creative State Financing

- Recent federal reports have identified that one of the greatest contributing factors to increased federal Medicaid expenditures is creative financing by the States.

Therefore, it is believed CMS will be watching Kansas very closely to ensure it complies with all federal rules and regulations for drawing down federal Medicaid match.

Designing Federal Financial Participation Alternatives

Preliminary models for federal financial participation maximization were proposed by the FFP Design Team to a public forum of stakeholders on October 24, 2001. One hundred stakeholders including representatives from Community Developmental Disability Organizations (CDDOs), Community Service Providers (CSPs) and advocacy groups were present.

These preliminary models proposed a DD waiver rate increase that resulted in significant reallocation of SGF funds based upon the number of Medicaid waiver recipients in each CDDO. The proposal set forth the significant systems changes that would be required to accomplish such an increase and reallocation, including not only this redistribution, but the flow of all payments to CDDOs rather than to CSPs.

The majority of the stakeholder response to the proposed models concurred with many of the key concerns identified by the FFP Design Team. Stakeholders identified the following potential outcomes and key ramifications of the preliminary models:

Maximizing Federal Funds to Greater Degree Means Moving Towards A Solely Medicaid-Funded System

- The decision to maximize federal funds is a decision to move closer to a system made up entirely of Medicaid-waiver-eligible individuals

Non-waiver-Eligible Persons would Lose Services in an All-Medicaid-Funded System

- The non-waiver-eligible persons currently served in the system could be placed in jeopardy by identifying all state funds as waiver match. Many of these persons are achieving self-sufficiency and independence with the minimal state-only funding by which they are supported. Many waiver-eligible persons are accessing less intense services supported by state general funds only. The loss of these funds could create greater dependency as waiver-eligible consumers turn to that source of funding rather than lose services all together.

Differential Rates A Barrier

- Differential rates across the state for the same service resulting from these models is unacceptable. Rates should only differ if there is a factual basis for that difference. In addition to the appearance of inequity, differential rates create challenges in achieving "portability"(funding to support services following the consumer when they move).

Gain in Maximization Offset by Administrative Disruption, Cost and Service Loss

- The complexity of the system change required by these models and its associated costs are not justified by the gain. Even with the optimum billing at the model rates, the additional funding to the system would only be one-half to one-third of what has been demonstrated by rate studies to be required for rate relief.

Loss of Service Delivery Flexibility and Responsiveness to Local Need

- Any maximization approach raises concern about the loss of diversity and flexibility of use of state funds. Relying on the Medicaid program exclusively at the present time is a complex policy decision with major ramifications.

It should be noted, however, that there were a number of stakeholders who supported the maximization models that were presented even in light of the concerns raised.

FY 2002 Model for Maximization

On November 1st and 8th the Design Team met to review feedback from the stakeholders regarding the proposals. In light of the concerns raised by stakeholders to the initially developed models, the team discussed alternative options to allow some infusion of new resources into the DD system in the current year.

The plan developed for FY2002 provides significant increases in Medicaid funding by increasing the amount SRS pays the CDDOs for administering the developmental disabilities system. CDDO Administrative payments are made to defray the CDDO's cost of administering the DD Reform Act. These payments are matched by Medicaid through the administrative match process.

Raising these payments and using a "certified match" process allows significant increased federal funding to be paid for community DD services in FY 2002. This effort will generate $6,804,660 in new federal funds in FY 2002. This reduces the amount of unmatched state and local funds from $18.4 to $8.7 million.

On December 4, a meeting with CDDOs was held to negotiate a 6-month contract to implement the proposed maximization plan. Contracts were processed to CDDOs on December 11. During the period January 2002 to June 2002, two quarterly payments will be made to distribute the $6.8 million in new federal funds. CDDOs will distribute the entirety of this funding throughout the community service provider system to address work force issues.

On December 20, a stakeholder informational meeting was held to discuss the FY2002 maximization plan. CDDOs, CSPs, advocacy groups, consumers, and families attended this meeting. Information about the entire maximization process to date can be found at the SRS Health Care Policy Community Supports and Services website,

www.srskansas.org/hcp/css/FFPTeam.htm

Next steps in the FFP Maximization Effort

Metropolitan Statistical Area (MSA) Rates

Rate studies and economic cost data indicate that the cost to provide services in urban areas is affected by wage pressures. Relying upon the 2001 DD services rate study produced by Myers and Stauffer, SRS is working with CDDOs in urban areas to increase DD waiver rates.

The nine urban counties affected serve 50% of the persons in the DD services system. Using local county funds as certified match, the proposed model of maximization will allow higher DD waiver reimbursement for urban areas of the state that experience higher than average services costs. Details of this effort are being finalized.

This aspect of maximization will reduce the remaining $8.7 million unmatched state general and county funding even further.

Determining What Maximization Efforts Remain Possible

The FFP Design Team will continue to meet to plan for a long term, sustainable system of increased federal reimbursement that will meet CMS requirements, minimize disruption to services for persons receiving state funded services, and address state wide distribution of state general fund support.

CAPACITY BUILDING EFFORTS

Capacity Building Plans

In June 2001, SRS and CDDOs jointly created guidelines for developing and implementing community capacity building plans to improve the quality and efficiency of service delivery.

- Capacity building refers to the process of stabilizing, improving and/or expanding the ability of the community to provide responsive, quality supports and services to community members with developmental disabilities. The purpose of such efforts is to build systems and networks that are responsive, flexible, and grow to meet the needs of the entire community.

To accomplish capacity building efforts the following will be accomplished:

- Identifying strengths within the local service area, including natural and community supports;

- Identifying barriers to meeting the independence, productivity, integration and inclusion goals of the developmental disabilities reform act;

In accordance with these guidelines each CDDO initially assessed these core system issues:

- **Work Force Issues**
  Designed to stabilize and enhance the work force of direct service professionals
- **Crisis Prevention/Management Plans**
  Designed to address the needs of people who are unserved or underserved, and to identify/address potential service gaps in the region
- **Identifying Generic Community Services & Natural Supports**
  Designed to explore resources that can be obtained, maximized and accessed in an effective and efficient manner to enhance the overall quality of services.

By October 1, 2001, the CDDOs had developed and submitted to SRS, CDDO plans that identified areas of strength and weakness in these core system issues. Based upon local factors, each CDDO selected initial areas for focused attention to strengthen system performance.

Progress reports, building upon initially selected goals and measuring implementation, are being submitted in mid-January 2002, with annual review and updated progress reports thereafter.

The statewide importance of work force issues was acknowledged by all stakeholders. It is important to have core data gathered across CDDO areas, thus a biannual report as to CDDO area specific average wage, turnover rate and vacancy rate for direct service professionals will be submitted by each CDDO. The first report will be submitted January 15, 2002 covering the period July 2001 through December 2001.

Attachment B

State of the States in Developmental Disabilities: 2002 Summary

Table 10

State Funds Potentially Available to Match Additional Federal Medicaid Funding: FY 2000

State	Total MRDD Spending	Unmatched State Funds	Unmatched % of Total Spending
California	$3,018,455,649	$1,216,962,846	44%
Georgia	$387,482,752	$136,610,417	35%
Maryland	$429,010,818	$147,851,855	34%
Ohio	$1,496,733,246	$470,277,392	31%
Alaska	$62,199,891	$18,229,964	29%
Missouri	$529,327,689	$137,435,106	26%
New Jersey	$964,924,023	$246,382,759	26%
North Carolina	$884,387,390	$224,020,030	25%
District of	$100,976,671	$24,937,848	25%
Virginia	$459,640,282	$113,421,535	25%
Illinois	$1,189,482,024	$290,729,774	24%
Massachusetts	$1,082,548,662	$254,247,030	23%
Texas	$1,471,066,279	$334,797,016	23%
Connecticut	$792,010,671	$179,266,642	23%
Iowa	$404,383,045	$84,159,786	21%
Montana	$82,437,039	$15,066,687	18%
Nevada	$59,510,674	$10,524,257	18%
Pennsylvania	$1,586,326,786	$268,962,117	17%
Mississippi	$219,714,390	$36,702,792	17%
Delaware	$86,438,507	$14,328,507	17%
Colorado	$317,147,739	$51,773,707	16%
Oklahoma	$363,373,002	$58,764,002	16%
Oregon	$354,737,292	$57,069,014	16%
Wisconsin	$696,730,140	$103,215,532	15%
Kentucky	$191,045,772	$27,946,645	15%
Nebraska	$170,534,352	$24,595,132	14%
Arizona	$367,652,283	$48,818,486	13%
Hawaii	$45,613,825	$6,014,554	13%
South Carolina	$407,416,390	$51,198,771	13%
New Mexico	$157,100,948	$16,568,847	11%
Indiana	$453,434,400	$47,602,153	10%
Minnesota	$825,368,640	$80,048,461	10%
Florida	$726,115,999	$67,084,539	9%
Washington	$547,319,612	$49,920,385	9%
Wyoming	$74,070,492	$6,524,150	9%
Louisiana	$492,170,115	$41,029,028	8%
West Virginia	$160,356,604	$12,508,159	8%
Rhode Island	$212,729,515	$14,901,558	7%
Tennessee	$468,475,727	$31,347,200	7%
South Dakota	$87,910,751	$5,570,268	6%
Michigan	$993,355,629	$55,134,520	6%
North Dakota	$108,829,336	$5,874,809	5%
Kansas	$313,046,654	$15,982,059	5%

Attachment B

State of the States in Developmental Disabilities: 2002 Summary

Table 10

State Funds Potentially Available to Match Additional Federal Medicaid Funding: FY 2000

New Hampshire	$130,818,027	$6,186,873	5%
Maine	$216,804,537	$9,541,051	4%
Utah	$166,999,686	$7,209,213	4%
Vermont	$79,935,565	$2,874,688	4%
Arkansas	$243,299,093	$8,740,014	4%
Alabama	$201,072,041	$6,461,760	3%
Idaho	$137,459,137	0	0%
New York	$4,292,345,285	0	0%
United States	**$29,310,325,076**	**$5,145,286,063**	**18%**

February 20, 2001
Testimony Presented Regarding Senate Bill 557

Thank you for allowing me to present testimony on Senate Bill 557. I am Ron Hammock, Executive Director of Creative Community Living (CCL). My agency serves individuals in Cowley and Butler Counties.

Adequate funding is an essential prerequisite required for providers do their job. Without these financial resources we are unable to pay for staff salaries, adequate training, and the other requirements of any business. As most of you are aware, funding for individuals with developmental disabilities is tiered. Specifically, rates are organized on five different levels, with more funding being available for those with the most severe disabilities. This makes good common sense as it costs more to provide services for individuals with severe disabilities for example, more staff, more medical care, closer supervision for longer periods of time, higher insurance rates. The enlightened Developmental Disabilities Act implemented in 1995 had tier funding as a basic tenet. One of the primary reasons it was possible to close Winfield State Hospital was the very fact that tier funding was in place. The successful closure of additional State Institutions depends on the continuation of adequate tier funding.

Most agree with the discussion above, but as often quoted, "The devil is in the details." How does one go about deciding the tiers and what are the criterion used to assign individuals to a tier? The answer is not an exact science. Estimates were based on several cost studies and comparisons, but these were "best guess" not exact costs. The BASIS is the assessment tool used to rank individuals by tier. The BASIS is designed to measure general levels of independence, severity of medical problems, and the presence or absence of behavioral disorders and mental health problems. Using this information, individuals with disabilities are assigned to a tier level and funded accordingly.

However, it was noted early on, that some individuals, particularly those last to leave institutions, had extraordinary needs. These individuals could not be adequately served using the existing tier rates; therefore, individual rates and special tier rates, were implemented. In order for individuals to qualify for individual or special tier rates their cases must be reviewed and approved by a local Community Developmental Disabilities Organization (CDDO) funding committee and approved separately by a representative of SRS at the State level. Individual rates are funded to the actual cost of services and have no limits on the amount of funding available. Special tier rates are capped at a specific amount based on the average costs associated with individual rates. Special tier rates are intended to have the advantages of simplicity (less paper work) and the allowance to retain any gains at the end of the year, which is exactly what is allowed with regular tier rates.

Creative Community Living serves over one hundred individuals with severe developmental disabilities. The majority of these people are former residents of Winfield State Hospital and are funded with special tier rates. Based on an independent rate study underwritten by SRS and conducted by Myers and Stauffer, certified public accountants, for the reporting period of July 1, 1999 through June 30, 2000, Creative Community Living's overall profitability was in the average range for all agencies providing services in Kansas. In other words, our agency is spending its money on services and is not making huge profits.

Senate Ways and Means
2-20-02
Attachment 5

Overall the individuals served by Creative Community Living are severely disabled. Most would agree that approximately 10% of individuals with developmental disabilities can be classified as severely or profoundly disabled, though the exact statistics are in dispute. These individuals benefit tremendously from living in the community at large, but they will likely never be totally independent. Without exceptional medical care and 24 hour supervision, many would perish in a short period. Realistically these individuals will continue to require these intensive services for the remainder of their lives.

What concerns the folks at Creative Community Living and other similar agencies who work with individuals with severe disabilities, is a pattern of adverse decisions and proposed changes related to the continuation of adequate funding for those with severe disabilities; specifically: the continuation of an inadequate allocation at the beginning of each fiscal year, the micro management of special tier rates, proposed changes to reimbursement for targeted case management, and the unfair distribution of potential rate increases gained from maximization efforts accomplished by matching programs which draw down additional Federal dollars. And perhaps most egregious, the eleventh hour passage of House Bill 2067 during last year's session with inferences that suggest special tiers do not need to be adjusted upward when additional funding is available in the future.

Allocation Problem

In conjunction with annual contracting between the CDDOs and the State, SRS allocates the funding approved by the legislature for services for people with developmental disabilities living in the community. It is my understanding that unless otherwise noted, the legislative intent is to fund the people currently in service at the same level and, if approved, begin new service for some individuals from the waiting list. During the last five years Cowley and Butler Counties as well as other CDDO areas have never been given an adequate amount of funding to serve the same people at the same level. We are told this phenomenon is caused by the formula. We have always been allocated additional dollars at the end of the fiscal year unspent by other CDDO areas. But must endure constant pressure by the State and CDDO to stay within the allocation even though the allocation is inaccurate. It is my contention that the basic reason for this chronic problem is a flawed distribution formula that during averaging does not account for the intensive use of services by individuals with severe disabilities. In and of itself this is not a significant problem unless there are not adequate funds to redistribute at the end of the year; however, there are some hidden problems for individuals with severe disabilities in this system.

The cases of individuals who desire to continue being funded by special tiers are required to prove their case before the local CDDO funding committee each year. This seems basically fair, but in most cases is a waste of time unless the individual's needs significantly change. The BASIS assessment would illuminate those cases where significant change had occurred. Nevertheless, we continue the same process year after year at considerable time, effort, and expense. However, this is not the primary cause of concern. The primary concern in this area is related to situations where the tier level according to the BASIS has changed. If the tier level goes up it suggests that the person being tested is doing better and thus receives less funding. This is never a problem with SRS. They accept each and every case without question when less funding is involved. However, if the change in tier is in the opposite direction, indicating the individual's situation has deteriorated, these changes that require more funding are routinely

disapproved at the State level. Justification for disapproval is based on the flawed assumption that the CDDO is spending over the allocation. In other words, those funded by special tier rates can only receive less funding, even if the case legitimately justifies more funding.

Issue of pressure and micro management of special tier rates

In January of 2002, all agencies serving people with individual or special rates were informed that each case would now be audited to cost using an ABC accounting format. A work group was formed to study the particulars. Why are individual and special tier rates singled out for this level of scrutiny? Why are not all individuals being audited? Purposeful or not, the result of this action is additional pressure, time, effort, and cost for those serving individuals with severe disabilities.

Targeted Case Management

Targeted case management is a service outlined in the Developmental Disabilities Reform Act of 1995. Case managers complete assessments, provide service planning and coordination, are advocates, and perform other essential functions. Case management is directly related to ensuring a high quality of life and service provision for individuals served. Currently case management is billed by the hour. Therefore, individuals with complex needs receive more time. The latest proposal made by a work group composed of providers, CDDOs, and SRS is recommending an encounter based billing system. Everyone in the system is allowed one monthly encounter. Everyone, regardless of need, has the potential to bill the same on this flat rate system. As of this date, the fiscal impact of this change on individual agencies has not been determined. Using the current rates established by this proposal, CCL's billing potential for case management will be reduced by $127,000. Other agencies specializing in services for individuals with severe disabilities will suffer similar reductions.

Future rate increases

SRS recently developed and implemented a method outlined in a draft dated November 8, 2001, to enhance funding in the community system. They used a certified match program to enhance rates on a one time only basis. SRS is now in the process of finding a way to make this method permanent and thereby improve rates. We appreciate their efforts in this area but request these changes be done in a fair manner. Several work groups composed of a mixture of community providers and SRS staff worked diligently for approximately six months to develop a proposal to maximize Federal match money and use the increased funding to enhance rates. The "final" proposal was presented publicly at the InterHab conference during which documents were distributed outlining two options which increased rates by no less than 3.96% or 5% for all CDDO areas. Then at the "eleventh" hour without substantiating their reasons, SRS scrapped both plans in favor of an alternative that in my opinion left millions of dollars "on-the-table," penalized individuals served in favor of perpetuation to the current system, risked State general

funds by not maximizing potential Federal match money, and discriminated against the severely disabled. Let me elaborate.

Compared to the most conservative of the original models, (the 5% minimum increase model), SRS left $11,724,200 with the Federal government that could have been used to enhance rates. In the system that was implemented, Cowley County with the heaviest concentration of individuals with severe disabilities, received a 2% increase, whereas, Nemaha County with the highest concentration of individuals being served with mild disabilities received the largest increase of 5%. What was most troubling about this action, an option that had a *minimum* increase of 5% for everyone was replaced with a plan that had a *maximum* of 5% increase for only one agency and less for everyone else. This type of decision scares me. I hope the future, permanent method of rate enhancement put in place, uses a more practical approach.

Bill 557

Last year the Legislature passed House Bill 2067. Using this bill as a guide, some providers attempted to eliminate special tier rates by recommending an increase in regular tier reimbursement while holding special tier rates constant. In effect special tier rates were eliminated as the regular rates were increased to a point where regular rates were higher than the "frozen" special tiers. This did happen. I was there. If left as written, I believe House Bill 2067 can be used as a mechanism to end individual and special tier rates and thereby remove funding that is needed to adequately fund services for individuals with severe disabilities. Senate Bill 557 deletes those features of Bill 2067 which allow for direct or indirect attacks on funding for people with severe disabilities. I urge you to support Bill 557.

Summary

We need your help to stop this disturbing trend to undermine the DD Reform Act by allowing processes to be enacted that negatively effect those who are the most severely disabled. You can do this by 1) insisting on an accurate, fair allocation system; 2) eliminating the unequal pressure coming to bear against special tier rates, 3) conducting an impartial fiscal impact study prior to the implementation of any changes to targeted case management billing, 4) maximizing State dollars currently in the system as intended by current law, 5) distributing any funds gained for rate increases in such a way that does not penalize individuals with severe disabilities, 6) insuring a way for SRS to fairly represents minority opinions in future decision making, and 7) passing Senate Bill 557.

Wednesday, Feb. 20, 2002

I appreciate the opportunity to speak to you today about Senate Bill 557 which the board of directors of Creative Community Living supports.

When Winfield State Hospital was named for closure, SRS, with the support of Gov. Bill Graves, gave the parents who had children in that facility assurances their children would receive the same or better services when placed in the community.

That happened even though we had to work very hard. We also had great support from our community hospital to provide dental services for our children. Dental care was the one service we had to make happen on our own.

The state understood that the people moving from the state hospital into the community had the greatest needs because of their mental, physical and medical needs. It set up a special tier rate to pay for these services that help to keep our children well and alive.

Last year House Bill 2067 was passed. It is a measure that would leave our children out of the money flow simply because they are the most severely handicapped and costly people served in a community setting. I not only believe that this bill is unfair, but also is discriminatory.

Senate Ways and Means
2-20-02
Attachment 6

On the other hand, Senate Bill 557 would put all the people served in a community setting on the same level. Those who have the most needs would continue to be provided for in a way that we can truly say is as good or better than when our children were at the state hospital.

In the beginning I was very much opposed to the closure of Winfield State Hospital. I and other parents started our own organization to serve our children. That organization is Creative Community Living or CCL.

Now that our children have been out in the community for the last five years, I would like to say that both our families and our children are happier than we ever have been.

There has been enough financial support to provide the services and direct care that are required for a quality of life we all desire. Without this necessary financial support, things would change very quickly and not in the direction we want to go.

Please give your consideration to Senate Bill 557.

Thank You!

Sharon K Bird
CCL Board President -
Michael's Mom

Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

Docking State Office Building
915 SW Harrison, 6th Floor North
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Senate Ways and Means Committee
10:30 a.m. Room 123-S
February 20, 2002

Testimony Regarding Senate Bill 513

Integrated Service Delivery
Candace Shively, Deputy Director
(785) 296-3271

Senate Ways and Means
2-20-02
Attachment 7

Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

Senate Ways and Means Committee, Room 123-S
February 21,2002 10:30 a.m.

Testimony Regarding Senate Bill 513

Mr. Chairman and members of the Committee, thank you for the opportunity to appear on SB 513. I am Candy Shively, Deputy Secretary of the Integrated Service Delivery Division of SRS. SB 513 would permit recoveries of excess funds remaining in funeral agreements and is a part of a package of bills developed by the Department to improve the effectiveness of and amount of recoveries for the Estate Recovery program in Kansas.

The Estate Recovery program was initially authorized by the Legislature in 1992 and has since become a federally mandated process. The program allows the agency to recover Medicaid expenses properly paid on behalf of a Medicaid recipient from his or her estate if the recipient was either 55 years of age or older or in a long term care arrangement. Most recoveries are from probate actions and family agreements but no recovery action is taken if there is a surviving spouse or a minor or disabled child. Recoveries in FY 2001 exceeded $3.7 million in Kansas and over $20 million since the program inception. In contrast, during FY 2001 the Department had over a $100 million in medical expenditures for the elderly alone, excluding long term care expenses.

Over the past years, the Department has noted an issue which could increase both the effectiveness of the program as well as the amount of recoveries. In light of current budget realities, we felt it particularly critical to pursue the issue of excess funeral trust funds. As noted earlier, this is one of three estate recovery bills we are pursuing this year and which as a total are expected to increase collections by an additional $125,000 in the first year, with recoveries in the out years in the amount of $200,000-$300,000.

Senate Bill 513 proposes three changes to the present system involving prearranged funeral agreements. First, it would require notice of the existence of the agreement to the Department when an applicant or recipient of medical assistance has such an agreement. Second, after the cost of the final disposition of the remains of a recipient of medical assistance has been paid, any excess funds remaining in such an agreement would be paid to the Department for application against the medical assistance paid on behalf of the deceased. Third, the Department would use the restrictions found in K.S.A. 39-709 (g)(2) which limit the recoveries to situations where there are no surviving spouse, no surviving minor child or no surviving disabled or blind child.

A recent case exemplifies the need for these changes. The Estate Recovery Unit reviewed a situation regarding a deceased medical assistance recipient with a pre-need agreement funded through

insurance valued at $7200. The insurance designated the funeral home as the primary beneficiary and a grandson as the contingent beneficiary. After the recipient's death, the grandson modified the funeral arrangement to a simple cremation with limited services. This reduced the cost of the funeral to approximately $2200. The grandson, then, requested and received the balance of the insurance proceeds as the beneficiary. This action not only deprived the deceased of the funeral contemplated but also allowed the funds to pass to the beneficiary despite the potential claim of the State. That claim amounted to over $40,000 in medical benefits. Such circumstances have occurred in other cases over the past few years as a way to avoid the State's claim in probate actions.

The provisions of this bill are similar to other rights the State has for the recovering of claims. In 1997, Kansas adopted transfer-on-death deeds. While these deeds would transfer real estate upon the death of the owner to a beneficiary, the statutes did allow the State to have a claim against the real estate for the medical assistance paid to the owner. Similarly, as part of the original implementation of the Estate Recovery program, statutes dealing with individually owned financial accounts with pay-on-death provisions were specifically deemed to not vest in the beneficiary when the State had a claim for medical assistance. These statutes, then, required the payment of the account to the Secretary in satisfaction of the medical assistance claim. This bill would offer a similar approach.

We wish to offer an amendment to our originally proposed bill and have attached a copy of those revisions. These revisions were developed in collaboration with the Kansas Funeral Directors Association who support the changes being made and are also here to testify regarding the bill. We ask for your consideration of this amended version.

Our goal is to be fair to all recipients of assistance while still allowing for enhanced collections in an accurate and equitable manner. This bill does not interfere with the right of an individual to fund a prearranged funeral agreement and such agreements are not considered in determining medical assistance eligibility. What it does permit is the ability of the State to recover funds remaining in that agreement once funeral expenses have been paid. Further, the State could only exercise this right when there is no surviving spouse, surviving minor child or surviving disabled or blind child. I ask for your support of this new measure to help us in further improving our efforts.

Session of 2002

SENATE BILL No. 513

By Committee on Public Health and Welfare

2-5

AN ACT concerning recipients of medicaid; after death requiring certain moneys to be recouped and repaid to the secretary of social and rehabilitation services; amending K.S.A. 16-301 and repealing the existing section.

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

Section 1. K.S.A. 16-301 is hereby amended to read as follows: 16-301. Any agreement, contract or plan requiring the payment of money in a lump sum or installments which is made or entered into with ~~*a medicaid recipient*~~, *or* any ~~*other*~~ person, association, partnership, firm or corporation for the final disposition of a dead human body, or for funeral or burial services, or for the furnishing of personal property or funeral or burial merchandise, wherein the delivery of the personal property or the funeral or burial merchandise or the furnishing of services is not immediately required, is hereby declared to be against public policy and void, unless all money paid thereunder shall be deposited in a bank or savings and loan association which is authorized to do business in this state and insured by a federal agency, or invested in a credit union which is insured with an insurer or guarantee corporation as required under K.S.A. 17-2246, and amendments thereto, all as herein provided, and subject to the terms of an agreement for the benefit of the purchaser of the agreement, contract or plan. For the purposes of this act, personal property or funeral or burial merchandise shall include caskets, vaults and all other articles of merchandise incidental to a funeral service, but shall not include grave lots, grave spaces, grave memorials, tombstones, crypts, niches and mausoleums.

Delete amendment

This act shall not prohibit the funding of a prearranged funeral agreement with insurance proceeds derived from a policy issued by an insurance company authorized to conduct business in this state.

New Sec. 2. (a) Whenever a person, who is a medicaid recipient or a person who receives medical assistance from the department of social and rehabilitation services and such person enters into an agreement, contract or plan requiring the payment of money in a lump sum or installments for the final disposition of a dead human body or funeral or burial services, or for the furnishing of personal property or funeral or burial merchandise, including any assigned or purchased insurance being used as part of and in conjunction with the agreement, contract, or plan, such persons shall inform the secretary of social and rehabilitation services

Senate Ways and Means
2-20-02
Attachment 8

~~or the secretary's designee the existence of such agreement, contract, plan or insurance.~~

~~(b) After the payment to a person, association, partnership, firm or corporation for the final disposition of a dead human body, or for funeral or burial services, or funeral or burial merchandise, including any assigned or purchased insurance being used as part of and in conjunction with the agreement, contract or plan, and the purchaser of the agreement, contract, plan or insurance is or has been a recipient of medical assistance or a deceased surviving spouse of a recipient of medical assistance, any remaining balance shall be paid to the secretary of social and rehabilitation services or the secretary's designee for recoupment of medical assistance expended on the deceased recipient.~~

~~(c) Payments under subsection (b) shall be governed by subsection (g)(2) of K.S.A. 39-709, and amendments thereto.~~

~~Sec. 3. K.S.A. 16-301 is hereby repealed.~~

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

Substitute

Section 2. 16-304. Same; payments upon death, conditions; balances. If any balance remains in the account upon the death of the person for whose services the funds were paid, the same shall not be paid by such bank, credit union or savings and loan association to the person, association, partnership, firm or corporation until the expiration of at least five days after the date of death of the person for whose services such funds were paid. The funds shall not be paid by the bank, credit union or savings and loan association until a certified copy of the death certificate of such person, a verification of death form or other acceptable proof of death shall have been furnished to the bank, credit union or savings and loan association, together with a verified statement setting forth that all of the terms and conditions of such agreement have been fully performed by the person, association, partnership, firm or corporation. If any balance remains in the fund after disposition of the fund in accordance with the terms of the agreement, contract or plan such balance shall inure to the benefit of the estate of the purchaser of the agreement, contract or plan unless the purchaser was a person who received medical assistance from the department of social and rehabilitation services or a deceased surviving spouse of a recipient of medical assistance, in which case the balance shall be paid to the secretary of social and rehabilitation services or the secretary's designee to the extent of medical assistance expended on the deceased recipient.

New Section 3. (a) Whenever a person, who is or has been a recipient of medical assistance from the department of social and rehabilitation services, enters into a prearranged funeral agreement, contract or plan pursuant to K.S.A. 16-301 or a prearranged funeral agreement, contract or plan funded by insurance proceeds, such person shall inform the secretary of social and rehabilitation services or the secretary's designee of the existence of such an agreement, contract or plan and shall inform the funeral establishment that such person is or has been a recipient of medical assistance.

(b) If any balance remains after payment for the final disposition of a dead human body, or for funeral or burial services, or funeral or burial merchandise, and the purchaser of the agreement contract, or plan is or has been a recipient of medical assistance or a deceased surviving spouse of a recipient of medical assistance, any remaining balance shall be paid according to K.S.A. 16-304 or if said agreement, contract or plan was funded by insurance, any remaining balance shall be paid by the insurance company or the person, association, partnership, firm or corporation providing the services or merchandise to the secretary of social and rehabilitation services or the secretary's designee, to the extent of medical assistance expended on the deceased recipient.

(c) Payments to the secretary of social and rehabilitation services under subsection (b) and K.S.A 16-304 shall be governed by subsection (g) (2) of K.S.A. 39-709,and amendments thereto.

Section 4. K.S.A. 16-301 and K.S.A. 16-304 are hereby repealed.

Section 5. This act shall take effect and be in force from and after its publication in the statute book.

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Date: February 20, 2002

To: Senate Ways and Means Committee

From: Pam Scott, Executive Director
Kansas Funeral Directors and Embalmers Association

Re: Senate Bill No. 513

Chairman Morris and members of the Senate Ways and Means Committee, I appear before you today concerning Senate Bill No. 513. This legislation allows for the recovery, by the Kansas Department of Social and Rehabilitation Services (SRS), of any excess balance remaining in prepaid funeral agreements after the payment of funeral and burial expenses.

Prearranged funeral agreements are generally funded with certificates of deposit with financial institutions or with insurance policies. The proceeds of the certificates of deposit or insurance policies are paid to the funeral home to the extent of funeral goods and services provided. Any excess proceeds are generally paid to the estate of the deceased unless the SRS Estate Recovery Unit has filed a claim for the excess proceeds.

Although the KFDA supports the intent of Senate Bill No.513, we do not believe the current language of the bill is the best way to accomplish the goal of returning excess funds to SRS. As a result, we sat down with representatives of SRS and came up with substitute language, which we believe will better accomplishes SRS's objectives taking into consideration current Kansas preneed law. We would like to offer the attached language as a substitute for Senate Bill No. 513.

The proposed new language does the following:

Section 1 removes language referring to a medicaid recipient. Such language is unnecessary since this statute deals with all preneed accounts. Also added is a sentence clarifying that insurance may also be used to fund prearranged funeral agreements.

Section 2 amends K.S.A. 16-304, the current Kansas statute that sets forth the procedure for handling excess funds in prearranged funeral accounts. The amendment

Senate Ways and Means
2-20-02
Attachment 9

would specifically provide that any excess balances remaining are to be paid to SRS when applicable rather than to the estate of the deceased.

New Section 3 in subsection (a) incorporates the language from New Section 2 (a) of Senate Bill No. 513 and adds a provision requiring the recipient to notify the funeral home that they are on assistance so that the funeral home will know to forward excess proceeds in it's possession to SRS. Subsection (b) provides that excess balances are to be paid in accordance with K.S.A. 16-304 unless the prearranged funeral agreement is funded by an insurance policy. If funded by insurance, either the insurance company or the person, association, partnership, firm or corporation providing the services or merchandise would pay any excess balance remaining to SRS.

The KFDA supports SRS in their efforts to recover medicare costs and believe the revised version of the legislation will help them better achieve their goal. We would ask that you adopt the substitute language that has been proposed.

Thank you for the opportunity to appear before you. I would be happy to address any questions you may have.

Section 1. 16-301. Prearranged funeral agreements; conditions. Any agreement, contract or plan requiring the payment of money in a lump sum or installments which is made or entered into with any person, association, partnership, firm or corporation for the final disposition of a dead human body, or for funeral or burial services, or for the furnishing of personal property or funeral or burial merchandise, wherein the delivery of the personal property or the funeral or burial merchandise or the furnishing of services is not immediately required, is hereby declared to be against public policy and void, unless all money paid thereunder shall be deposited in a bank or savings and loan association which is authorized to do business in this state and insured by a federal agency, or invested in a credit union which is insured with an insurer or guarantee corporation as required under K.S.A. 17-2246, and amendments thereto, all as herein provided, and subject to the terms of an agreement for the benefit of the purchaser of the agreement, contract or plan. For the purposes of this act, personal property or funeral or burial merchandise shall include caskets, vaults and all other articles of merchandise incidental to a funeral service, but shall not include grave lots, grave spaces, grave memorials, tombstones, crypts, niches and mausoleums. This act shall not prohibit the funding of a prearranged funeral agreement with insurance proceeds derived from a policy issued by an insurance company authorized to conduct business in this state.

Section 2. 16-304. Same; payments upon death, conditions; balances. If any balance remains in the account upon the death of the person for whose services the funds were paid, the same shall not be paid by such bank, credit union or savings and loan association to the person, association, partnership, firm or corporation until the expiration of at least five days after the date of death of the person for whose services such funds were paid. The funds shall not be paid by the bank, credit union or savings and loan association until a certified copy of the death certificate of such person, a verification of death form or other acceptable proof of death shall have been furnished to the bank, credit union or savings and loan association, together with a verified statement setting forth that all of the terms and conditions of such agreement have been fully performed by the person, association, partnership, firm or corporation. If any balance remains in the fund after disposition of the fund in accordance with the terms of the agreement, contract or plan such balance shall inure to the benefit of the estate of the purchaser of the agreement, contract or plan unless the purchaser was a person who received medical assistance from the department of social and rehabilitation services or a deceased surviving spouse of a recipient of medical assistance, in which case the balance shall be paid to the secretary of social and rehabilitation services or the secretary's designee to the extent of medical assistance expended on the deceased recipient.

New Section 3. (a) Whenever a person, who is or has been a recipient of medical assistance from the department of social and rehabilitation services, enters into a prearranged funeral agreement, contract or plan pursuant to K.S.A. 16-301 or a prearranged funeral agreement, contract or plan funded by insurance proceeds, such person shall inform the secretary of social and rehabilitation services or the secretary's designee of the existence of such an agreement, contract or plan and shall inform the funeral establishment that such person is or has been a recipient of medical assistance.

(b) If any balance remains after payment for the final disposition of a dead human body, or for

Senate Ways and Means
2-20-02
Attachment 10

funeral or burial services, or funeral or burial merchandise, and the purchaser of the agreement contract, or plan is or has been a recipient of medical assistance or a deceased surviving spouse of a recipient of medical assistance, any remaining balance shall be paid according to K.S.A. 16-304 or if said agreement, contract or plan was funded by insurance, any remaining balance shall be paid by the insurance company or the person, association, partnership, firm or corporation providing the services or merchandise to the secretary of social and rehabilitation services or the secretary's designee, to the extent of medical assistance expended on the deceased recipient.

(c) Payments to the secretary of social and rehabilitation services under subsection (b) and K.S.A 16-304 shall be governed by subsection (g) (2) of K.S.A. 39-709,and amendments thereto.

Section 4. K.S.A. 16-301 and K.S.A. 16-304 are hereby repealed.

Section 5. This act shall take effect and be in force from and after its publication in the statute book.