Approved: May 29, 2003
Date

MINUTES OF THE HOUSE COMMITTEE ON APPROPRIATIONS.

The meeting was called to order by Chair Melvin Neufeld at 9:00 a.m. on February 14, 2003, in Room 514-S of the Capitol.

All members were present except: Representative Klein, Excused

Committee staff present:
Alan Conroy, Legislative Research Department
J. G. Scott, Legislative Research Department
Amy Deckard, Legislative Research Department
Audrey Nogle, Legislative Research Department
Jim Wilson, Revisor of Statutes
Mike Corrigan, Revisor of Statutes
Nikki Feuerborn, Administrative Analyst
Sue Fowler, Committee Secretary

Conferees appearing before the committee:
Rick Shults, SRS, Director of Management Operations
Janis DeBoer, Acting Secretary, Department on Aging

Others Attending: See Attached

HB 2257 and **HB 2303** were referred to Social Services Budget Committee. **HB 2325** was referred to Tax, Transportation, Judicial and Retirement Budget Committee.

Representative Nichols moved for the introduction of legislation regarding LEPC, school budget reform incentives to adhere to best practices. Motion was seconded by Representative Minor. Motion carried.

Representative Shultz moved for the introduction of legislation regarding school buses and speed limits. Motion was seconded by Representative Bethell. Motion carried.

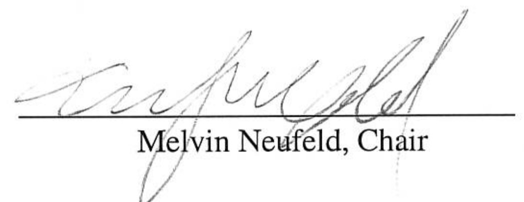
Representative Bethell moved for the introduction of legislation to remove CDDO positions. Motion was seconded by Representative Landwehr. Motion carried.

Representative Nichols moved for the introduction of legislation for economic affordable community housing through the KDFA. Motion was seconded by Representative Feurborn. Motion carried.

Rick Shults, Director of Management Operations for the Division of Health Care Policy in the Department of Social and Rehabilitation Services presented information regarding two of the home and community based services waivers that provide long-term care to persons with disabilities and how the growth of these waivers has affected institutional services in Kansas (Attachment 1).

Janis DeBoer, Acting Secretary of Aging presented information on the impact of home and community based services for the frail and elderly on nursing facility utilization (Attachment 2).

The meeting was adjourned at 10:10 a.m. The next meeting is scheduled for February 17, 2003.



Melvin Neufeld, Chair

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

APPROPRIATIONS COMMITTEE GUEST LIST

DATE: February 14, 2003

NAME	REPRESENTING
Nancy Pierce	Ks. Health Care Assn.
Doug Farmer	KDOA
Craig Kaberline	KS Area Agencies on Aging Assoc.
Jennifer Schwartz	Assistive Technology for Kansans
Bob Harder	UMC - KS
[illegible]	KG
Stephanie Wilson	The Alliance
Mike Hutfles	The Alliance
Sheli Sweeney	KDOA
JAY ARNOLD	Coalition For Independence
Margaret Zillinger	SRS
Josie Torrez	KACIL
Andy Sanchez	KAPE
Stuart Little	Assoc. of CMHCs
Mike Hammond	Assoc. of CMHCs

Kansas Department of

Social and Rehabilitation Services

Janet Schalansky, Secretary

House Appropriations Committee
February 14, 2003

HCBS Waiver Trends

Division of Health Care Policy
Rick Shults, Director of Management Operations
785.296.6999

For additional information contact:
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HOUSE APPROPRIATIONS

DATE 2-14-03
ATTACHMENT 1

Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

House Appropriations Committee
February 14, 2003

HCBS Waiver Trends

Chairman Neufeld and members of the Committee, thank you for the opportunity to present to you today. My name is Rick Shults. I am the Director of Management Operations for the Division of Health Care Policy in Social and Rehabilitation Services. I am pleased to present to the Committee information regarding two of the home and community based services waivers that provide long term care to persons with disabilities and how the growth of these waivers has affected institutional services in Kansas.

Background

Medicaid waivers are federally approved requests to waive certain specified Medicaid rules. For instance, federal Medicaid rules generally allow states to draw down federal Medicaid funds for services provided in institutions for persons with severe disabilities. But many community supports and services provided to persons with disabilities are not covered by the regular federal Medicaid program. Home and community based services (HCBS) waivers give the state federal approval to draw down federal Medicaid matching funds for community supports and services provided to persons who are eligible for institutional placement, but who choose to receive services that allow them to continue to live in the community. The Center for Medicare and Medicaid Services (CMS) requires that the cost of services paid through HCBS waivers be, on the average, less than or equal to the cost of serving people in comparable institutions. States who receive these waivers must also assure CMS that the people served on the waivers remain healthy and safe. However, CMS does not require that states monitor the safety and health of the persons on waivers using rigid, federally mandated standards, as they do for institutional services. CMS also allows states to manage access to waivers. So HCBS waivers are not entitlements like institutional services. Finally, states are given broad latitude in establishing reimbursement rates for waiver funded services. Kansas has experienced great success in using the flexibility provided by HCBS waivers to serve many people with severe disabilities in community settings in a cost effective manner. I would like to briefly review the successes of the two waivers that provide long term care for persons who are developmentally disabled (DD) and persons who are physically disabled (PD).

Developmental Disability Waiver

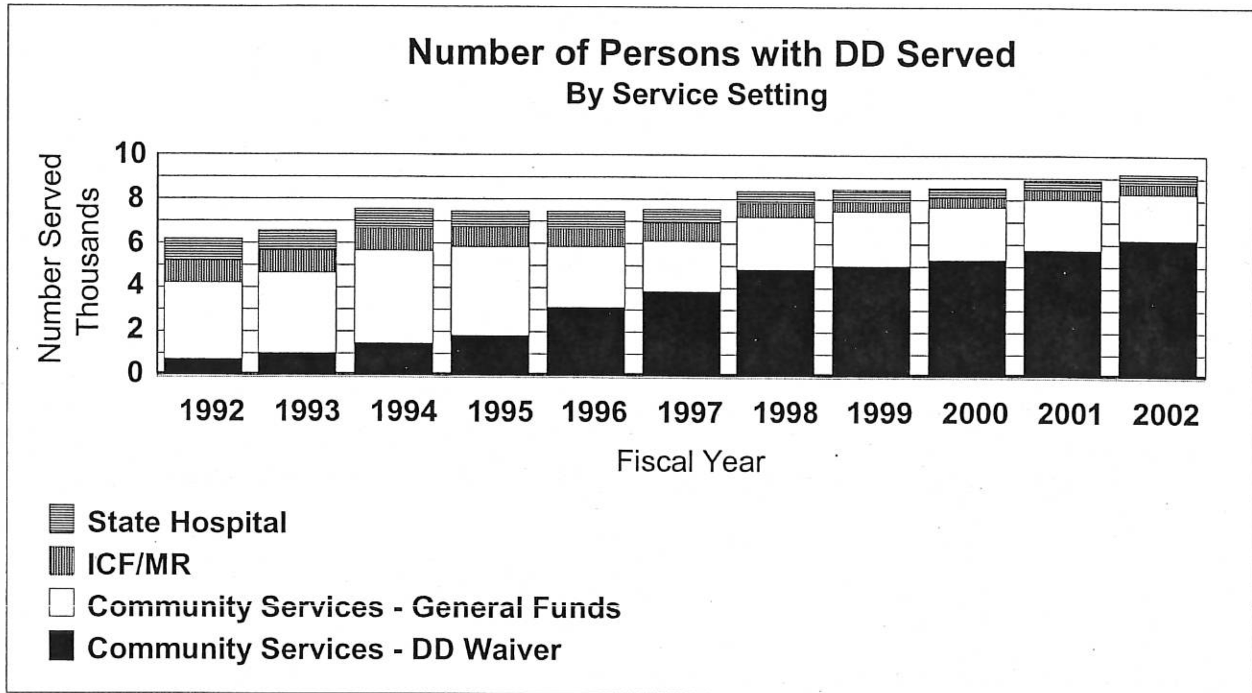
The DD Waiver provides Medicaid funding for persons who are eligible for admission to state or private institutions called intermediate care facilities for the mentally retarded (ICFs/MR). Over

the years, Kansas has used the DD Waiver for several purposes. First, it is used to help pay for the costs of placing persons from state hospitals and private institutions into community-based service settings. In the late 1980s the waiver was used to help pay the cost of community services for persons being placed from Norton State Hospital. Then, in 1992 Kansas began using the flexibility of the DD Waiver to more aggressively offer people living in state hospitals and their families the choice to move to community services through a process called the Community Integration Project. As a result of these efforts enough Kansans moved from state hospitals to allow the closure of Winfield State Hospital. In addition, in the last 10 years, nine of ten large private ICFs/MR have closed and many of the persons they once served are now being served in the community with DD Waiver funding.

Second, Kansas has used the DD Waiver to draw more federal funds for the cost of services for persons whose services were previously funded with only general funds. Beginning in FY 1994, SRS and Community Developmental Disability Organizations (CDDOs) began moving people whose services were funded with only state general funds onto the DD Waiver so additional federal Medicaid matching funds could be obtained for their services. The savings from this effort were used to serve people from the community DD waiting list and, in 1996 when the waiting list was eliminated for a short period of time, savings were used to provide a rate increase to community service providers. Through this process Kansas expanded eligibility for DD Waiver services to what is believed to be the maximum extent feasible.

Third, DD Waiver funding has allowed Kansas to access federal Medicaid matching funds to serve literally thousands of people who were waiting for community DD services. Since 1991, this has included supports for families whose children with DD continued to live at home. Without the federal matching funds made possible by the DD waiver, nearly 3/5ths of those removed from the DD waiting list, or about 1,800 people, would still be unserved or living in institutions.

The chart on the next page graphically displays the numbers of people with DD served from these various funding streams:

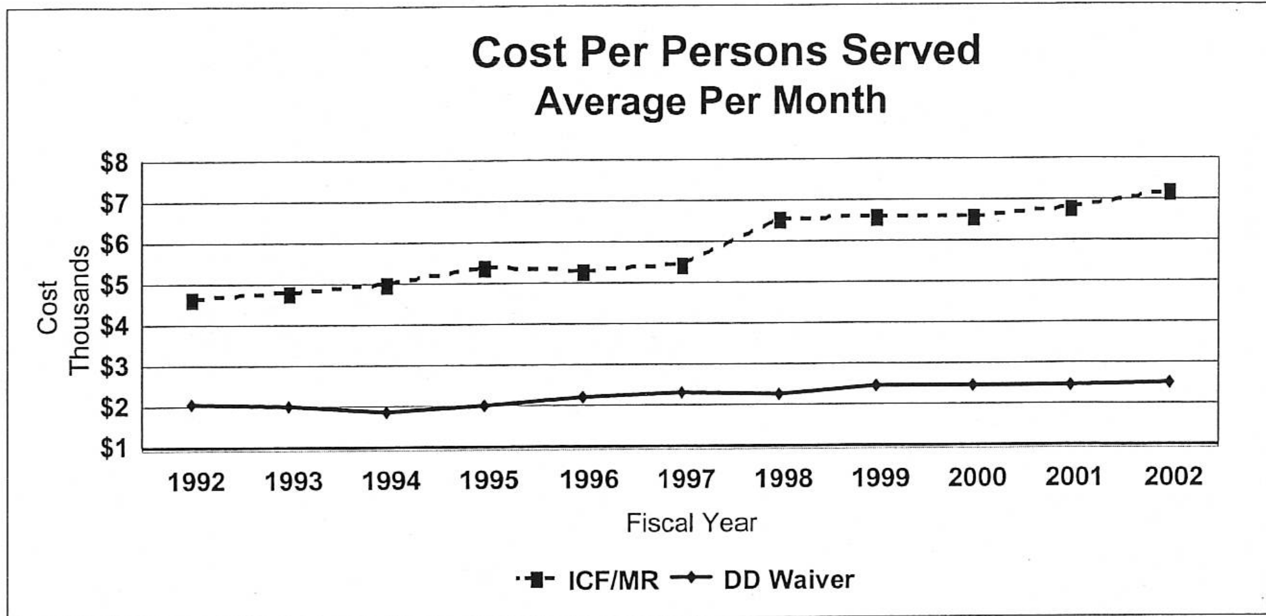


As the chart shows, the number of persons with developmental disabilities (DD) served in Kansas by the DD waiver increased by 5,469 from FY 1992 through FY 2002. Included in this number are about:

- 3,000 people taken off community waiting lists,
- 1,130 people who chose to move from state or private institutions, and
- 1,280 people who were served in the community with state general funds, but who were moved to DD waiver funding.

The waiting list for community DD services, however, continues to be a concern. Currently, there are 661 unserved persons waiting for community DD services. The FY 2004 GBR contains $5,082,592 to serve additional people from the DD waiting list. But, the demand for services continues to rise. So, even with this additional funding, the DD waiting list is projected to reach 931 persons by the end of FY 2004.

Occasionally, the question arises regarding the cost of serving persons in community settings. It would only be speculation to project what the cost of serving people in institutions would be if Kansas did not have a DD waiver. However, the chart on the following page shows the average per person cost of serving persons through the DD Waiver and public and private ICFs/MR:



The average costs of serving persons through the DD Waiver have risen far more slowly than the average rates paid for private and public ICFs/MR.

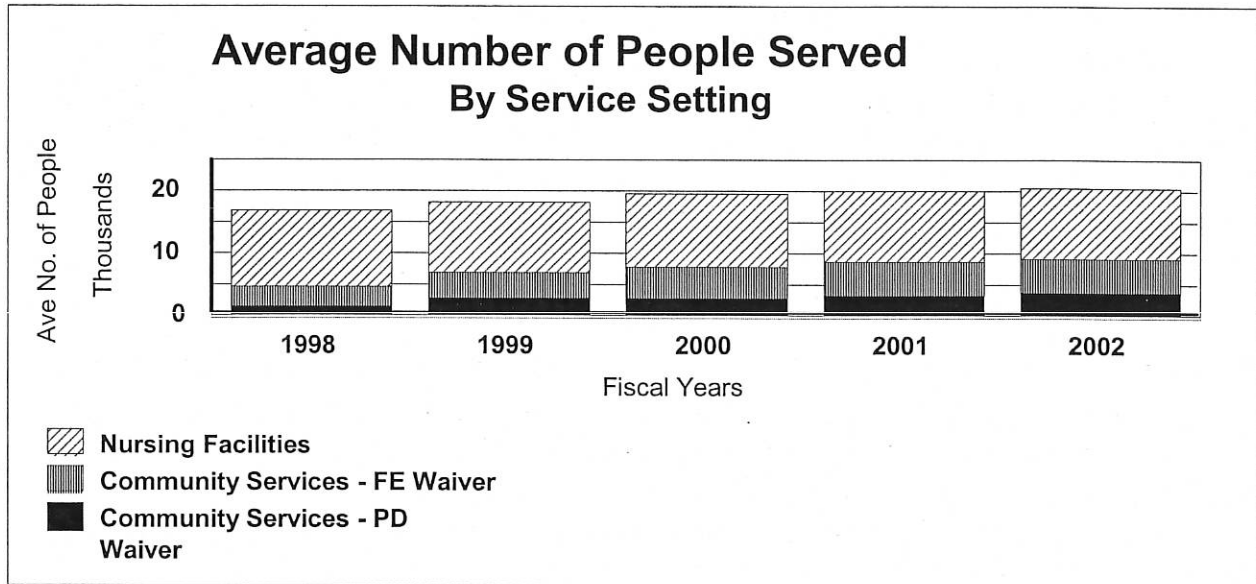
- The average monthly cost for serving people on the DD Waiver increased by about $550 from FY 1992 through FY 2002.
- The average monthly cost of serving people in public and private ICFs/MR increased by $2,560 per month from 1992 through FY 2002.
- The percentage increase of average monthly costs for the DD Waiver has been 21.8% over 10 years, or 2.2% per year.
- The percentage increase of average monthly costs for ICFs/MR has been 55% over 10 years, or 5.5% per year.

The DD Waiver has provided a cost effective means to allow people to move from public and private institutions to community based services. It has also allowed a significant number of people whose services were funded with all state general funds to generate federal Medicaid matching funds to defray the cost of their services. Savings from this funding shift allowed people to be taken from the DD waiting list and to give providers a rate increase. Finally, it has provided a way to more aggressively address the community DD waiting list. All of this was accomplished through controlled access, without establishing a new entitlement and with a very modest increase in the cost per person.

Physical Disability Waiver

In 1997, SRS began a home and community based services waiver specifically for persons with physical disabilities (PD Waiver). The PD Waiver funds community based services to persons with severe physical disabilities who are eligible for nursing facility placement, but who choose

to remain in their home. The PD Waiver was designed to fund the kinds of supports that are unique to generally younger persons with physical disabilities. Since 1998 the number of persons served through the PD Waiver has risen steadily. The following chart shows the overall growth of the PD Waiver, FE Waiver, and number of persons in nursing facilities paid by Medicaid. The FE Waiver is shown on this chart so that all waivers related to nursing facilities are seen together. I want to make clear however, the PD Waiver and FE Waiver serve people with significantly different needs.

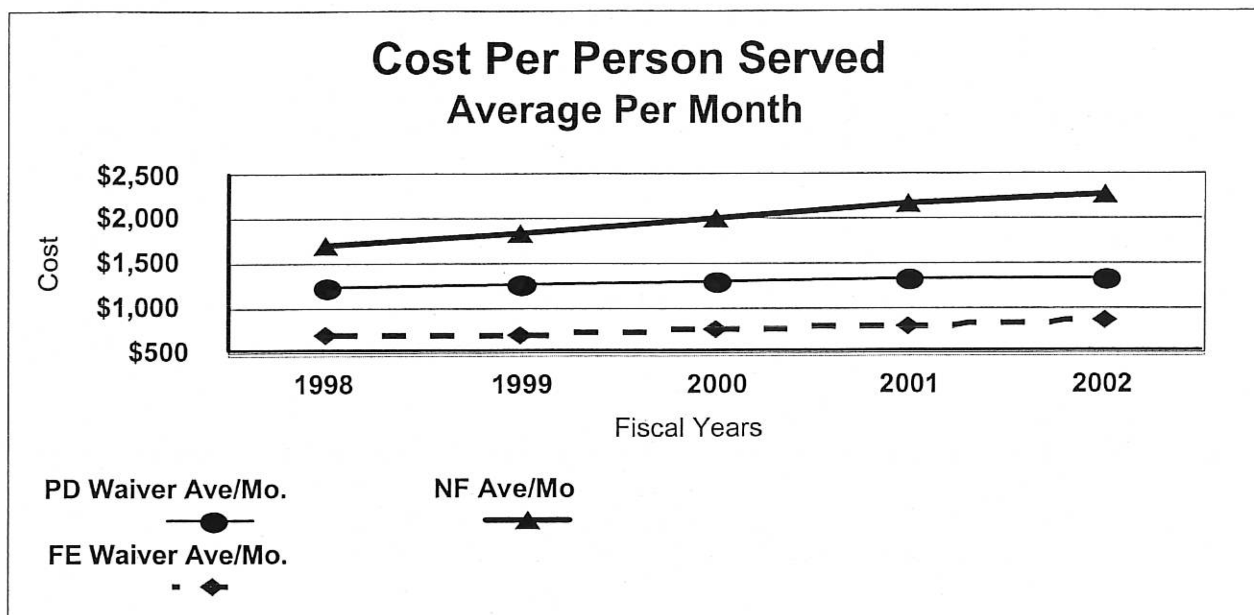


The data shows the following:

- The number of persons served through the PD Waiver has grown an average of 31.5% per year,
- The number of persons served through the FE Waiver has grown an average of 17.7% per year, and
- The number of persons that Medicaid funds in nursing facilities has declined an average of 1.72% per year.

This data seems to clearly indicate that the availability of the PD and FE waivers have provided community based alternatives to people with disabilities and limited the growth of nursing facilities.

The PD Waiver waiting list, however, remains a concern. Currently, there are 744 persons on the PD Waiver waiting list. The FY 2004 GBR includes $2,541,296 to serve additional persons from the waiting list. But, the demand for services continues to rise. So, even with this additional funding, the PD Waiver waiting list is projected to grow to 1,925 by the end of FY 2004.



The average cost of serving persons with physical disabilities in community settings is much less than the average cost of nursing facilities. In addition the increase in waiver costs have been much less than the increases experienced by nursing facilities.
The costs of serving all of these persons has risen in recent years, but the increase in costs for persons on the PD Waiver has risen less than the other two programs.

- The increased costs of the PD Waiver for this time period have averaged 2.1% per year
- The increased costs of the FE waiver for this time period have averaged 6.25% per year, and
- The increased costs of nursing facilities for this time period have averaged 8.5%.

Summary

The DD and PD Waivers provide a safe and cost effective way for people with severe disabilities to be served in their own homes and communities. These waivers have allowed Kansas to greatly reduce its reliance on expensive and highly federally regulated institutions. The waivers also allow Kansas to secure significant federal funds to pay for these services. But most importantly, the HCBS waivers allow people to live the kind of life they want to live, near their family and friends, in their own homes. Over the years SRS and others have compiled many stories about the lives of people who are on the waivers. More than the facts and figures I presented today, these stories tell of the true success of the HCBS waiver programs in Kansas.

Thank you for letting me present to you today. This concludes my formal presentation and I would be happy to stand for questions.

Kansas Department on Aging

HOUSE APPROPRIATIONS
DATE 2-14-03
ATTACHMENT 2

Impact of Home and Community Based Services for the Frail Elderly on Nursing Facility Utilization

House Appropriations Committee

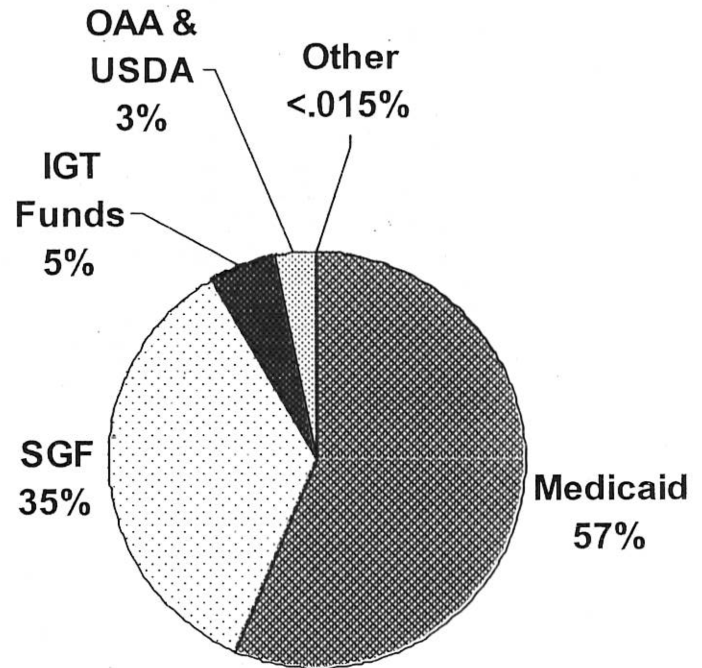
February 14, 2003
Janis DeBoer, Acting Secretary

For information contact:
Sheli Sweeney, Legislative Liaison
(785) 296-1299 or michelle@aging.state.ks.us

Doug Farmer, Assistant Secretary
(785) 296-6295 or dougf@aging.state.ks.us

Kansas Department on Aging
FY 2002 Funding Sources

Medicaid	$223,272,190
State General Fund	$140,824,187
IGT Funds	$21,089,830
OAA & USDA	$11,312,578
Other	$328,013
Total	$396,826,798



Kansas Department on Aging FY 2002 Expenditures

Nutrition **$8,840,080**

- Congregate
- Home Delivered Meals

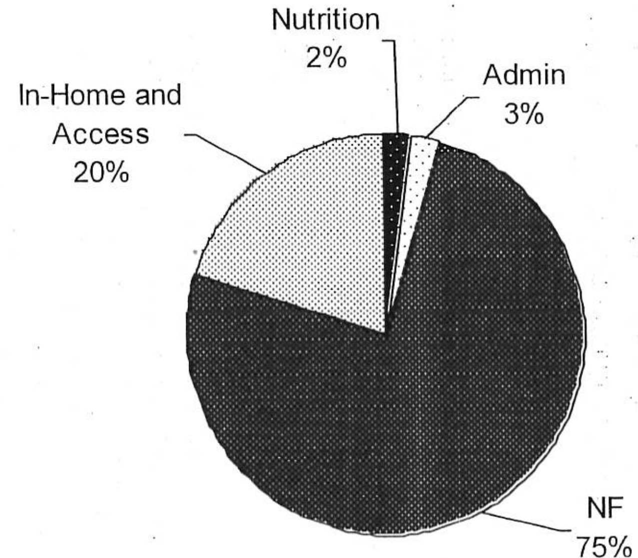
Access and In-Home **$78,881,780**

- Older Americans Act (OAA)
- Senior Care Act (SCA)
- Income Eligible (IE)
- Home and Community Based Services for Frail Elderly (HCBS/FE)
- Targeted Case Management (TCM)
- Senior Pharmacy Program
- Partnership Loan Program

Nursing Facility **$298,201,922**

Administration **$10,249,130**

- Includes Client, Assessment, Referral and Evaluation (CARE)



KDOA Customers Served FY 2002

HCBS/FE	**5,697**
Nursing Facility	**10,979**
CARE	**13,324**

- As of 1/31/03, HCBS/FE waiting list: 1,036

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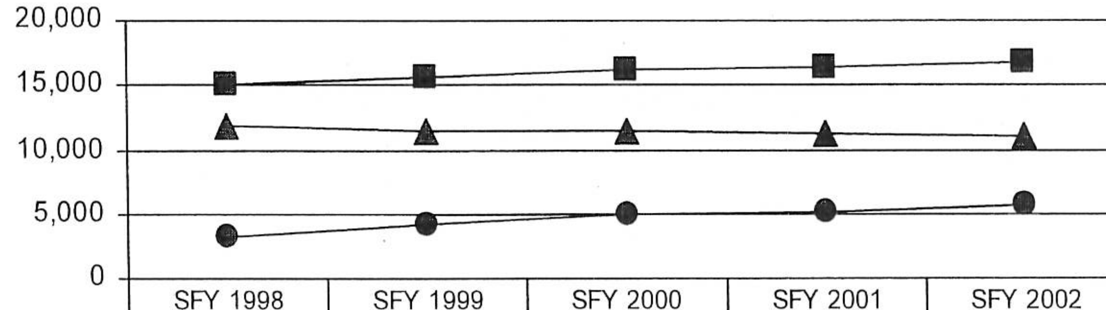
Monthly Medicaid Averages of Customers Served

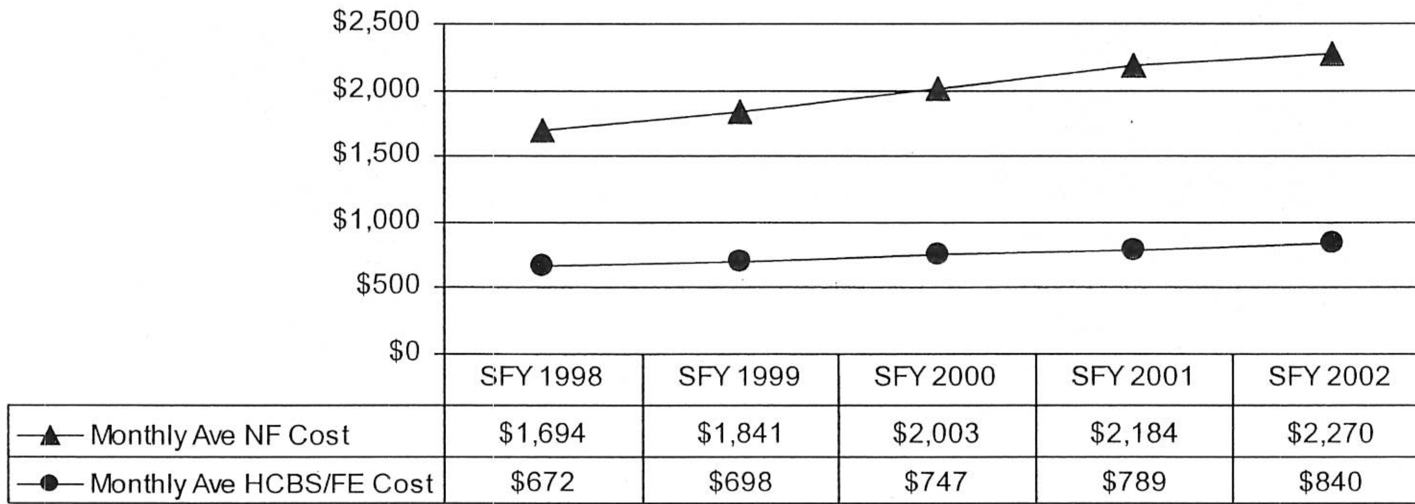


	SFY 1998	SFY 1999	SFY 2000	SFY 2001	SFY 2002
Total Average	15,120	15,624	16,271	16,399	16,676
Monthly Ave of NF	11,788	11,340	11,394	11,162	10,979
Monthly Ave of HCBS/FE	3,332	4,284	4,877	5,237	5,697
Total Customer % Yearly Increase		3.33%	4.14%	0.79%	1.69%

- For SFY 2002, the increase in the average monthly number of customers served on the HCBS/FE and Nursing Facility programs was 1.69%, which is slightly less than the population growth of 2.03% for the elder population, aged 80 and over.

- The average age on the HCBS/FE waiver is 79 and the average age for residents in a nursing facility is 84.

Monthly Average Medicaid Expenditures per Customer



	SFY 1998	SFY 1999	SFY 2000	SFY 2001	SFY 2002
Monthly Ave NF Cost	$1,694	$1,841	$2,003	$2,184	$2,270
Monthly Ave HCBS/FE Cost	$672	$698	$747	$789	$840

- In addition to the above analysis, the Department of Social and Rehabilitation Services conducted a study to determine the impact of HCBS/FE on nursing facility utilization (see Attachment A). The results from that study support KDOA's finding that HCBS/FE is a cost-effective alternative to nursing facility placement.

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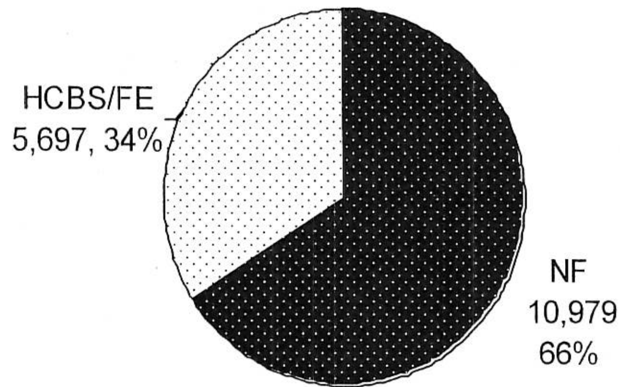
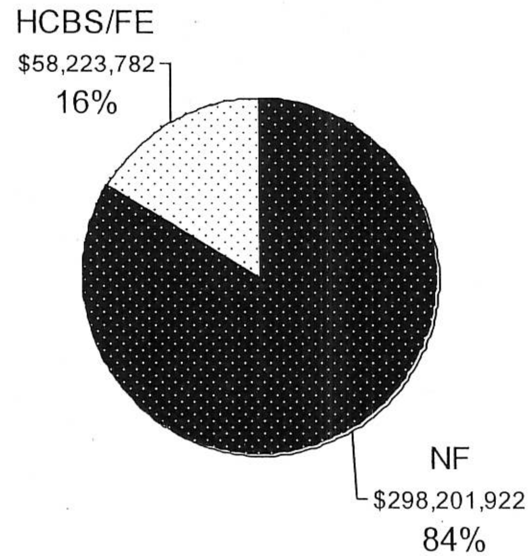
Comparison of Nursing Facility and HCBS/FE Customers and Expenditures

Monthly Average Served



Annual Expenditures



Attachment A

Are Home and Community-Based Services Less Costly than Nursing Home Care?

TI Shireman, SK Rigler, KS Braman, RM Day. Univ of Kansas Schools of Pharmacy and Medicine, the Landon Center on Aging, and Kansas Dept of Social & Rehabilitative Services

Background: Kansas Medicaid covers home and community-based services (frail elderly (FE) program) as an alternative for older adults who are eligible for nursing home (NH) care but wish to stay in the community.
Objectives: To describe demographic and health characteristics of Kansas Medicaid enrollees receiving NH or FE services and to compare their relative Medicaid expenditures.
Methods: We compared one-year direct medical costs, from Medicaid's perspective, for a random sample of NH and FE recipients (n=1050 and n=1165, respectively), using mean monthly costs to adjust for enrollment time. We explored the influence of demographic factors and comorbidities on cost differences between the NH and FE groups using multiple linear regression models.
Results: The NH cohort was older than the FE cohort, (83.2 vs 76.9 years), more likely to be white (93.4% vs 82.0%), and more likely to have dementia (34.4% vs 5.6%) or psychoses (28.6% vs 10.4%). The FE cohort had a higher prevalence of major medical diagnoses and died at a higher rate than their NH counterparts. After adjusting for key demographic and clinical features, mean monthly total costs for the FE cohort were \$1,147 ($p < 0.001$) lower than for the NH cohort. When we excluded direct NH and FE-specific costs, the FE cohort's mean monthly costs were \$243 higher than for NH cohort ($p < 0.001$), reflecting higher use of inpatient and outpatient services.
Conclusions: FE program enrollment was associated with reduced total costs relative to NH care. When considered with a concurrent analysis of nursing home placement rates, results support the notion that these services are a cost-effective care alternative for frail older adults.
Supported by a grant from the Kansas Department of Social and Rehabilitative Services.

Do Home and Community-Based Services Reduce Nursing Home Placement?

TI Shireman, SK Rigler, KS Braman, RM Day. Pharmacy Practice, Univ of Kansas School of Pharmacy and Medicine, Landon Center on Aging, and Kansas Dept of Social & Rehabilitative Services

Background: Kansas Medicaid covers home and community-based services (frail elderly (FE) program) as an alternative for older adults who are eligible for nursing home (NH) care but wish to stay in the community.
Objectives: To determine whether FE services lowered the rate of subsequent NH admission.
Methods: Retrospectively, we identified a randomly selected cohort of community-dwelling, elderly Medicaid enrollees. Those enrolled in the FE program (n=963) were compared to those who did not receive any FE or NH services during the base year (n=2992). The outcome was any NH use during the subsequent year and modeled using logistic regression accounting for differences in demographic factors and comorbidities.
Results: Persons receiving FE services were more likely to be white (82% vs 78%), female (78% vs 70%), and older (78 yrs vs 75 yrs). The 3 most prevalent comorbidities for both groups were hypertension, arthropathies, and diabetes. Subsequent rates of NH use were 4.4% lower among FE enrollees than for the non-FE community-dwelling cohort. After adjusting for differences in age, race, gender and major comorbidities, non-FE community-dwellers were 1.49 (95% CI 1.16-1.92) times more likely to enter a NH as compared to FE enrollees.

Conclusions: FE program enrollment reduced the likelihood of subsequent NH use among older Medicaid recipients. Combined with cost analyses reported elsewhere, results support the notion that these services are a cost-effective care alternative for frail older adults. Supported by a grant from the Kansas Department of Social and Rehabilitative Services.