Approved:3-6-04
Date

MINUTES OF THE PRESIDENT'S TASK FORCE ON MEDICAID REFORM.

The meeting was called to order by Chairperson Senator Stan Clark at 3:30 p.m. on February 24, 2003 in Room 519-S of the Capitol.

All members were present except:

Committee staff present: Norman Furse, Revisor of Statutes
Emalene Correll, Legislative Research
Ann McMorris, Secretary

Conferees appearing before the committee:

1. Jerry Slaughter, Kansas Medical Society
2. David Ross, M.D., Kansas Medical Society
3. Janet M. Williams, Communityworks, Inc., Mission
4. Terry Campbell, Kelley Detention Services
5. Fred Lucky, Vice President, Kansas Hospital Association
6. Gia Scott, LINK, Inc., Hays
7. Mark Bailey, Wichita PACE Program, Via Christi HOPE (Health Care Outreach Program for the Elderly)
8. Mary Ellen Connely, Via Christie Regional Medical Center, Wichita
9. Sister Ann McGuire, Sisters of Charity, Leavenworth and Member of Board of Directors, Providence Medical Center, Kansas City
10. Mike Skinner, GNB Enterprises, Junction City (medical transportation provider)
11. Randy Jost, Kansas Health Care Association
12. Karen Elliott, Director, Community Home Health, Onaga
13. Mary Holloway, Resource Center for Independent Living, Inc.(HCBS provider)
14. Judy Bagby , Kansas Health Care Association
15. David Johnson, Association of Community Mental Health Centers of Kansas, Inc.
16. Terri Roberts, Kansas State Nurses Association
17. Jan Jenkins, Director, Douglas County Visiting Nurses Association, Lawrence
18. Rexanne K. Beauchamp, RN CCRN
19. Martha Hegarty, Kansas Health Care Association (written only)

Others attending: See attached list.

Chairman Clark announced the schedule for the Task Force for the week of March 3.

March 4 Room 519S 9:00 a.m. to 5:00 p.m.
Medicaid 101 and Presentation and Discussion of Survey Medicaid Data
March 5 Room 231-N 9:30 a.m.
Work on report - identify specific initiatives and strategies to implement
March 5 Room 234-N 3:30 p.m.
Presentation by James Frogue
March 6 Room 231-N 9:30 a.m.
Presentation by James Frogue
March 6 Room 234-N 3:30 p.m.
Work on report
March 7 Room 231-N on Senate Adjournment
Work on Report

Response to Request at Feb. 17 Meeting

The Department of Aging responded to questions from the Task Force at the February 17, 2003 meeting. (Attachment 1)

Presentations by Medicaid Providers

1. Jerry Slaughter, Kansas Medical Society, provided the report of the KMS Medicaid Fee Schedule Task Force. (Attachment 2) The lack of adequate reimbursement in Medicaid is a continuing and serious problem. This state has very good participation among physicians in the Medicaid Program because the

reimbursement has fallen further and further behind, the network of Physicians who provide care to the 250,000 persons in this state is in jeopardy of unraveling. We believe the goal of the program should be that every Medicaid patient should have a primary care physician. This is good clinically and economically. (Note: he will provide actuarial review of reimbursement by Medicaid in Kansas.)

Recommendations made by the KMS Task Force

- The state of Kansas should make a commitment to increasing the Medicaid physician fee schedule so that it is equivalent to the Medicare fee schedule, and then maintaining the fee schedule at the Medicare level going forward.
- The Medicare Resource-Based Relative Value Schedule (RBRVS) should be adopted as the fee schedule methodology utilized by all Kansas Medicaid programs
- The Kansas Medicaid physician fee schedule should be adjusted annually by the amount that the Medicare fee schedule is adjusted by the Centers for Medicare and Medicaid Services.
- The initial adjustment and annual updates to the fee schedule should apply across the board to all physicians and the services provided by them. Selecting specified services for adjustment or updates should be avoided.
- In order to spread out the financial impact on the state of the proposed revision, the amount should be phased in over a three-year period.

2. David Ross, Medical doctor, Arkansas City

I was asked to give a physician's perspective on the Medicaid Program. Physicians view Medicaid as a social obligation of a program that their ethical standards by which they are bound to serve. Physicians approach all patients the same. One of the primary drivers is pharmacy costs and how physicians prescribe drugs for - (1) to have the most success; (2) low side effects; (3) unacceptable effects on other medications or medical condition. In most cases, we consider cost last.. He cited a case where a patient who had been doing well on a particular drug was recommended for a more costly drug and he didn't feel the change was necessary, but state regulations for nursing homes would have placed a large penalty on the nursing home if that new drug wasn't prescribed. The cost for 30 days of the less expensive drug was $30 and the expensive drug was $280.00. The problem of escalating cost is that more and more people are living longer and longer, with more chronic diseases, taking more medications, that are more and more expensive, using more technology, with higher expectations in the context of more and more lawyers. (No written paper available, Chair asked Dr. Ross to send a written statement).

3. Janet M. Williams, Communityworks, Inc., Mission (Attachment 3) There are two disturbing trends we see as a result of the current fiscal crisis. First, people we provide services become more dependent upon us and, second, employees are struggling to make ends meet. Reasons people are becoming more dependent: (1) waiting lists for all waivers; (2) rate decreases; (3) client obligation increases. She noted that Kansas was the first state to have a waiver specifically for people with brain injuries. Without the waiver Kansas would be paying for the person in an institution indefinitely, now the State of Kansas saves $40,000 per person per year by providing these services in the home. She urged moving the entire program toward self-sufficiency.

4. Terry Campbell, EVP, Clarence M. Kelley Detention and Youth Services, we achieve the best results in re-directing or re-focusing the youth by utilizing a team approach in a therapeutic atmosphere involving all levels of staff. He urged that funding be more aligned to meet the associated costs of providing for the detention program. (Attachment 4)

5. Fred Lucky, Vice President, Kansas Hospital Association (Attachment 5)

6. Gia Scott, Living Independently in Northwest Kansas (LINK, Inc.) Hays (Attachment 6)

7. Mark Bailey, Via Christi HOPE, Wichita spoke on the Program of All-Inclusive Care for the Elderly (PACE) (Attachment 7)

8. Mary Ellen Connely (for Tim Pollard), Via Christi Regional Medical Center, Wichita (Attachment 8)

9. Sister Ann McGuire, Sisters of Charity, Leavenworth and member of Board of Directors, Providence Medical Center, Kansas City, KS. (Attachment 9)

10. Mike Skinner, G&B Enterprises, Junction City - his firm transports medical supplies. He had no written comments but spoke on the cost to provide this service and the reimbursement his company receives.

11. Randy Jost, Kansas Health Care Association, suggested pharmacy selection could be made through Medicaid instead of Medicare and the cost would be lower due to volume.

12. Karen Elliott, Director, Community Home Health, Onaga commented that the current prior authorization system is not very effective and time consuming for Providers and for the Prior Authorization Unit. She suggested emailing requests for Medicaid Prior Authorizations would be more time and cost efficient. (Attachment 10)

13. Mary Holloway, Resource Center for Independent Living Inc. (HCBS provider) encouraged consideration of (1) recognition that in all waivers, there is a need to address developing informal supports that will assist in helping the consumer; (2) provide and assure opportunities for the person with a disability to develop their place of value within their own community; and (3) Assure that when people utilize the informal supports, they are not penalized. (Attachment 11)

14. Judy Bagby, Kansas Health Care Association. provided information on Maximum Data Set (MDS) (Attachment 12)

15. David Johnson, Association of Community Mental Health Centers of Kansas, Inc. presented general information about mental illness, community-based mental health services, how the mental health needs of Kansans are being met, services to adults with severe and persistent mental illness (SPMI), services to children/adolescents with Serious Emotional Disturbance (SED), Medicaid and optional services, the findings of the ten year study of Medicaid by Kaiser Family Foundation, and the unintended implications of potential pollicy decisions. He suggested a solution would be to increase feceral funding for Medicaid through an increase in the Federal Medical Assistance Percentages. (Attachment 13)

16. Terri Roberts, Kansas State Nurses Association, provided a report by Families USA entitled "Medicaid: Good Medicine for State Economies". (Attachment 14)

17. Jan Jenkins, Director, Douglas County Visiting Nurses Association, presented problems that are putting home health agencies under undue financial stress and placing the medicially indigent citizens of Douglas County and the State of Kansas at risk for institutionalization. (Attachment 15)

- Problem: Prior Authorization process for new patients and every 60 day reauthorization
- Solution: Reimburse home health agencies on a "per episode" basis.

- Problem: Prior Authorization process for PRN (unscheduled visits)
- Solution: Medicaid could Prior Authorize up to a certain number of PRN visits at the start of care.

- Problem: Increase in VNA administrative time/cost due to codes and authorization numbers required for billing
- Solution: A "per episode" reimbursement system would eliminate the need for these differing authorization numbers.

- Problem: Discharge of a patient and then readmittance, the PA's are blended together for both episodes and the agency doesn't know which visits are authorized.
- Solution: A "per episode" reimbursement system would eliminate the need for PA's.

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18. Rexanne Beauchamp, RN, was unable to attend but shared her experiences as an RN in an emergency room in an email. Chairman Clark read portions of the message which related to the Task Force's goal. (Attachment 16)

19. Written testimony was provided by Martha L. Hegarty, who owns and operates a 52 bed skilled nursing facility called Country Care. (Attachment 17)

Discussion followed.

Adjournment.

Respectfully submitted,

Ann McMorris, Secretary

Attachments - 17

President's Task Force on Medicaid Reform

DATE: FEBRUARY 24, 2003

Name	Representing
Randy Jost	Kansas Health Care Association
Judy Bagby	KHCA
Nancy Pierce	KHCA
Dale Blomquist	Ks Home Care Association
Brenda Carver	Caring Hearts of Wichita
Shelly Gillum	Caring Hearts of Wichita
Josie Torres	KACIL
[illegible]	RCIL
Mike Skinner	G & B Enterprises
NANCY CORKINS	DILLONS / KPhA
Ryan Schlink	KPhA
Craig Kaberle	KAAAA
Sheri Daudet	National MS Society
David Ross, M.D.	KMS
Jerry Slaughter	KMS
Christina Collins	KMS

President's Task Force on Medicaid Reform

DATE: FEBRUARY 24, 2003

Name	Representing
Vicki Pickrell	Midland Adult Day Programs
[illegible]	Midland Hospital Corp
[illegible]	ViaChristi HOPE
Terri Roberts	Kansas State Nurses Assn.
Karen Elliott	Community Home Health Chaps/St Marys
Jan Jenkins	Douglas County Visiting Nurses Assn.
Linda Lubensky	KS Home Care Assoc.
Terry Campbell	Kelley Detention & Youth Services
John J Federin	KDS
Bob Harder	UMC-KS
Chip Wheelen	Assn of Osteopathic Med.
Connie Ann Rower	KS Governmental Consulting
Bobbi Williams	Ks. Pharmacists Assoc.
Barbara Meyer	Intern - Gatewood
Connie Hubbell	KFMC
Lisa Scott	UNK Inc

KANSAS

PAMELA JOHNSON-BETTS, SECRETARY

DEPARTMENT ON AGING

KATHLEEN SEBELIUS, GOVERNOR

February 24, 2003

The Honorable Stan Clark
Chairman, President's Medicaid Reform Task Force
Statehouse, 449-N
Topeka, Kansas 66612

Dear Senator Clark:

Thank you for the opportunity to respond to questions from the February 17, 2003 meeting of the President's Medicaid Reform Task Force.

Question 1. How many individuals receiving Home and Community Based Services for the Frail Elderly (HCBS/FE) have plans of care that exceed the average cost for nursing facility services?

Response. When comparing actual HCBS/FE costs per month to the average nursing facility cost of $2,270 per month, there are 4% to 9% of plans of care whose actual expenditures exceed the average monthly nursing facility cost.

Question 2: Can the Kansas Department on Aging provide level of care (LOC) information on those customers that would be eligible for Medicaid?

Response. The mean LOC score for non-diverted customers was 74.0 and the mean LOC score for those non-diverted customers indicating Medicaid as a potential source of payment for support services was 74.8.

The mean LOC score for diverted customers was 65.8 and the mean LOC score of those diverted customers indicating Medicaid as a potential source of payment for support services was 65.7.

Comparison of LOC Scores for diverted and non-diverted customers is based on the indication of "Medicaid as a potential source of payment for support services". This variable for **Potential** Medicaid is NOT verified or confirmed with SRS; it is based on the CARE customer's self-report and/or the CARE Assessor's evaluation. Therefore, the reliability of this variable predicting which older adults or CARE customers would use Medicaid is limited. This variable is NOT mutually exclusive; CARE customers have multiple sources of payment for support services.

NEW ENGLAND BUILDING, 503 S. KANSAS AVENUE, TOP
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http://www.agingkansas.org/kdoa/

Please feel free to contact me if you have further questions or comments at 368-6684. Thank you very much.

Sincerely,

Janis DeBoer
Deputy Secretary

cc: Doug Farmer
Michelle Sweeney
Phyllis Schaper
Juanita Lewis

Report of the KMS Medicaid Fee Schedule Task Force

Vernon A. Mills, MD, Chairman

January 2002

Background

Medicaid-related programs in Kansas rank only behind Blue Cross Blue Shield and Medicare in terms of persons covered. Medicaid covers more children than any other health insurer, growing considerably with the start of the new uninsured children's program created by Title XXI of the federal Social Security Act. About one-third of all newborn deliveries are covered by Medicaid each year in Kansas. In all, Medicaid will provide health care benefits to approximately 200,000 Kansans this year, and is expected to grow another 10% in the next year. Medicaid is funded by a federal-state participation formula that varies somewhat from state to state. In Kansas, the federal financial participation formula for the vast majority of services is 60% federal, 40% state. A notable exception is the uninsured children's program, which has a higher federal match of 72% federal, 28% state. Total medical services expenditures for this year will reach almost $900 million, representing about 12.5 million provider claims processed.

In the last decade the fastest growing component of the Medicaid services budget has been prescription drug costs, which this year will approach $200 million. Pharmacy services currently represent about 27% of expenditures. Next highest in terms of total expenditures is inpatient hospital, at about 22% of the budget, followed by physician services at 12%. The expenditures for physician services have been relatively flat over the last decade, and actually declined as a percentage of the overall medical services budget.

Physician participation in Kansas Medicaid programs has been good historically. A high percentage of physicians in all specialties participate as part of the Medicaid provider network. For example, a 2000 study by the American Academy of Pediatrics showed that 89% of Kansas pediatricians participated in Medicaid. It is widely accepted that a high degree of physician participation improves access to care, thereby enhancing prevention and early intervention of problems, reducing utilization of costly hospital emergency departments, and improving patient outcomes. It follows that in addition to being good for the individual patient, a strong physician network is also cost effective for the state.

The Problem

In recent years, several areas of the state, both rural and urban, have begun to experience problems associated with physicians being less willing to keep their practices open to new or even existing Medicaid patients. In a growing number of areas new Medicaid patients have had difficulty finding primary care physicians willing to take on responsibility for their care (the majority of Medicaid patients now must be assigned to a primary care physician, regardless of the program they are covered under). Additionally, physicians in the non-primary care specialities have also begun to limit the number of Medicaid patients they will see in their practice. State officials have expressed concern over whether there will be an adequate physician network to care for the increasing numbers of individuals qualifying for Medicaid programs in the coming years.

The reason physicians cite most often for limiting the number of Medicaid patients they will see in their practice is low reimbursement. Research continues to suggest that physician fee levels affect both access to care and outcomes for Medicaid patients. A number of qualitative and quantitative studies show that physicians' decisions to provide care to Medicaid populations are related to both Medicaid fee levels and to such fee levels compared to other payors. These studies show that, as Medicaid fee levels increase, physicians are more likely to participate in the program, and those participating may treat more Medicaid patients as a result (The Urban Institute, *Recent Trends in Medicaid Physician Fees, 1993-1998,* September 1999).

The Kansas Medicaid physician fee schedule* is substantially below that of most state Medicaid programs, Medicare, and private insurance programs (Mathematica Policy Research, Inc., January 1998). For the purposes of this discussion we did not attempt a comparison of Medicaid fees to private insurers. A representative sample of codes across several specialties, however, found that Medicaid fees were in many cases only 20% to 45% of the corresponding fees paid by one statewide Kansas private insurer. In the aggregate, the Kansas Medicaid physician fee schedule is 71% of the Medicare fee schedule (*Comparison of Medicaid and Medicare Physician*

Fee Schedules, DeFrain Mayer Actuaries, November 2001). Wide variation among categories of service exist, however, with some services substantially below Medicare and others nearer it. For example, a 2001 study by the American Academy of Pediatrics found that numerous preventive medicine codes in Kansas Medicaid ranged from 25% to 39% of the comparable Medicare codes. Almost 7 out of 10 pediatricians reported that Medicaid reimbursement did not cover their overhead costs. The DeFrain Mayer study showed across most specialties that the bulk of evaluation and management codes were reimbursed in the range of 50% to 61% of corresponding Medicare fees. Likewise, several common surgical procedures are reimbursed by Medicaid at 55% to 65% of the Medicare fee schedule.

Under the federal rules which govern Medicaid programs, the establishment of the physician fee schedule is left to individual states to determine. Consequently, there is much variation among the states' fee schedules. Almost two-thirds of the states have adopted the Medicare Resource-Based Relative Value Schedule (RBRVS) as the methodology for reimbursing physicians. The Kansas fee schedule is not based on the RBRVS, and the last time it went through a complete revision and update was 1975. Since then several minor modifications and enhancements have been made, but overall the fee schedule has fallen further and further out of date. Budget constraints and the rapid growth in pharmacy, long term care and home health costs have been significant impediments to a comprehensive revision and improvement in the fee schedule.

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*Payment for physician services in Kansas is made exclusively on a fee for service basis. As many states have done, Kansas Medicaid has begun to transition its non-disabled population into capitated managed care programs (as of January 2002, a little over 75,000 children and adults were covered in the managed care programs). However, the capitation is only at the health plan level, not the provider level. Recent studies (*An Analysis of Kansas' Medicaid Managed Care Capitation Policies Affecting Children*, Maternal and Child Health Policy Research Center, Washington, D.C., November 2000) have shown that capitation rates paid to the health plan which contracts with the state were the lowest of 42 states surveyed. The capitation rates are derived from actuarial estimates of utilization experience based on the underlying provider reimbursement schedules. The capitation rates were adjusted upwards in 2001, but only to reflect increased utilization and expected mix of individuals enrolled in the program.

Findings

The Task Force is well aware of the difficult budget challenges facing the Governor and legislature at the present time. The economic recession has significantly slowed the growth in state general fund revenue, while the cost of providing needed services and programs has continued to increase. It is expected that the number of Kansans eligible for Medicaid, for example, will grow due to higher unemployment. Likewise, it is probable that the factors driving Medicaid costs upwards - increasing caseloads, pharmacy costs, utilization of services, and improvements in technology - will continue to absorb a larger part of the overall budget.

However, unless a comprehensive improvement in the physician fee schedule is undertaken, it is quite likely that substantial erosion of the physician network will occur. If the network starts to unravel the consequences to the state are considerable. From a budgetary standpoint, costs will increase due to more care being provided in emergency departments. As care becomes more episodic, preventive services will decline and patients will present sicker with more complicated conditions to treat. That will drive outpatient and inpatient hospital costs, and pharmacy costs even higher. Illnesses such as asthma and diabetes, very treatable and manageable if diagnosed early, will become significantly more expensive for the state.

Several studies have shown that the Kansas Medicaid fee schedule for physician reimbursement is out of date, inadequate, well below national norms, and unfair to the one group of health care providers that has historically participated in Medicaid programs in very high numbers in spite of very low reimbursement. For most physicians, Medicaid reimbursement does not cover the cost of overhead in their practice. Most states use the federal Medicare fee schedule, the RBRVS, as both the template and benchmark for their Medicaid physician fee schedule. Doing so assures that the fee schedule stays relatively current, as adjustments are made annually as the Medicare fee schedule is updated by federal regulation. Linking the Kansas Medicaid fee schedule to the Medicare fee schedule would also eliminate the problem of targeting certain services for adjustment from time to time, which causes the overall fee schedule to become a confusing

hodgepodge that bears little resemblance to a rational reimbursement methodology. The total cost to increase the Kansas Medicaid fee schedule so that it equaled Medicare rates would be $37 million (DeFrain Mayer report). Because the federal/state match is 60/40, the cost would be $22 million federal funds, and $15 million state funds. While Medicare rates are still below private insurers' rates, they are at a level which would assure that the Medicaid physician network would remain intact statewide.

Recommendations

The Task Force believes that the state should act to improve fee schedule for physician services to prevent deterioration of the physician network. It has been established that doing so will improve access to care and patient outcomes, as well as making overall expenditures more cost effective for the state. Recognizing that the state is in a difficult budgetary situation, a phased-in approach to improving the fee schedule would be a reasonable approach. Taking steps to gradually increase the fee schedule over a few years would send a positive message to physicians that the state is serious about improving the situation. The Task Force makes the following recommendations:

Recommendation 1 - The state of Kansas should make a commitment to increasing the Medicaid physician fee schedule so that it is equivalent to the Medicare fee schedule, and then maintaining the fee schedule at the Medicare level going forward.

Recommendation 2 - The Medicare Resource-Based Relative Value Schedule (RBRVS) should be adopted as the fee schedule methodology utilized by all Kansas Medicaid programs.

Recommendation 3 - The Kansas Medicaid physician fee schedule should be adjusted annually by the amount that the Medicare fee schedule is adjusted by the Centers for Medicare and Medicaid Services.

Recommendation 4 - The initial adjustment and annual updates to the fee schedule should apply across the board to all physicians and the services provided by them. Selecting specified services for adjustment or updates should be avoided.

Recommendation 5 - In order to spread out the financial impact on the state of the proposed revision, the amount should be phased in over a three year period.

Acknowledgments

The Kansas Medical Society would like to gratefully acknowledge the contributions of actuaries Thomas Handley and Heather Robinson of DeFrain Mayer; KaMMCO's financial support for the actuarial study; and to the entire Task Force:

Vernon Mills, MD, Leavenworth, Chairman
John Barlow, MD, Manhattan
Dennis Cooley, MD, Topeka
Richard Gomez, MD, Topeka
Fred Freeman, MD, Manhattan
Douglas Horbelt, MD, Wichita
Robert Kenagy, MD, Wichita
Stephen Miller, MD, Parsons
Mark McCune, MD, Shawnee Mission
Robert Moser, Jr., MD, Tribune
J. Edgar Rosales, MD, Salina
Scott Robinson, MD, Lawrence
David Ross, MD, Arkansas City, KaMMCO
Jeff Sellers, MD, Topeka
Kim Templeton, MD, KUMC
Roger Unruh, DO, Wichita, Kansas Association of Osteopathic Medicine

Presentation to
President's Task Force on Medicaid Reform
Senator Stan Clark, Chair
February 24, 2003

Thank you for the opportunity to present before you today. My name is Dr. Janet Williams and I own communityworks inc, a home health agency in the State of Kansas. I am also Associate Professor of Occupational Therapy at the University of Kansas Medical Center.

Communityworks started providing services to people who experienced traumatic brain injuries 10 years ago. Over time we have expanded our services to work for people through several Home and Community based waiver services including the head injury waiver, physical disability waiver and frail elder waiver.

There are two disturbing trends we see as a result of the current fiscal crisis. First, we see the people we provide services become more dependent upon us and second, we see employees struggling to make ends meet. These trends can be alleviated by investing in self sufficiency up front, decreasing the need for services later and increasing the capacity of qualified staff.

1. Increased dependence

As a provider of services, we have always been proud of supporting people to become self sufficient, no longer needing our services. Over time, as the budget is cut more and more, we have seen people become more dependent on our services and need them for longer amounts of time. There are several reasons why people are becoming more dependent rather than independent:

- Waiting lists- The waiting lists for all waivers has grown exponentially over the past several years. The longer a person waits to get services, the more services s/he needs by the time they are able to receive them. And, they need those services longer because the secondary disabilities are far more complex than the original disability (ie, skin breakdown, contractures, seizures).
- Rate decreases- Those people with more significant disabilities have a more difficult time finding qualified staff to work for them when they are at home. We are seeing more people lose staff, and more people having to remain in nursing homes because they cannot get the qualified staff they require. Overall, staff turnover is much higher because, as you already know, human services work is already one of the lowest paying jobs and with rate decreases, even lower.

- Client obligation increases- Living on $716.00 per month was difficult enough. Now that people must live on $645.00 per month they are using more case management/ independent living counseling hours to assist in budgeting, getting medical supplies, figuring out how to get to the physician since it isn't paid for by Medicaid and finding affordable housing. (We used to say safe affordable housing but that has become an oxymoron for the people for whom we work). We are also seeing people drop services all together thus leading to the need for even more services later.

Each of these cuts has eroded the basic premise of supporting people to become independent. Now, we are struggling just to assist people to stay in their own home with utilities.

2. Employee retention

A majority of our staff (98%) are women and quite a few of the women are single mothers. With the $1.50 per hour rate decrease we have faced having to freeze increases and start people at a lower hourly rate. Fewer people are taking advantage of our health insurance and 401k plan because they are struggling for day to day existence. For example, it is a basic necessity to have a vehicle to get to work. It was difficult before the budget cuts for people to get their car fixed, now it is close to impossible. We assist in any way that we can with pay advances and driving people to work until they make the money to fix the car, but you can only do that so often and for so long when there are 147 employees to consider.

I do believe there are some choices to make that will increase self sufficiency while not necessarily increasing the budget.

Invest in Self Sufficiency

I am here to tell you that services designed to give the tools toward self sufficiency work. We have had proof of this for the past 10 years with the Home and Community based Head Injury waiver. It works because people can become self sufficient, go off services and be glad to be done with us.

Kansas was the first state in the country to have a waiver specifically for people with brain injuries. This waiver allows people between the ages of 16 and 55 to receive the services they would traditionally receive in a hospital, at home. They can only use these services when they are Medicaid eligible, meaning after they have used every other resource available to them.

The State of Kansas saves $40,000 per person per year by providing these services in the home as compared to an institution. There are many hidden cost savings as well. People only use these services for an average of 2 years. Many become independent while others may transition to other waivers at a much lower cost. Without the waiver Kansas would be paying for the person in an institution indefinitely.

The model for the head injury waiver works and needs to be applied to other waivers. The core service is transitional living skills. A person sets goals and achieves those goals with the assistance of an independent living skills teacher. Once goals are attained, new goals are set until the person is able to do as much as possible for him or herself.

Transtional living services need to be added to both the physical disability and developmental disability waivers. Give people the means to have fewer services by providing independent living skills teachers for a time limited period, up front, to save in the long run.

We work with 49 people on the head injury waiver and 45 people on the physical disability waiver All people on the head injury waiver must be working on goals and they know their services are time limited, based on their progress. This is not an option for people on the physical disability waiver, even if they want to become more independent (and I would say most would definitely prefer we not be in their lives). Waiting lists would be shorter, Kansas would save more money in the long run and more people would be able to live without the waiver.

Thank you again for your time today. I believe that stopping ongoing whittling of money from different parts of the current system and moving the entire program toward self sufficiency, is a win win for everyone.

I am happy to answer questions.

3-3

Medicaid Issues

Prepared for

President's Task Force on Medicaid Reform

Written testimony provided by

Terry Campbell
Executive Vice President
Clarence M.* KELLEY *Detention and Youth Services

February 24, 2003

President's Task Force on
Medicaid Reform
February 24, 2003
Attachment 4-1

I would like to thank Senator Clark and the members of the President's Special Task Force on Medicaid Reform for this opportunity to testify.

My name is Terry Campbell and I serve as the Executive Vice President for Clarence M. Kelley Detention and Youth Services (KDYS), which consists of four Kansas corporations that operate six juvenile programs within the state. Currently KDYS operates four Level V residential treatment programs and two detention centers. The detention centers are the Greater Western Kansas Regional Juvenile Detention Center in WaKeeney and the Clarence M. Kelley Youth Center in Topeka serving a total of 41 youth. Our residential programs are Sappa Valley Youth Ranch in Oberlin, the Trego County Secure Care Center in WaKeeney, Forbes Juvenile Attention Center in Topeka, and the Clarence M. Kelley Transitional Living Center in Topeka, for a total of 148 residential treatment beds serving both "juvenile offenders" and "children in need of care".

All of our Level V residential programs are Medicaid certified, which I might add is no easy or cheap task to accomplish. To be Medicaid certified there are several levels of service that must be provided, some of which must be performed by Masters level or above mental health professionals licensed by the state of Kansas. Examples of programs conducted by these

professionals are the development of a master treatment plan for each youth entering the program, a professional assessment and diagnosis, supervision of non-licensed, but having a degree, personnel in conducting counseling in areas of drug and alcohol abuse, anger management, and education. The licensed professionals also must provide a minimum of three hours of therapy a week to each youth.

Kelley Detention and Youth Services (KDYS) currently have a licensed mental health professional at each of our Level V facilities overseeing the programs in consultation with Jack Hewitt, Ph.D. our director of therapeutic services. We believe the best results are achieved by utilizing a team approach in a therapeutic atmosphere involving all levels of staff, especially line staff who are in constant contact with the juvenile. Again, while this concept has proven to attain the best results in re-directing or re-focusing the youth, it also has more costs associated with it. Strangely enough the cost set by the state to detain youth in secure facilities, with little or no programs, is currently $120 per day, while the current daily rate paid to Medicaid certified programs is $106.50. Unless I am mistaken, the detention rate costs the state the entire $120 per day, while the daily rate for Medicaid is provided with 60% coming from the federal and 40% from the state.

Therefore, placements in Medicaid certified facilities are saving the state sixty cents on the dollar. We are especially proud of our services for we provide the therapeutic programs needed, while the youth resides in a staff secure setting for the safety of both the juvenile and the community.

While I feel the Medicaid program in Kansas has many benefits, it is somewhat unrealistic to feel you can maintain staff, with the level of education needed to meet Medicaid requirements, at the current rate of funding. We find this especially difficult in the rural areas of the state where we have developed programs to not only benefit juvenile service professionals, but communities with whom we have partnered. Sappa Valley Youth Ranch in Oberlin is a good example. While it serves a large population of youth in western Kansas and is much more convenient for youth service workers, it is extremely difficult to employ Master's level professionals let alone those licensed in the state.

Along with the high cost to retain licensed professionals, other Medicaid requirements place tremendous burdens on agencies and companies that provide these services. An example is the one staff to six youth ratio that must be maintained for line staff and the ratio requirement of one case manager per fourteen youth. I am not contesting, nor am I in disagreement

with this requirement, I am merely mentioning it to demonstrate the added cost Medicaid certified programs have over detention programs. Other associated costs, besides the basics of lodging, meals, clothing, physical hygiene, recreation and education, are the required psychological and medical assessments, transportation for outside counseling and individual therapy, and communications costs to conduct and/or maintain contact with the youth's family and outside case manager.

I would reiterate that I understand and appreciate the need for most, if not all of the requirements for Medicaid certification, I just feel funding needs to be more aligned to meet the associated costs.

Again, thanks for the opportunity to appear before this committee and provide testimony on behalf of our facilities and others providing this much needed, and very important, service for the youth of our state.

Testimony of the Kansas Hospital Association
Fred J. Lucky, Vice President
to
President's Task Force on Medicaid Reform
February 24, 2003

The Kansas Hospital Association appreciates the opportunity to testify before the President's Task Force on Medicaid Reform. Hospitals have a long tradition of partnering with the State to provide needed health care services to the State's most vulnerable citizens – the poor, the frail and the elderly – under the Medicaid program. Ultimately this Task Force will have to answer a very basic question: Is the Kansas Medicaid program sustainable for either the State or hospitals given the economic and demographic forces acting on both? The answer to that question, and therefore the challenge for all of us, has to be a resounding "yes." I hope to bring to light how the Medicaid program is inextricably linked to the viability of all hospital services for all Kansans, not just the Medicaid enrollees.

Kansas' hospitals are the foundation of our State's health care system. A foundation built with people taking care of people 24 hours a day, seven days a week – doctors, nurses and other clinical professionals, support staff, as well as executives and volunteers – working together to support an essential public service. Unfortunately, there are cracks in that foundation that are growing at an alarming rate:

- ***Worker shortages*** that will reach crisis proportions in the coming decades due to the aging of the population;
- ***Rising demand for hospital services and constrained capacity*** that cause emergency department overcrowding and ambulance diversions;
- ***Excessive regulatory burdens*** that take caregivers away from the bedside and diverts financial resources away from patient care;
- ***Rapidly rising costs*** for labor, pharmaceuticals and new technology that, if not matched with increases in payment, threaten the financial stability of hospitals;
- ***Growing number of uninsured people*** (10.5 percent of all Kansans) that threatens access to timely and appropriate care and strains the financial resources of the hospitals who care for these individuals;
- ***Decreased access to capital*** that is required to meet rising demand, keep up with advances in technology, and maintain facilities;
- ***Payment shortfalls for Medicaid*** – shortfalls that were extremely exacerbated by this current fiscal year's budget allotments and intensified even further by the Governor's budget recommendations for FY 2004.

- ***Unrestrained growth in uncompensated care*** - charity care and bad debt expenses in 2001 totaled $283,941,546, over 8 percent of net patient revenue and that figure continues to grow.

Given these forces acting on the foundation of hospital care, it is vital that Medicaid be a program that does not threaten the care for all patients. In physics has been proven that for every action there is an equal and opposite reaction. The same corollary can be applied to health care economics. When you have one payer, particularly one representing over 10 percent of all of the inpatient discharges in the state such as Medicaid, that significantly underpays for their services, someone else has to make up for their shortfall. If not other payers, then in the case of county and district hospitals with hospital tax levies, then the taxpayers will have to make up the difference. If that is not available, then ancillary hospital services like home health, skilled nursing units and wellness programs must necessarily be reduced or eliminated altogether.

Growth of Medicaid

The total number of Medicaid enrollees has continued to grow over the past three years. According to SRS data, the number of Medicaid enrollees (Medicaid, MediKan, and SCHIP) grew from 273,212 in FY 2000 to 332,395 in FY 2002. Expectedly over the same time period, hospital expenditures for Medicaid enrollees grew also, from $174.48 million to $195.36 million, but not at a much different per capita rate. If you calculate total expenditures by enrollee you actually have a decrease in hospital expenditures of 8 percent over the same period of time. It is easy to see that this level of funding for a growing Medicaid population is not sustainable for too much longer.

Medicaid Payment System

In 1988, SRS changed the way they paid hospitals for inpatient services from a per-diem basis to a prospective, per case basis called Diagnosis Related Groups or DRGs. Medicare had developed this payment system for hospitals in 1983 and it based on a complex statistical formula. Cost containment is the fundamental premise of this type of payment system and it incentivises hospitals to be efficient in the delivery of care. When those efficiencies lead to lower costs, the hospital gains, when they do not the hospital loses. For outpatient services, on the other hand, SRS uses an established "fee-for-service" payment system that has basically remained flat for the past 20 years.

How does Kansas stand up with other states in regard to Medicaid payments? For the past several years, Kansas has routinely ranked towards the bottom of all states in relation to the percentage of costs paid to hospitals under Medicaid according to the Medicare Payment Advisory Commission, Congress' independent advisor on Medicare and

Medicaid policy. This was further evidenced in a study commissioned by SRS in 1997 by the Mathematica Policy Group. The report summary stated, in part:

> *In the aggregate, Medicaid ... reimbursement in Kansas is substantially below that of most state Medicaid programs, Medicare, and private insurance. Kansas rates are especially low for many primary care services, such as hospital and office visits and immunizations.*

The legislature responded to this alarming data by adding $4.0 million in SGF in FY 1999, as the "first installment of a five year program" to bring the reimbursement for hospitals and physicians up to acceptability. We are still waiting on installments two through five.

Current Medicaid Payment Policy

Attached to our testimony is a document entitled ***"Keeping the Promise – the Medicaid Safety Net"*** that we prepared to heighten awareness of the true level of payment reductions to hospitals resulting from the last round of budget allotments, and the potential impact those reductions will have on the hospitals in communities all across the state.

Combined with the FY 2004 budget recommendations, Kansas hospitals are being asked to continue to provide the same level of services to not only the Medicaid beneficiaries for which these budget reductions are targeted, but for all their patients while receiving in excess of $21 million less over the next 18 months in Medicaid payments. It would be naïve to assume that some critical services for all Kansans, not just Medicaid recipients, will not be threatened by these cuts.

The payment reductions included in the current year's allotment, as well as those proposed in the Governor's FY 2004 budget focus on services that on the surface, cause little harm to direct patient access and care. A deeper analysis, however, is in order.

First, in the November allotment, SRS announced that hospital rate reductions, most to be effective on January 1 for the balance of FY 2003 would total $1.5 million dollars in all funds. Given the description of the announced cuts, we challenged the department to be more forthcoming with their estimates. Subsequently, the department revealed that the total was closer to $8.3 million, nearly six times the announced allotment. Had they not limited the 10 percent across the board reduction on inpatient services to two months after we brought this to their attention, the figures would have been far greater. You can understand, therefore, our dismay at seeing an additional $12.7 million in payment
President's Task Force on Medicaid Reform

reductions for FY 2004 since we already exceeded the November allotment by nearly $7 million. Our concerns are:

Graduate Medical Education – payments totally eliminated for the balance of FY 2003 ($2.75 million) and all of FY 2004 ($5.5 million). These payments go to the hospitals, ten in total, that support the interns and residents, both financially and clinically, that represent the future of health care throughout our state. To say that this is bad public health policy would be an understatement and consideration should be given to restore these payments at the earliest possible time. I know that Senators Feliciano and Schodorf have a keen interest in these programs and are working with both campuses of the Medical School to find creative ways of seeing these dollars restored.

DRG Outlier Payments – Medicaid's DRG payment system is based upon a pre-determined, fixed-price methodology. Any DRG payment system, whether used by Medicaid, Medicare or any other insurance program, has provisions to compensate for cases that fall outside the norm. Severe cases for burns, head injuries and neonatal babies are the most common, but by no means all, of these types of cases. SRS and the Governor's budget announced payment reductions of $1.05 million for the balance of FY 2003 and $2.2 million for FY 2004. Again these numbers are questionable. Our estimate of the FY 2004 impact, and it has been confirmed by SRS, is that the number is in excess of $4.7 million – over two times the published amount. Unfortunately, once a case is eligible for an outlier payment the hospital has already lost thousands of dollars treating the patient, now they are being asked to lose thousands more. Let's examine just one type of these cases, neonatal care. In Kansas 24 percent, or nearly 10,000 out of 40,000 births require some form of extraordinary care, for Medicaid babies the number is in excess of 26 percent. Many of these babies require the services of a neonatal intensive care unit. Given these reductions, at some point hospital boards are going to question whether it is more economically viable to ship these patients to a facility possibly hundreds of miles away than to keep a high cost unit open that drains scarce resources from the rest of the hospital.

DRGs Payments Over Charges – As I stated earlier, DRGs had two objectives when they were first developed – to encourage innovation and creativity in patient care and to incentivize hospitals that became efficient in delivering lower-cost patient care. If a hospital succeeded they were rewarded by the fixed DRG payment sometimes exceeding even their charges. If not, they were incentivized to try harder. These predetermined DRG rates are statistically determined to do just that. To penalize hospitals because they are able to achieve economies in two

percent of their cases renders the statistical analysis that creates the DRG payments invalid.

Out-of-State Hospitals – Occasionally Medicaid clients utilize hospital services outside the boundaries of Kansas because those services are not available locally. Oftentimes these are major medical centers that provide unique and frequently high cost services. They will now be paid at the lowest hospital payment rate. At some point, they too will ask the question of whether they want, or need, to provide services to Kansas Medicaid beneficiaries.

On too many occasions the publicly announced reductions in acute hospital payments have been grossly understated. The impact on the outlier payments is just the most recent example. One could only assume that if a thorough re-examination of the balance of the estimates were done, they too would be understated. One must question whether the objective of these payment reductions is merely to achieve some arbitrary budget figure or to fundamentally change Medicaid health care policy. If so, the process should not be done in the context of the budget alone, but rather an open and frank public discussion of the consequences of these actions should be aired.

In our brochure, "***Keeping the Promise – the Medicaid Safety Net***" we state that hospitals have a promise to keep to their communities – to be there 24/7 regardless of the sickness, tragedy or calamity. Government has promises to keep as well … to provide fair, just and adequate payments for the patients they cover to ensure that their community hospital will continue to be there 24/7.

Hospitals are the foundation of the health care services in their communities and are being asked by Medicare, Medicare and even Blue Cross to do more with less. At the same time, they are being asked to be prepared to respond to any crisis, terrorist or otherwise, at all times. And in their community shortages of nurses and other healthcare workers are compounded by their neighbors growing older and requiring more services. The cracks in the foundation of community health care services are growing alarmingly larger and must be sealed. We ask that you remember this as you consider the future of Medicaid in Kansas under this Task Force's charge.

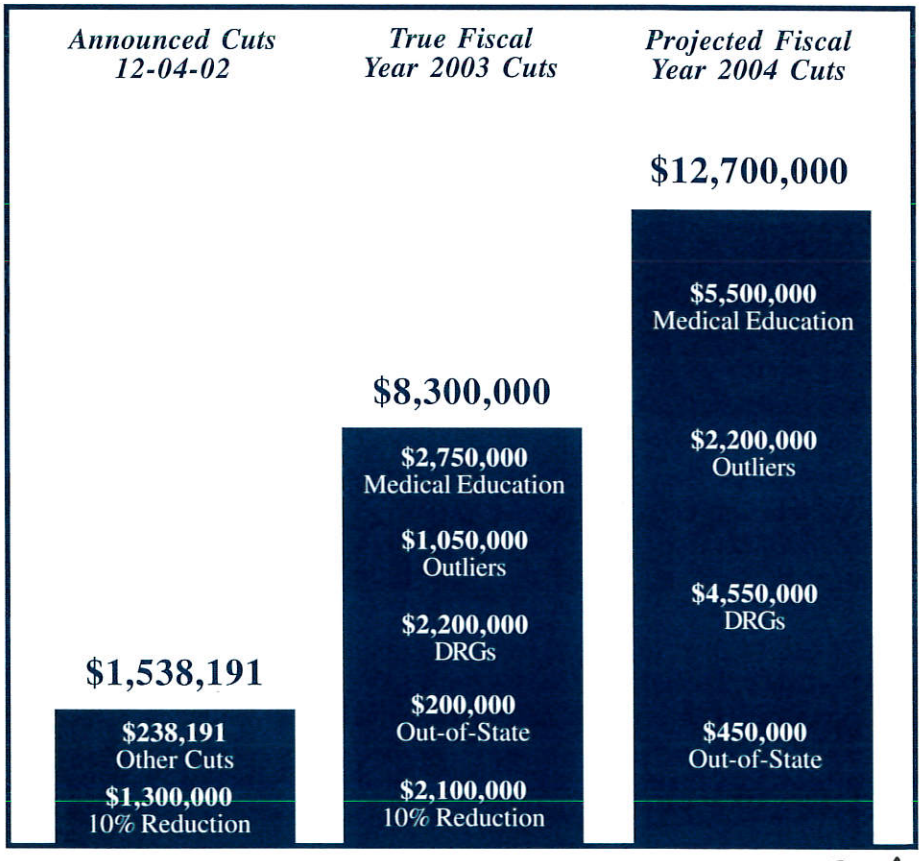
Attachment: Keeping the Promise – the Medicaid Safety Net

Keeping the Promise - *the Medicaid Safety Net*

The Kansas Medicaid program is at a crossroads. The number of individuals covered by medical assistance programs has increased substantially over the past several years. Hospitals continue to treat these patients even though reimbursement is below the costs incurred for such treatment. Now, because of the state budget crunch, Medicaid reimbursement is proposed to be reduced to even lower levels. Specific cuts include:

- Medical education payments to help train physicians, nurses and other health care providers;
- Outlier payments for extremely difficult, high-cost cases;
- Reimbursement for services where the diagnosis related group (DRG) is set higher than a particular charge;
- Medicaid payments to out-of-state hospitals; and
- An across-the-board 10 percent reduction in Medicaid rates.

These cuts were first announced in late 2002. Unfortunately, the impact of these cuts is much greater than originally stated. The following graph demonstrates this fact.



KANSAS HOSPITAL ASSOCIATION

5-6

From Cuts to Consequences

Budget reductions for hospitals have targeted five areas and have consequences that far outreach the Medicaid program. Those dollars help support vital health care programs for all Kansans and are dollars that cannot be shifted to other payers. What are the consequences of these cuts?

Medical Education - Annual Reduction of $5,500,000. Hospitals provide the clinical environment for the training of over 250 residents and interns, primarily from the University of Kansas School of Medicine - Wichita, and hundreds of nursing students. These students are the future of health care for all Kansans. It is bad public health policy to totally eliminate funding to cover the costs of these programs. Consideration should be given to restoring all of these cuts.

Outliers - Annual Reduction of $2,200,000. DRGs fail to account for extremely high-cost cases such as burns and neonatal intensive care unit babies. Provisions to cover a fraction of these high-cost cases are made through "outlier" payments. NICUs, burn units and transplantation services are threatened by these payment reductions.

DRGs Over Charges - Annual Reduction of $4,550,000. Predictable fixed-payment DRG systems are statistically determined and relied upon by hospitals in forecasting for future costs. These payment systems recognize that very few cases occur where the payment exceeds the charges, such as in maternity and well baby care. These cases help subsidize the remainder of the cases that are woefully under funded by the state's payment formula, resulting in Kansas hospitals being among the nation's lowest reimbursed for Medicaid services.

Out-of-State Hospitals - Annual Reduction of $450,000. Certain out-of-state providers, such as Children's Mercy Hospital, offer services that are not available in Kansas. The decision to reduce payments to the lowest level without regard for these services can be problematic for individuals needing that care.

10% Payment Reduction - Two Months for $2,100,000. Already listed as being one of the nation's lowest paying states, Kansas' DRG payment system fails to pay for the actual costs of providing care for Medicaid patients. By reducing those payments by 10 percent, even for only two months, it further exacerbates the already fragile financial condition of many of the state's community hospitals.

The Bottom Line

Kansas hospitals are keeping the promise of care—that they will be there, providing the right care, at the right time, in the right place. Hospitals are people taking care of people—doctors, nurses, other health care professionals, support staff, as well as executive and volunteer leaders—working in unique ways to provide essential health care services. In times of need, Kansans depend on the hospital promise …

Hospitals are there, 24/7, when any health care need arises;
Hospitals are there, 24/7, when disaster strikes a community;
Hospitals are there, 24/7, when an uninsured child needs care; and
Hospitals are there, 24/7, when others have closed for the night.

Government has promises to keep as well ... by providing the resources necessary to finance mandates placed on hospitals, by funding the services that it has promised will be available to Medicaid patients and by helping hospitals meet ever-increasing patient demands and community expectations. But even as hospitals strive to continue meeting their communities' current needs and rising expectations, their ability to keep the promise of care is being severely challenged.

5-7

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Presentation to
President's Task force on Medicaid Reform
Senator Stan Clark, Chair
February 24, 2003

Thank you for the opportunity to present before you today. My name is Gia Scott and I am the Personal Development Coordinator for Living Independently in Northwest Kansas (LINK, Inc.). Brian Atwell, Executive Director for LINK, Inc., is not able to present this testimony today and has asked me to present this to the task force. LINK is a Center for Independent Living that provides independent living services to 22 counties in Northwest Kansas, and also provides Home and Community Based Services (HCBS) primarily throughout the western half of the state.

I would like to thank this committee for your work in exploring the Long Term Care issues. LINK provides waiver services throughout the entire state, but primarily to consumers that struggle with daily challenges in the rural western areas of the state.

LINK has been providing independent living services to consumers in Northwest Kansas since 1979. During the past decade, waiver services such as Home and Community Based Services have allowed many consumers to remain independent and living in the community of their choice. This has allowed many individuals with disabilities the dignity of living in their own homes, spending money in their community on such things as rent, groceries, utilities, and paying taxes. Many times the consumers we work with have at least a part-time job.

LINK provides long term care options to individuals who are eligible for various waivers –Physically Disabled, Frail Elderly, Head Injury, and Developmentally Disabled. Currently we are providing payroll services to 300 individuals on PD, FE, MRDD, and HI waivers. We also provide Independent Living Counseling services to 256 consumers on the PD waiver. CIL's choose to provide IL Counseling services because according to our philosophy, we believe people have the ability and the right to be independent, and many consumers have the ability to move off the system with the right services and training provided, often for a short time. The benefit of CIL's providing this service is that CIL's are required to have a staff of at least 51% people with disabilities. This allows for peer support,

as well as an understanding of the needs of individuals with disabilities living in the community. It is also easier to counsel a consumer about needs versus wants when the counselors themselves have a disability. While we are a Medicaid provider for various services through these waivers, we also are able to provide a number of what we call our "traditional services" to these individuals as well. We currently receive a grant from the Federal government for $211,000 to provide these services in our 22 county service area. We have been able to continue to provide what we have felt to be important and needed services to consumers without an increase in these funds for a number of years. These services can assist with learning skills to become more independent, helping to find information and resources, assisting with finding affordable, accessible housing or assisting in making their current housing accessible to them, to name a few of these services. If the individual has chosen to "self-direct" their care, we can also assist with recruiting, hiring, and managing personal assistants, if they are in need of this assistance.

Two years ago CIL's suggested lowering provider reimbursement rates, trying to relieve budget issues at that time. Now the cuts have been made so deeply that it is difficult to keep staff and continue to provide quality services. We are extremely frustrated with the provider reimbursement rate that the Department on Aging made on only the self-directed rates. This seems aimed to discourage individuals from being self-directed, and making their own choices and therefore being more independent. As a Medicaid provider for payroll services, we are required to cover the Personal Assistants with workers compensation, unemployment insurance, as well as paying payroll taxes.

The budget cuts are affecting our consumers in many ways – the lowering of the Protected Income Level is making some consumers choose between paying bills, buying food or receiving services. The consumers who lost services are struggling with trying to find ways to achieve daily living tasks. Personal assistants have been laid off due to consumers losing services. Daily, we hear from consumers who are struggling trying to get by while sitting on frozen waiting lists. Acute care needs are increasing, as we hear of many individuals needing more hospitalization due to medical needs increasing.

How this affects us as a provider is multifaceted: the reduction in reimbursement rates means a loss in the funding we had available to assist

consumers struggling with daily living tasks, assisting them in finding possible informal supports and we are struggling to not lay off our current staff. We have cut back our travel as much as possible, however in a rural area, that effectively cuts back on services. We also have extra costs as an agency since we employ a majority of people with disabilities, including higher costs for health insurance and for workers compensation.

As a provider in rural Western Kansas, we foresee the need for community based services to continue to grow. The growth in community based services can be contributed to several factors, #1 people would rather live in a setting of their choice versus an institution, #2 our population continues to age and medical technology allows people to live longer and more independently, #3 people have more dignity and self-worth being independent and #4 it is more cost effective to provide services in a community based setting rather than an institution.

Thank you for the opportunity to present to you today. I would be happy to stand for questions.

P.A.C.E. - Program of All-inclusive Care for the Elderly

Testimony to The President's Task Force on Medicaid Reform

February 24th, 2003

By Mark Bailey, CEO

Via Christi HOPE

The senior population of Kansas is getting older and health care providers are being asked how we are going to take care of them. We all are aware of the Kansas budget crunch, and we know that communities and faith based organizations are being asked to fill in the gaps of service. What are we to do and who will pay for it?

Today, in Wichita there is a program that meets the growing needs of seniors without further burdening the state of Kansas's senior care budget. The program is called Via Christi HOPE and it is a national model referred to by the federal government as P.A.C.E.- Program of All-inclusive Care for the Elderly.

Five years ago, the management staff of Via Christi Senior Services, Wichita, Kansas, visited the first PACE site which is located in San Francisco, California. This new model of service was innovative and embraced a philosophy of keeping seniors in their homes, providing an alternative to long term care institutionalization. Upon returning from that initial trip, Via Christi Senior Services knew that this type of program was what the residents of Wichita needed to remain in their homes. First, came the initial discussions with the Kansas Department of Aging, Kansas Department for Social and Rehabilitative Services, the Centers for Medicare & Medicaid Services (CMS) to investigate the feasibility of bring a PACE site to Wichita. Second, there was an extensive commitment of staff time researching the model and developing the site and program to meet CMS requirements. Additionally, during the feasibility and development stage, Via Christi Senior Services funded the project at a cost of $1.2 million dollars. With the completion of the PACE site and signing a service agreement with KDOA, SRS, CMS and Via Christi Senior Services, the first PACE site in Kansas opened in September of 2002.

PACE is an innovative national model that enables individuals who are 55 years of age or older to live independently and avoid an institutional placement. If their care needs become medically necessary, PACE is there to assist and coordinate the services for long term care. With today's fragmented health care financing and delivery systems, PACE brings these key components together to serve the unique needs of each individual. PACE is the alternative for seniors who are daily living with chronic care needs. PACE is the answer to an extended family of caregivers trying to decide who will take care of mom or dad this month. PACE helps coordinate health care providers and assists policy makers to determine the most cost efficient way to spend the state's senior care dollars. In a nutshell, PACE provides the "one stop shopping" that seniors have been asking for - one place they can go to get the health care services they need.

PACE is a form of managed care, which means Via Christi HOPE accepts a capitated rate in the form of a monthly "premium." Most PACE participants are dually eligible, having both Medicare and Medicaid benefits, but a person can pay privately for the full services available. It is through an approach of intervention and intervention developed by the interdisciplinary team to manage their care needs and provider contracts that enables PACE to provide this service.

The prospective rate setting methodology used for PACE reimburses the program for services provided while providing savings to the State of Kansas and CMS. As required by federal regulations, the Wichita PACE site was awarded permanent provider statues in the fall of 2002 as a cost-effective means to provide care.

· Existing PACE sites have shown that managing the Medicare capitated rates paid to a PACE site has saved the federal government 5% a year and early research suggests the amount saved could be higher.

· Savings to the State of Kansas from the Medicaid capitated rates is estimated to be a savings of 10% which is include in the rate.

For this capitated payment, PACE assumes the full morbidity risk for each participant in the program. The monthly capitated payment is a fixed amount, regardless of changes in the participant's health status, services needed, emergent care and long term care housing if needed.

PACE, a new model of service delivery, is filling a desperate need among seniors needing care who otherwise are eligible for nursing home placement. Currently the daily range of nursing home care is approximately $90-130 per day plus prescription medications, while the all-inclusive capitated rate received from the state per PACE participant is $2368 per month, a significant savings to the state.

Enrollment at the Sedgwick County PACE site will reach 70 participants by July 1, 2003. In the FY 2004 budget year, an anticipated enrollment of 200 participants is expected. Currently, there are more than 1,000 people in the State of Kansas waiting for services through Home and Community Based Service assistance. PACE can fit this need. Persons living in Sedgwick County on the HCBS waiting list and meet program requirements are candidates for PACE enrollment. With the initial success of the site in Wichita, we are currently exploring the feasibility of developing a second PACE site in FY 2005.

PACE sites are similar to Adult Day Care facilities. Services provided at the Sedgwick County PACE site include: social activities, meals, assistance with activities of daily living, medication administration and transportation. In addition, the site also has a primary care clinic, rehab center and access to specialty services, as well as coordinating home health services delivered to the participants' home.

PACE is the future of senior focused health care delivery in a network of contracted providers. PACE provides the choices needed to keep seniors in their homes, independent in the community and attached to their family, while saving the State of Kansas money.

For more information, contact:

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Testimony presented to President's Task Force on Medicaid Reform
Feb. 24, 2003

Senator Clark, members of the Committee:

I am Tim Pollard, chief financial officer and vice president of Finance for Via Christi Regional Medical Center in Wichita. I'd like to thank you for allowing me to come speak to you today about some of the challenges we face in providing care to the state's Medicaid and uninsured populations.

I'd like to start by providing you a brief overview of the Medical Center and its Wichita network. Via Christi Regional Medical Center is Wichita's only not-for-profit and only locally owned and operated acute-care facility. The Medical Center is comprised of three separate campuses, St. Joseph, St. Francis and Good Shepherd, and collectively staffs 859 beds. It provides a full range of acute care and specialized services, ranging from high-risk OB to neuroscience to skilled nursing to specialized intensive care units for burn, cardiovascular, neonatal, pediatric, neuro-critical and surgical.

Via Christi Regional Medical Center is Wichita's third-largest private employer, employing the equivalent of 4,000 full-time workers making on average $42,000 a year. The workforce is 80 percent female and half of the employees are single parent wage earners.

The Medical Center's primary and secondary service area is Sedgwick and the six surrounding counties, which accounts for approximately 85 percent of all inpatient admissions. The other 15 percent comes from the tertiary service area, which includes all other Kansas counties, the northern tier of Oklahoma, and other states.

Via Christi-St. Francis has for years been known as a regional acute-care hospital and trauma center, housing south-central Kansas' only Burn Center and the region's only heart and kidney transplant program. Via Christi-St. Joseph, which houses one of the state's busiest Emergency Departments, has long served as a community hospital and leader in OB and newborn intensive care services--as well as the area's leading provider of inpatient mental health services. Those services are now offered at the Medical Center's 2-year-old Good Shepherd Campus, Wichita's only inpatient behavioral health facility.

In addition, the Via Christi Rehabilitation Center provides in- and outpatient rehabilitation services at its 60-bed facility. Via Christi Riverside Medical Center, an osteopathic community hospital, adds another 125 acute care and skilled nursing beds. However, for the purposes of my appearance here today, I'd like to focus on the Regional Medical Center, which like other large, urban teaching hospitals, is facing significant challenges.

Nationwide, the aging population and growing consumer demand for services have meant higher volumes. An aging hospital workforce has meant a shortage of skilled replacements entering the

workforce and significantly higher labor costs. Dramatic increases in the costs of pharmaceut and medical/surgical supplies have made it increasingly difficult to hold the line on expenses. Meanwhile, there's been no more than a 1 percent increase in Medicare reimbursements in any given year for the past decade.

These types of difficulties are not new to healthcare. Nor are they new to Via Christi, which continues to be the state's largest provider of charity care, providing $7.9 million in charity care and another $19 million in bad debt in the '02 fiscal year. Via Christi also has continued to maintain and expand crucial equipment, buildings and community-based programs, but doing so is becoming more and more of a struggle. In fiscal year '02, Via Christi Regional Medical Center posted $460 million in revenues and $456 million in expenses. This translates to a total income from operations of $4 million, or a 0.9 percent margin or less than 1 cent per dollar of revenue.

That's too slim a margin to meet what is anticipated to be a $60 - 80 million need each year for the next three to five years to update our facilities and purchase needed equipment. And it's not sufficient to cover the increasing amount of free or subsidized care for the poor and other non-billed community services as detailed in the 2002 Community Partnership report you have in front of you.

The 1 percent margin also doesn't reflect the reductions in Medicaid payments to hospitals that went into effect in Jan. 1, 2003, because of the state budget shortfall. These cuts include the total elimination of the medical education add-on to Medicaid DRGs, a 20 percent reduction for Medicaid outlier payments, and allowing the lower of DRG or charges. Statewide, this would mean a $12.5 million reduction, of which $4.4 million, or 35 percent of the total reduction, coming from Via Christi. The $5.5 million in medical education reductions is primarily from the University of Kansas School of Medicine-Wichita residency programs through Via Christi and Wesley. It should be noted, however, that 60 percent of the Wichita graduates stay in Kansas. As a state hospital, the KU Hospital is funded differently and, as a result, will not see any reductions from the GME cuts. As for the outlier reduction, Via Christi is the hardest hit hospital in the state, with its cut amounting to $1.2 million of the $4.7 million from all hospitals, or 25 percent of the total.

And even before these projected reductions Medicaid paid less than cost for services, especially the most complex cases such as newborn intensive care, burn units and trauma cases. If you'll turn to Chart One, you'll see that 10 percent of the Medical Center's acute-care admissions in FY '02 were Medicaid funded. The state's fiscal year '02 payments to Via Christi Regional Medical Center totaled $24.7 million, which is 21 percent of the $115 million statewide total payments for hospital Medicaid services. The cost of providing those services was $41.9 million, resulting in $13.7 million in unreimbursed expenses. In other words, for every actual dollar expended on providing services to Medicaid patients, the Medical Center received 67 cents in return.

On Chart Two, I've detailed the revenues vs. the actual cost of providing Emergency Department, obstetrical and newborn, and behavioral health services. As you can see, the cost of providing these services exceeds the reimbursement. For every dollar Via Christi expends in treating Medicaid funded patients in the Emergency Department, it receives 69 cents. For every dollar expended in providing OB and Newborn Services to Medicaid-funded patients, it receives 90 cents. For neonates, the sickest of Kansas newborns, it receives 80 cents; with the proposed cuts, it will receive 63 cents. And for every dollar spent on Behavioral Health, it receives $1.03.

While that might make it appear that Via Christi breaks even on Behavioral Health, that is not the case for two reasons. First, the psychiatrist's decision to admit a patient is often overruled by a Mental Health Consortium screener, but the hospital must adhere to the psychiatrist's diagnosis. Second, once a hospital opens its doors to inpatient psychiatric services, it must treat all patients who present. As you can see on Chart Three, the Good Shepherd Campus admits three times as many uninsured than

the hospital's other service lines. Nearly 17 percent of the care provided is not paid for, result a $2 million loss for hospital psychiatric services.

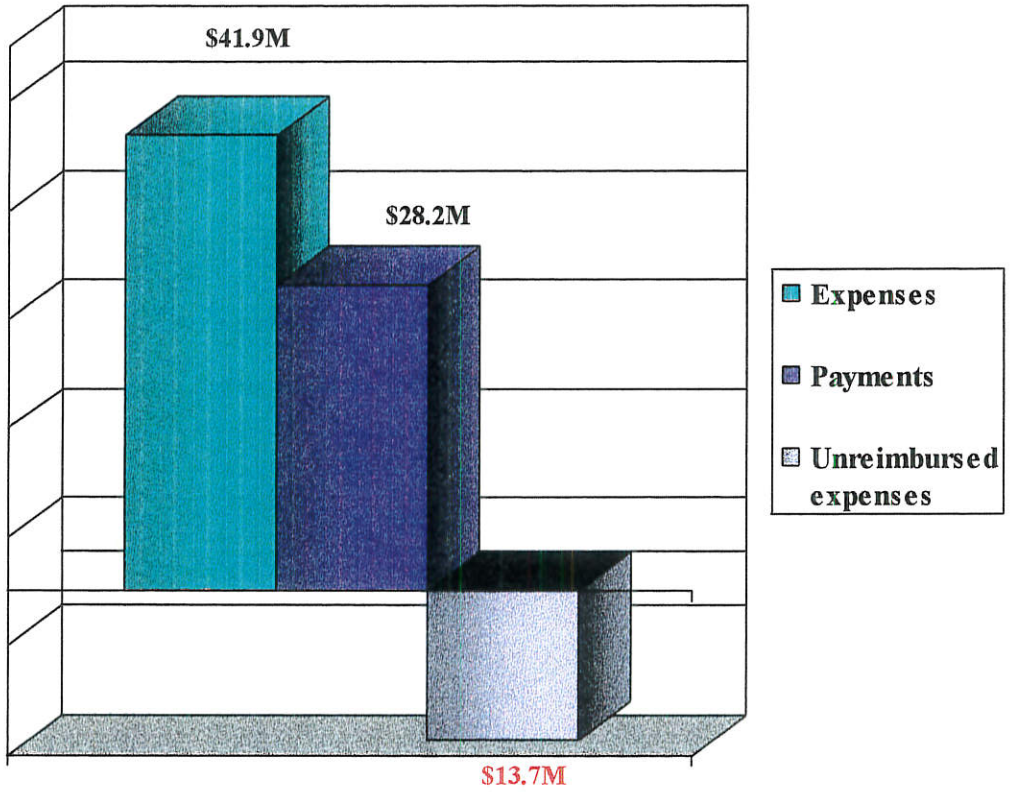
Via Christi's response to these kinds of challenges traditionally has been to find other ways to fund these shortfalls. Indeed, it is the mission of our sponsoring congregations to provide compassionate care to all in need, and in doing so, meet the needs of the community at large. But we also must be good stewards of the community's resources. We're doing all that we can to ensure that the community's needs continue to be met in the future.

In June 2002, Via Christi launched five financial initiatives. We also brought in a group of well-respected national consultants last fall to do a top-to-bottom review of the Medical Center and our other Wichita operations. Based on the group's report in November, we developed a new organizational structure for the Medical Center, one that allows us to build on the strengths of our individual hospital campuses and be more responsive to our customers. Under this new structure, which we're in the process of implementing, nursing and patient-care services are campus-based, while other services, such as Human Resources, Information Management and Finance, continue to be centralized so that we can continue to realize the efficiencies of scale that prompted the merger of the two hospitals. We're benchmarking our costs, patient outcomes and patient satisfaction to those of similar institutions across the country to make sure that we're in step with the best practices of similar hospital operations around the country, and if not, identify the problem and respond accordingly.

We believe these moves will allow us to capitalize on the strengths of each of our campuses and help us better manage our resources and continue to meet the community's needs. Even so, we need your help. Via Christi and Wichita's other acute-care hospital, HCA Wesley Medical Center, are being asked to absorb 61 percent of the projected Medicaid reduction for FY '04. With what we're already facing in FY '03, we simply cannot absorb such cuts and continue to offer the same level of care and breadth of services. Hospitals can no longer turn to the insured market to cover the losses sustained by providing services to the Medicaid and uninsured population. Those of us who provide a significant amount of care to these populations, as both hospitals in Wichita do, must receive equitable Medicaid payments to remain viable businesses.

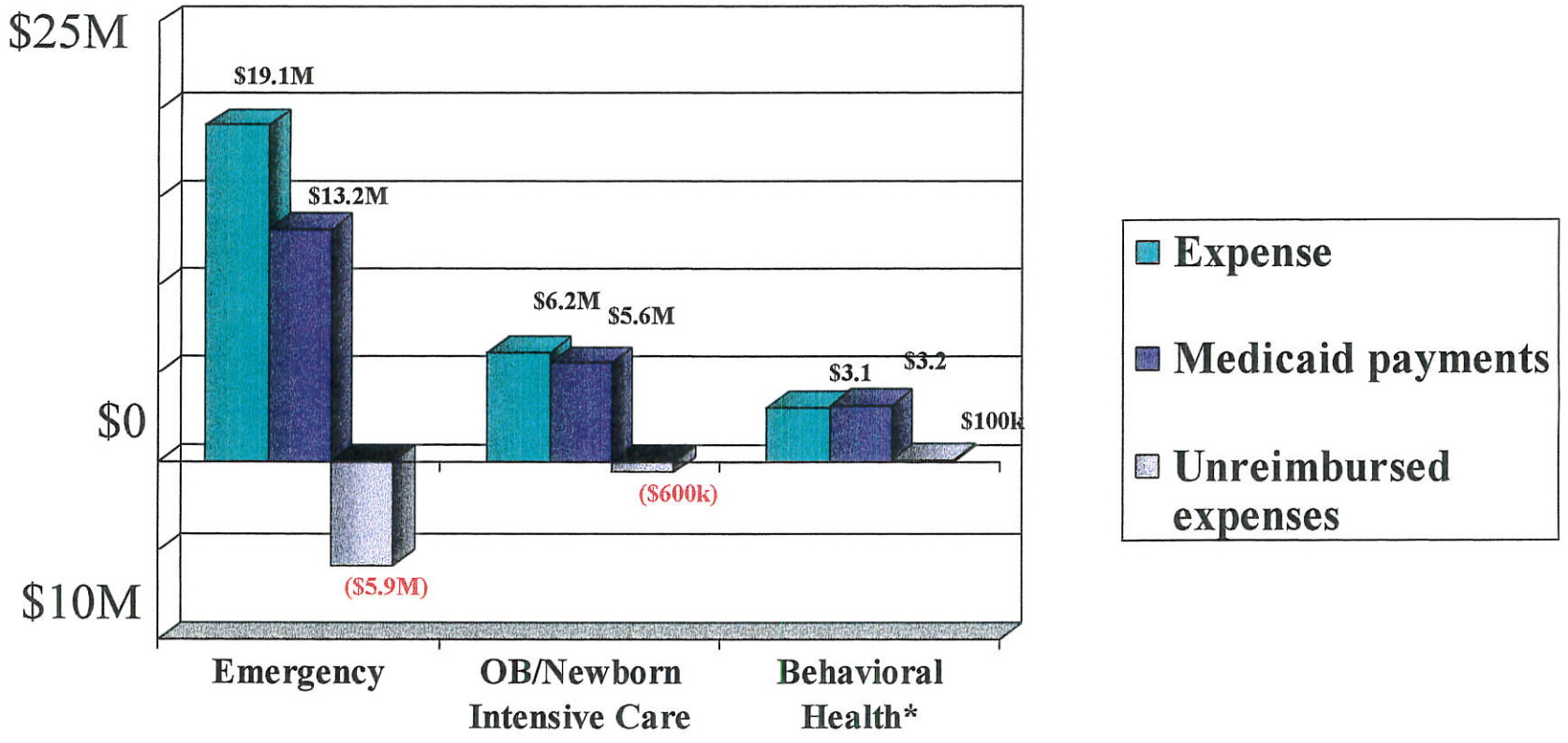
I appreciate your time and attention. I now would be glad to try and answer any questions you may have.

Chart 1
VCRMC FY '02 Acute Care
Total Medicaid Revenue/Expenses



Source: VCRMC financial statements

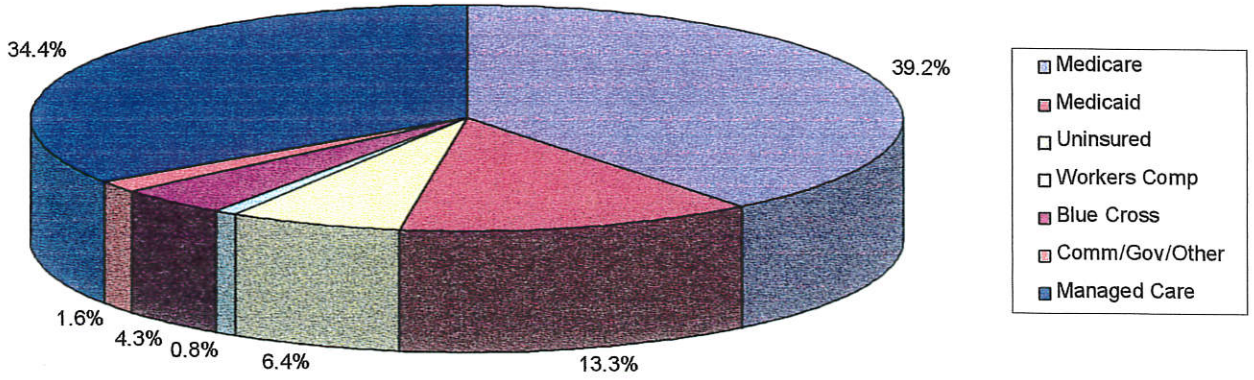
Chart 2
VCRMC FY '02 Acute Care
Medicaid Revenue/Expenses



Source: VCRMC financial statements

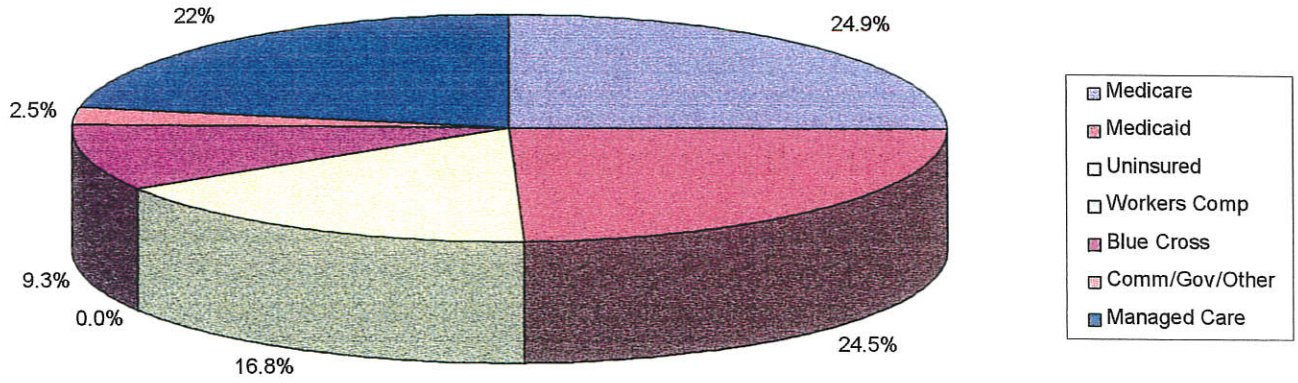
*See Chart 3

Chart 3
VCRMC Inpatient Cases
By Payor
FY '02



Source: VCRMC financial statements

Behavioral Health Inpatient Cases
By Payor
FY '02



Source: VCRMC financial statements

February 24, 2003

Providence Health Testimony
"President's Task Force on Medicaid"
Kansas Legislature

By Sister Ann McGuire, S.C.L., Member, Providence Health Board of Directors

Thank you for the opportunity to speak briefly with you this afternoon about the impact of Medicaid reimbursement from the perspective of Providence Health—Providence Medical Center in Kansas City, Kansas/Wyandotte County and Saint John Hospital in Leavenworth, Kansas.

I am Sister Ann McGuire, a member of the Providence Health Board of Directors. I am a Sister of Charity of Leavenworth, the religious community that is the Sponsor for the Sisters of Charity of Leavenworth Health System of which Providence Health is an Affiliate. I am also the Executive Director of Duchesne Clinic, Kansas City, Kansas, and Saint Vincent Clinic, Leavenworth, Kansas, two primary care clinics serving persons who are uninsured. Duchesne and Saint Vincent are also Affiliates of the Sisters of Charity of Leavenworth Health System.

These various associations make me very aware of the ample opportunities for us to fulfill our Mission. They also heighten my awareness of the monumental challenges related to providing healthcare services for persons who are uninsured and underinsured.

Each of these organizations I've mentioned—the Sisters of Charity, the Health System, Providence Health and the clinics—are deeply steeped in a heritage and a commitment to provide healthcare services for persons who are underserved. St. Francis Health Center and Marian Clinic, located here in Topeka, are also affiliates of the Sisters of Charity of Leavenworth Health System and share this same mission.

In fact, in our ministry, the health system, hospitals and clinics actually share a common Mission Statement. It reads:

> We will, in the Spirit of the Sisters of Charity,
> reveal God's healing love
> by improving the health of the individuals and communities we serve,
> *especially those who are poor and vulnerable.*

As the Providence Health Board of Directors analyzed environmental trends as part of our strategic planning process this year, we recognized that in our markets the number of persons who are uninsured and underinsured continues to increase. This mirrors national trends, but I believe it is magnified in Wyandotte County where socioeconomic challenges abound.

President's Task Force on
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Let me share some of the facts with you:

- Wyandotte County's unemployment rate is 9.6 percent. Leavenworth County has also experienced increased unemployment.
- Wyandotte County's median household income is $7,000 less than the state average of $33,784 (1999 stats).
- Per capita income in Wyandotte County is $16,005 (1999 stats).
- 35.1 percent of Wyandotte County households have an annual income of less than $25,000.
- The expense of health insurance premiums continues to increase.

There's a snowball or domino effect that results from all of this. These factors negatively impact the ability of an individual or a family to maintain health insurance. We have increasing numbers of the "working poor"—persons who are employed but who cannot afford health insurance premiums.

These persons don't seek out preventive care nor are they able to receive ongoing treatment for chronic illnesses. Because they lack health insurance and the financial resources to pay for care, these persons frequently end up in emergency rooms that they use as primary care clinics and often require hospitalizations that might have been avoided with preventive or maintenance care. This in turn leads to increased volumes and costs of uncompensated care at the hospitals.

These factors coupled with declining reimbursements from Medicaid, Medicare and managed care and with increasing costs of labor, supplies and pharmaceuticals, challenge the ability of hospitals to meet operating expenses, to expand and develop new services for the future, and to plan and make capital improvements. In many respects, a combination of these multiple forces has the potential to overwhelm the ability of local hospitals to serve their communities.

In FY 02, 13.71 percent of Providence Medical Center's gross charges resulted from self-pay and Medicaid patients. For the first eight months of the current fiscal year (June 2002-January 2003), self-pay and Medicaid equate to 14.81 percent of gross charges—a 1.11 percent increase. In terms of dollars and cents, for the eight months of this current year, Providence Medical Center's gross charges have been $241.1 million; of that amount, $35.7 million has been self-pay and Medicaid.

When we look at newborn admissions alone, 68.42 percent of Providence Medical Center newborn admissions are self-pay and Medicaid for the current fiscal year compared to 61.08 percent for FY 02--a 7.34 percent increase. Providence has a special collaborative program with the local health department and an obstetrics/gynecology physicians' group to provide prenatal care for low-income women, many of whom we can help qualify for Medicaid.

I have focused on gross charges and Medicaid and self-pay volumes to give you a sense that almost 15 percent of Providence Medical Center's gross charges result from Medicaid and self-pay patients and subsequently result in low reimbursement or no

reimbursement for services provided. When you consider that of the gross charges for Medicaid patients, we receive an average of 23 to 25 cents on the dollar—or in other words, for every dollar's worth of charges, Medicaid reimburses us 23 to 25 cents--you can understand the challenge and the dilemma we face.

Plus, with recent state budget constraints, Providence Health's Medicaid inpatient DRG reimbursements were cut by 10 percent for January and February of this year. The outlier computation for Medicaid patients with lengthy hospitalizations has also been reduced.

Some reimbursement from Medicaid is clearly better than nothing! Providence Health works diligently with patients to help qualify them for Medicaid and transition them from the self-pay to the Medicaid payer category. We have been very actively involved in promoting the registration of children in HealthWave and in Medicaid. We have the program I mentioned earlier to help low-income women access prenatal care. We believe these efforts help the patients and the hospital, and in the long run contribute to a healthier community.

We do many other things directed toward improving or enabling access to care for persons who are undeserved. This Saturday night, our two clinics are hosting Caritas Celebrates, our annual fund-raiser. A week later on March 8, Providence will hold the Founders' Gala. Proceeds from both events go toward providing healthcare for persons unable to afford the services. March 10-16, Providence Health will heighten awareness of employees and the community through the observance of "Cover the Uninsured Week," being promoted nationally by the Robert Wood Johnson Foundation.

Preserving and strengthening Medicaid and developing other innovative programs to enhance access to healthcare are very important and critical parts of this whole picture and process.

We understand that President Bush has proposed expanding flexibility in Medicaid spending to the states to include some additional funding. The ultimate goal is to enable states to get creative in expanding access to healthcare services.

We've seen this work with HealthWave to the extent that we can get children enrolled. In closing, we advocate for

- continuation of the Children's Health Insurance Program;
- lessening the stringent eligibility requirements in Kansas for Medicaid for adults and/or creating a program to encompass some of the working poor with health plan coverage; and
- increasing reimbursement for hospital providers to a more just rate.

Thank you.

Community HomeHealth

100 West 8th Street Onaga, Kansas 66521

(785)889-7200 or 1-800-622-6124

Fax: (785)889-4808

To: President's Task Force on Medicaid Reform
From: Karen Elliott RN, Manager- Community HomeHealth Onaga/St. Marys
Date: February 24, 2003
Re: Medicaid Reform, Provider Issues

- The current prior authorization system is not very effective and is very time consuming for Providers and for the Prior Authorization Unit. It is going to harm the Medicaid population by limiting access to Home Health services. Because of limited approvals from the Prior Authorization Unit Providers, because of limited resources, have begun to refuse patients that are high-level case management, and/or who have multiple disease processes. Other Medicaid clients have been discharged from Home Health Agencies because of the Prior Authorization Unit's refusal to approve the Physician ordered visits.

- E-mailing requests for Medicaid Prior Authorizations would be much quicker and more convenient.

- We need more PRN visits, especially on clients who have a history of needing them.

- We need more visits for clients who are chronically ill. It takes more time than ½ hour every other week (which is the amount of time that is normally approved) to manage a chronically ill patient. They become ill very quickly and most tend to not seek medical care as early as they should.

- Non-HCBS clients do not need Prior Authorization for medically necessary Nursing services unless more than one visit a day is needed. This would also be effective for HCBS clients. Home Health Agencies provide medical care, not HCBS services like Attendant Care and Housekeeping, so there would not be a duplication of services.

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606 First Street	114 East 2nd Street	102 W. 5th Street	100 W. 8th Street	206 Grand
Centralia, KS 66415	Frankfort, KS 66427	Holton, KS 66436	Onaga, KS 66521	St. Marys, KS 66536
1-800-622-6124	1-800-622-6124	1-800-622-6124	1-800-622-6124	1-800-622-6124
Fax: (785)857-3397	Fax: (785)292-4821	Fax: (785)364-3468	Fax: (785)889-4808	Fax: (785)437-3425

Mary Holloway

Thank you for the opportunity to speak with you today as a provider of HCBS services in the state of Kansas.

The Resource Center for Independent Living, Inc works within the perimeters of the program to help people to remain independent.

As an Independent Living Center we work for people to be able to remain participants in the community and remain independent. The HCBS program has been designed as a support of those goals.

It is my understanding that this committee has a goal of identifying a future path of success for HCBS programs and for the services that are needed. I would like to say that that path will need to have more than one option if the budget constrictions of the State and the needs of the consumer are to be assured.

In your efforts to attain your goal, I would encourage you to consider the following:

a. Recognize that in all waivers, there is a need to address developing informal Supports that will assist in helping the consumer.
b. Provide and assure opportunities for the person with a disability to develop their place of value within their own community,
c. Assure that when people utilize the informal supports, they are not penalized.

As an agency, we saw more people willing to go off the waivers when there wasn't a waiting list than in the last few years when there was.

The establishment of long waiting lists has immobilized the persons with disabilities who would and could try trusting their talents and locating and utilizing informal supports. Waiver services become "treasures" that people fear stepping away from. We see consumers moving from self-direction to non-self-direction, not because they can't self direct or won't self-direct, but because there is a feeling that if further cuts will be made they must take this opportunity to demonstrate the possibility of another barrier to their own independence.

We need to work to support and encourage such programs as Ticket To Work and any other community resource. But at the same time, there needs to be the assurance that any loss of that employment or community resource will not leave institutionalization as the only option.

As you reach your decisions, please remember that it will require a team to help us build Home Based Community Services into something that isn't a secret, but has the value that it needs to have within our lives.

Recognize that in some communities the only way that people can obtain the services that they need regularly is currently with payment.

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Recognize and honor the contributions of those that provide the care they do without compensation. Consider ways to make that the treasure that should be kept vs. the HCBS program.

On April 4, 1994, my then, 32 year old brother, John drove his motorcycle at 70 miles per hour, into the passenger door of another vehicle. John had surgery to remove the rearview mirror out of his head where it was imbedded between the helmet and the visor. He had crushed both legs and doctors would see what they could do with that if he survived. He had been sent from his home town to Wichita. My parents had been called, but I have 6 brothers and, I would need to try to reach them. I did. We took shifts so that we could all keep our jobs and own families going. We would be fine. I received a letter dated June 1st that John had used up his insurance, a $2 million dollar cap. We applied for Medicaid for him. On Tuesday and Thursday nights and every other weekend for the entire weekend, I would take my children, a son age 4 years and twin daughters age 6 years old. We would drive the two and ½ hours to stay in his hospital room with him and try to assure his survival. We were a good family, we could cope with this.

I come from a farm family. As the end of June approached and John was still in a coma, Dad age 74 helped out with harvest so mom could help out with John, who still remained in ICU in a coma, in Wichita. By July 4th harvest was almost over and my father suffered a stroke. So with the family busy running to Wichita, we now needed to divide resources again and shift some of the reserve to Dad, who remained in Concordia. We also had lost the support system for the farming operations. For the next several months our entire family unit recalls someone suggesting to each of us, that we were not doing enough for someone.

My father finished rehab and was moving cattle into corrals from the pastures, that means it is late fall by the time John began opening his eyes. By Christmas John was in his own home. On the Head Injury waiver and we had a path for what we hoped would be termed a recovery.

Our family and John were now alone in this recovery process. When John looked at his walker and couldn't recall what it was, so threw it in the ditch and fell several times walking down the road. It was "due to lack of family support". When John was in the shower from when the PCA left on Friday night until Sunday morning because he couldn't remember if he was getting into the shower or getting out. He kept turning the faucets on and off, and "the family needed to do more." John got in his car and wrecked it because he didn't recall that he couldn't drive, John was scolded, belittled and the family as well.

By 1997 John had really learned all he was able or willing to do. He could no longer drive a truck and didn't like volunteering because there wasn't a paycheck involved. He had learned to read again. He does his own bookwork and pays his own bills.

He physically is unable to do many things that are a part of his daily routine. He can't button a shirt; he can't separate his fingers to hold a pencil. He can't speak without holding his tongue on the roof of his mouth, making communication difficult. He can't bend his knees without pain. He can't put on his shoes. To be honest with you, he needs attendant care, sometimes. But in 1997 he had a choice. John could go to work or could stay on Medicaid and use the PD waiver for services. He went to work, knowing that if it didn't work out. He could use the PD waiver until he figured out another way to make it work out. A risk that is not available to him today and to be honest would be a much more frightening decision. John went on and off the PD waiver 4 times that first 18 months.

Today, John will wash dishes at one of three different restaurants in Concordia where he works. He earns less than he did when he was on Social Security and he no longer has a medical card. He will wear baggy pants that he can slide on over his shoes incase no one stops by tonight to visit, because that will mean he won't be able to take his shoes off. He eats one meal per day because additional weight make his legs hurt worse and he is afraid that will make it harder to work. He has not been on any waiver service since fall of 1998.

I am not sure what the future holds for John or for any of us. I do know this. For John and many others like him, success is the ability to find ways to be independent. The waiver helped John and our family build options for finding solutions that would not forever over-extend the family unit or create other crisis points.

I appeal to your creative abilities. Find ways to make HCBS programs a ramp to independence and community participation through such opportunities as the Ticket To Work. Find ways to delete the waiting list that has become the sidewalk to institutions. Find ways that make us all equal participants in our own successful futures. Don't punish consumers by endorsing processes that offer less funding for attendants if the consumer self-directs his or her own care.

You will find when a person with a disability is a partner in the success of the programs that are needed the person with a disability will assure that the program remains successful economically.

Mary Fern Holloway
CEO – Resource Center for Independent Living, Inc
Osage City, Kansas

Testimony to the Medicaid Reform Task Force
02-24-2003

I am Judy Bagby , Director of Nursing Services for Midwest Health services, Inc a Kansas based company that provides services in the long term care setting. I received my BSN from Avila University in 1974 and have maintained my R.N. license in good standing since 1974. I am also a LNHA in the state of Kansas. My work experience has included hospital both urban and rural and also Public Health. In 1982 I did venture in employment to the long- term care arena. I have continued to be employed in this area of nursing since 1982 . Over the years it has continued to be a poorly perceived area to practice my profession. Today there continues to be misinformation on life in the long-term setting. The nursing home of 1982 is not what is present in 2003. Many residents that are being admitted to the nursing home from the hospital are more acutely ill and less than 2 years ago would have remained in the hospital for longer stays. Most of these are receiving Medicare benefits and often are discharged to a more independent setting. This could include returning to their prior spell of illness living arrangement.

When residents are admitted to a facility, other than Medicare-A, they are coming with multiple health needs and declining ADL levels. Families try to keep their loved ones in other living situations and are being admitted when the 24 hour a day resource is no longer available either physically or financially. The resident because of changes not under their control can no longer stay in their current living environment safely. Many of the residents we admit that are not Medicare-A have alteration in cognition and are taking multiple medications.

With the implementation of the MDS, a nationwide standardized assessment tool, a facility on an ongoing basis is assessing and reassessing the resident to maximize the individuals abilities and needs. We provide services to a population with specialized needs. We are always looking for what the individual needs and how or if these needs can be met by the facility. We are doing ongoing education related to restraint usage and appropriate medications for the geriatric population.

Today in our environment you see flexible dining, encouragement to bring furnishings from home and "neighborhood" living assignments. With advances in medicine, early detection of potential health problems and health promotion we are seeing the people living to older ages. Long-term care offers a variety of choices and it is when the needs are the most that we are seeing them in the nursing home setting.

President's Task Force on
Medicaid Reform
February 24, 2003
Attachment 12-1

Numeric Identifier_____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME⊙	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	GENDER⊙	1. Male 2. Female
3.	BIRTHDATE⊙	Month — Day — Year
4.	RACE/⊙ ETHNICITY	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
5.	SOCIAL SECURITY⊙ AND MEDICARE NUMBERS⊙ [C in 1st box if non med. no.]	a. Social Security Number b. Medicare number (or comparable railroad insurance number)
6.	FACILITY PROVIDER NO.⊙	a. State No. b. Federal No.
7.	MEDICAID NO. *["+" if pending, "N" if not a Medicaid recipient]*⊙	
8.	REASONS FOR ASSESS-MENT	[Note—Other codes do not apply to this form] a. Primary reason for assessment 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 10. Significant correction of prior quarterly assessment 0. *NONE OF ABOVE* b. *Codes for assessments required for Medicare PPS or the State* *1. Medicare 5 day assessment* *2. Medicare 30 day assessment* *3. Medicare 60 day assessment* *4. Medicare 90 day assessment* *5. Medicare readmission/return assessment* *6. Other state required assessment* *7. Medicare 14 day assessment* *8. Other Medicare required assessment*

9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form		
I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.		
Signature and Title	Sections	Date
a.		
b.		
c.		
d.		
e.		
f.		
g.		
h.		
i.		
j.		
k.		
l.		

GENERAL INSTRUCTIONS

Complete this information for submission with all full and quarterly assessments (Admission, Annual, Significant Change, State or Medicare required assessments, or Quarterly Reviews, etc.)

12-2

⊙ = Key items for computerized resident tracking

☐ = When box blank, must enter number or letter [a.] = When letter in box, check if condition applies

Resident _____ Numeric Identifier _____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION

SECTION AB. DEMOGRAPHIC INFORMATION

1.	DATE OF ENTRY	*Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date* Month — Day — Year
2.	ADMITTED FROM (AT ENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other
3.	LIVED ALONE (PRIOR TO ENTRY)	0. No 1. Yes 2. In other facility
4.	ZIP CODE OF PRIOR PRIMARY RESIDENCE	
5.	RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY	(*Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above*) Prior stay at this nursing home — a. Stay in other nursing home — b. Other residential facility—board and care home, assisted living, group home — c. MH/psychiatric setting — d. MR/DD setting — e. *NONE OF ABOVE* — f.
6.	LIFETIME OCCUPATION(S) [Put "/" between two occupations]	
7.	EDUCATION (*Highest Level Completed*)	1. No schooling 2. 8th grade/less 3. 9-11 grades 4. High school 5. Technical or trade school 6. Some college 7. Bachelor's degree 8. Graduate degree
8.	LANGUAGE	(*Code for correct response*) a. Primary Language 0. English 1. Spanish 2. French 3. Other b. If other, specify
9.	MENTAL HEALTH HISTORY	Does resident's RECORD indicate any history of mental retardation, mental illness, or developmental disability problem? 0. No 1. Yes
10.	CONDITIONS RELATED TO MR/DD STATUS	(***Check all conditions** that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely*) Not applicable—no MR/DD (Skip to AB11) — a. MR/DD with organic condition Down's syndrome — b. Autism — c. Epilepsy — d. Other organic condition related to MR/DD — e. MR/DD with no organic condition — f.
11.	DATE BACKGROUND INFORMATION COMPLETED	Month — Day — Year

SECTION AC. CUSTOMARY ROUTINE

1.	CUSTOMARY ROUTINE (*In year prior to DATE OF ENTRY to this nursing home, or year last in community if now being admitted from another nursing home*)	(***Check all that apply.** If all information UNKNOWN, check last box only.*)
	CYCLE OF DAILY EVENTS	
	Stays up late at night (e.g., after 9 pm)	a.
	Naps regularly during day (at least 1 hour)	b.
	Goes out 1+ days a week	c.
	Stays busy with hobbies, reading, or fixed daily routine	d.
	Spends most of time alone or watching TV	e.
	Moves independently indoors (with appliances, if used)	f.
	Use of tobacco products at least daily	g.
	NONE OF ABOVE	h.
	EATING PATTERNS	
	Distinct food preferences	i.
	Eats between meals all or most days	j.
	Use of alcoholic beverage(s) at least weekly	k.
	NONE OF ABOVE	l.
	ADL PATTERNS	
	In bedclothes much of day	m.
	Wakens to toilet all or most nights	n.
	Has irregular bowel movement pattern	o.
	Showers for bathing	p.
	Bathing in PM	q.
	NONE OF ABOVE	r.
	INVOLVEMENT PATTERNS	
	Daily contact with relatives/close friends	s.
	Usually attends church, temple, synagogue (etc.)	t.
	Finds strength in faith	u.
	Daily animal companion/presence	v.
	Involved in group activities	w.
	NONE OF ABOVE	x.
	UNKNOWN—Resident/family unable to provide information	y.

SECTION AD. FACE SHEET SIGNATURES

SIGNATURES OF PERSONS COMPLETING FACE SHEET:

a. Signature of RN Assessment Coordinator — Date

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature and Title	Sections	Date
b.		
c.		
d.		
e.		
f.		
g.		

12-3

☐ = When box blank, must enter number or letter [a.] = When letter in box, check if condition applies

Resident _____ Numeric Identifier _____

MINIMUM DATA SET (MDS) — *VERSION 2.0*
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING
FULL ASSESSMENT FORM
(Status in last 7 days, unless other time frame indicated)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1.	RESIDENT NAME	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	ROOM NUMBER	
3.	ASSESSMENT REFERENCE DATE	a. *Last day of MDS observation period* Month — Day — Year b. Original (0) or corrected copy of form (enter number of correction)
4a.	DATE OF REENTRY	Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days) Month — Day — Year
5.	MARITAL STATUS	1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced
6.	MEDICAL RECORD NO.	
7.	CURRENT PAYMENT SOURCES FOR N.H. STAY	(*Billing Office to indicate; **check all that apply in last 30 days***) Medicaid per diem a. Medicare per diem b. Medicare ancillary part A c. Medicare ancillary part B d. CHAMPUS per diem e. VA per diem f. Self or family pays for full per diem g. Medicaid resident liability or Medicare co-payment h. Private insurance per diem (including co-payment) i. Other per diem j.
8.	REASONS FOR ASSESSMENT [*Note—If this is a discharge or reentry assessment, only a limited subset of MDS items need be completed*]	a. Primary reason for assessment 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 6. Discharged—return not anticipated 7. Discharged—return anticipated 8. Discharged prior to completing initial assessment 9. Reentry 10. Significant correction of prior quarterly assessment 0. *NONE OF ABOVE* b. ***Codes for assessments required for Medicare PPS or the State*** *1. Medicare 5 day assessment* *2. Medicare 30 day assessment* *3. Medicare 60 day assessment* *4. Medicare 90 day assessment* *5. Medicare readmission/return assessment* *6. Other state required assessment* *7. Medicare 14 day assessment* *8. Other Medicare required assessment*
9.	RESPONSIBILITY/ LEGAL GUARDIAN	(*Check all that apply*) Legal guardian a. Other legal oversight b. Durable power of attorney/health care c. Durable power attorney/financial d. Family member responsible e. Patient responsible for self f. *NONE OF ABOVE* g.
10.	ADVANCED DIRECTIVES	(*For those items with supporting **documentation** in the medical record, **check all that apply***) Living will a. Do not resuscitate b. Do not hospitalize c. Organ donation d. Autopsy request e. Feeding restrictions f. Medication restrictions g. Other treatment restrictions h. *NONE OF ABOVE* i.

SECTION B. COGNITIVE PATTERNS

1.	COMATOSE	(*Persistent vegetative state/no discernible consciousness*) 0. No 1. Yes (**If yes, skip to Section G**)
2.	MEMORY	(*Recall of what was learned or known*) a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem b. Long-term memory OK—seems/appears to recall long past 0. Memory OK 1. Memory problem
3.	MEMORY/ RECALL ABILITY	(*Check all that resident was **normally able to recall during last 7 days***) Current season a. Location of own room b. Staff names/faces c. That he/she is in a nursing home d. *NONE OF ABOVE* are recalled e.
4.	COGNITIVE SKILLS FOR DAILY DECISION-MAKING	(*Made decisions regarding tasks of daily life*) 0. *INDEPENDENT*—decisions consistent/reasonable 1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only 2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required 3. *SEVERELY IMPAIRED*—never/rarely made decisions
5.	INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS	(*Code for behavior in the **last 7 days.***) [***Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time***]. 0. Behavior not present 1. Behavior present, not of recent onset 2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening) a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked) b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day) c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought) d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out) e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement) f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)
6.	CHANGE IN COGNITIVE STATUS	Resident's cognitive status, skills, or abilities have changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated

SECTION C. COMMUNICATION/HEARING PATTERNS

1.	HEARING	(*With hearing appliance, if used*) 0. *HEARS ADEQUATELY*—normal talk, TV, phone 1. *MINIMAL DIFFICULTY* when not in quiet setting 2. *HEARS IN SPECIAL SITUATIONS ONLY*—speaker has to adjust tonal quality and speak distinctly 3. *HIGHLY IMPAIRED*/absence of useful hearing
2.	COMMUNICATION DEVICES/ TECHNIQUES	(***Check all that apply** during last 7 days*) Hearing aid, present and used a. Hearing aid, present and not used regularly b. Other receptive comm. techniques used (e.g., lip reading) c. *NONE OF ABOVE* d.
3.	MODES OF EXPRESSION	(***Check all used** by resident to make needs known*) Speech a. Writing messages to express or clarify needs b. American sign language or Braille c. Signs/gestures/sounds d. Communication board e. Other f. *NONE OF ABOVE* g.
4.	MAKING SELF UNDERSTOOD	(*Expressing information content—however able*) 0. *UNDERSTOOD* 1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts 2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests 3. *RARELY/NEVER UNDERSTOOD*
5.	SPEECH CLARITY	(*Code for speech in the **last 7 days***) 0. *CLEAR SPEECH*—distinct, intelligible words 1. *UNCLEAR SPEECH*—slurred, mumbled words 2. *NO SPEECH*—absence of spoken words
6.	ABILITY TO UNDERSTAND OTHERS	(*Understanding verbal information content—however able*) 0. *UNDERSTANDS* 1. *USUALLY UNDERSTANDS*—may miss some part/intent of message 2. *SOMETIMES UNDERSTANDS*—responds adequately to simple, direct communication 3. *RARELY/NEVER UNDERSTANDS*
7.	CHANGE IN COMMUNICATION/ HEARING	Resident's ability to express, understand, or hear information has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated

☐ = When box blank, must enter number or letter [a.] = When letter in box, check if condition applies

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SECTION D. VISION PATTERNS

1.	VISION	(*Ability to see in adequate light and with glasses if used*) 0. *ADEQUATE*—sees fine detail, including regular print in newspapers/books 1. *IMPAIRED*—sees large print, but not regular print in newspapers/books 2. *MODERATELY IMPAIRED*—limited vision; not able to see newspaper headlines, but can identify objects 3. *HIGHLY IMPAIRED*—object identification in question, but eyes appear to follow objects 4. *SEVERELY IMPAIRED*—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects	
2.	VISUAL LIMITATIONS/ DIFFICULTIES	Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self)	a.
		Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes	b.
		NONE OF ABOVE	c.
3.	VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes	

SECTION E. MOOD AND BEHAVIOR PATTERNS

1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	(*Code for indicators observed in last 30 days, irrespective of the assumed cause*) 0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to five days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)	
		VERBAL EXPRESSIONS OF DISTRESS	
		a. Resident made negative statements—e.g., "*Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die*"	
		b. Repetitive questions—e.g., "*Where do I go; What do I do?*"	
		c. Repetitive verbalizations—e.g., calling out for help, ("*God help me*")	
		d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received	
		e. Self deprecation—e.g., "*I am nothing; I am of no use to anyone*"	
		f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others	
		g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack	
		h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions	
		i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues	
		SLEEP-CYCLE ISSUES	
		j. Unpleasant mood in morning	
		k. Insomnia/change in usual sleep pattern	
		SAD, APATHETIC, ANXIOUS APPEARANCE	
		l. Sad, pained, worried facial expressions—e.g., furrowed brows	
		m. Crying, tearfulness	
		n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking	
		LOSS OF INTEREST	
		o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends	
		p. Reduced social interaction	
2.	MOOD PERSISTENCE	**One or more indicators** of depressed, sad or anxious mood **were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days** 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered	
3.	CHANGE IN MOOD	Resident's mood status has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	
4.	BEHAVIORAL SYMPTOMS	(A) *Behavioral symptom* ***frequency in last 7 days*** 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 days in last 7 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily (B) *Behavioral symptom alterability in last 7 days* 0. Behavior not present OR behavior was easily altered 1. Behavior was not easily altered	(A) (B)
		a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)	
		b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)	
		c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)	
		d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)	
		e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)	

5.	CHANGE IN BEHAVIORAL SYMPTOMS	Resident's behavior status has changed as compared to **status of 90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	

SECTION F. PSYCHOSOCIAL WELL-BEING

1.	SENSE OF INITIATIVE/ INVOLVEMENT	At ease interacting with others	a.
		At ease doing planned or structured activities	b.
		At ease doing self-initiated activities	c.
		Establishes own goals	d.
		Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services)	e.
		Accepts invitations into most group activities	f.
		NONE OF ABOVE	g.
2.	UNSETTLED RELATIONSHIPS	Covert/open conflict with or repeated criticism of staff	a.
		Unhappy with roommate	b.
		Unhappy with residents other than roommate	c.
		Openly expresses conflict/anger with family/friends	d.
		Absence of personal contact with family/friends	e.
		Recent loss of close family member/friend	f.
		Does not adjust easily to change in routines	g.
		NONE OF ABOVE	h.
3.	PAST ROLES	Strong identification with past roles and life status	a.
		Expresses sadness/anger/empty feeling over lost roles/status	b.
		Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community	c.
		NONE OF ABOVE	d.

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. (A) ADL SELF-PERFORMANCE—(*Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup*)
   - 0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
   - 1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
   - 2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days
   - 3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
     —Weight-bearing support
     — Full staff performance during part (but not all) of last 7 days
   - 4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days
   - 8. *ACTIVITY DID NOT OCCUR* during entire 7 days

(B) ADL SUPPORT PROVIDED—(*Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification*)

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur during entire 7 days

			(A) SELF-PERF	(B) SUPPORT
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c.	WALK IN ROOM	How resident walks between locations in his/her room		
d.	WALK IN CORRIDOR	How resident walks in corridor on unit		
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). **If facility has only one floor,** how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
g.	DRESSING	How resident puts on, fastens, and takes off all items of **street clothing**, including donning/removing prosthesis		
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		

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2.	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) *Code for most dependent in self-performance and support.* (A) BATHING SELF-PERFORMANCE codes appear below 0. Independent—No help provided 1. Supervision—Oversight help only 2. Physical help limited to transfer only 3. Physical help in part of bathing activity 4. Total dependence 8. Activity itself did not occur during entire 7 days *(Bathing support codes are as defined in* ***Item 1, code B above****)*	(A)	(B)

3.	TEST FOR BALANCE (see training manual)	*(Code for ability during test in the* ***last 7 days****)* 0. Maintained position as required in test 1. Unsteady, but able to rebalance self without physical support 2. Partial physical support during test; or stands (sits) but does not follow directions for test 3. Not able to attempt test without physical help		
		a. Balance while standing		
		b. Balance while sitting—position, trunk control		

4.	FUNCTIONAL LIMITATION IN RANGE OF MOTION (see training manual)	*(Code for limitations during* ***last 7 days*** *that interfered with daily functions or placed resident at risk of injury)* (A) *RANGE OF MOTION* 0. No limitation 1. Limitation on one side 2. Limitation on both sides (B) *VOLUNTARY MOVEMENT* 0. No loss 1. Partial loss 2. Full loss	(A)	(B)
		a. Neck		
		b. Arm—Including shoulder or elbow		
		c. Hand—Including wrist or fingers		
		d. Leg—Including hip or knee		
		e. Foot—Including ankle or toes		
		f. Other limitation or loss		

5.	MODES OF LOCOMOTION	*(Check all that apply during* ***last 7 days****)*			
		Cane/walker/crutch	a.	Wheelchair primary mode of locomotion	d.
		Wheeled self	b.		
		Other person wheeled	c.	*NONE OF ABOVE*	e.

6.	MODES OF TRANSFER	*(Check all that apply during* ***last 7 days****)*			
		Bedfast all or most of time	a.	Lifted mechanically	d.
		Bed rails used for bed mobility or transfer	b.	Transfer aid (e.g., slide board, trapeze, cane, walker, brace)	e.
		Lifted manually	c.	*NONE OF ABOVE*	f.

7.	TASK SEGMENTATION	Some or all of ADL activities were broken into subtasks during **last 7 days** so that resident could perform them 0. No 1. Yes	

8.	ADL FUNCTIONAL REHABILITATION POTENTIAL	Resident believes he/she is capable of increased independence in at least some ADLs	a.
		Direct care staff believe resident is capable of increased independence in at least some ADLs	b.
		Resident able to perform tasks/activity but is very slow	c.
		Difference in ADL Self-Performance or ADL Support, comparing mornings to evenings	d.
		NONE OF ABOVE	e.

9.	CHANGE IN ADL FUNCTION	Resident's ADL self-performance status has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	

SECTION H. CONTINENCE IN LAST 14 DAYS

1. CONTINENCE SELF-CONTROL CATEGORIES
*(**Code for resident's PERFORMANCE OVER ALL SHIFTS**)*

0. *CONTINENT*—Complete control *[includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]*

1. *USUALLY CONTINENT*—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly

2. *OCCASIONALLY INCONTINENT*—BLADDER, 2 or more times a week but not daily; BOWEL, once a week

3. *FREQUENTLY INCONTINENT*—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week

4. *INCONTINENT*—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time

a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed	
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed	

2.	BOWEL ELIMINATION PATTERN	Bowel elimination pattern regular—at least one movement every three days	a.	Diarrhea	c.
				Fecal impaction	d.
		Constipation	b.	*NONE OF ABOVE*	e.

3.	APPLIANCES AND PROGRAMS	Any scheduled toileting plan	a.	Did not use toilet room/ commode/urinal	f.
		Bladder retraining program	b.	Pads/briefs used	g.
		External (condom) catheter	c.	Enemas/irrigation	h.
		Indwelling catheter	d.	Ostomy present	i.
		Intermittent catheter	e.	*NONE OF ABOVE*	j.

4.	CHANGE IN URINARY CONTINENCE	Resident's urinary continence has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	

SECTION I. DISEASE DIAGNOSES

Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

1.	DISEASES	*(If none apply, CHECK the NONE OF ABOVE box)*			
		ENDOCRINE/METABOLIC/ NUTRITIONAL		Hemiplegia/Hemiparesis	v.
				Multiple sclerosis	w.
		Diabetes mellitus	a.	Paraplegia	x.
		Hyperthyroidism	b.	Parkinson's disease	y.
		Hypothyroidism	c.	Quadriplegia	z.
		HEART/CIRCULATION		Seizure disorder	aa.
		Arteriosclerotic heart disease (ASHD)	d.	Transient ischemic attack (TIA)	bb.
				Traumatic brain injury	cc.
		Cardiac dysrhythmias	e.	PSYCHIATRIC/MOOD	
		Congestive heart failure	f.	Anxiety disorder	dd.
		Deep vein thrombosis	g.	Depression	ee.
		Hypertension	h.	Manic depression (bipolar disease)	ff.
		Hypotension	i.		
		Peripheral vascular disease	j.	Schizophrenia	gg.
		Other cardiovascular disease	k.	PULMONARY	
		MUSCULOSKELETAL		Asthma	hh.
		Arthritis	l.	Emphysema/COPD	ii.
		Hip fracture	m.	SENSORY	
		Missing limb (e.g., amputation)	n.	Cataracts	jj.
		Osteoporosis	o.	Diabetic retinopathy	kk.
		Pathological bone fracture	p.	Glaucoma	ll.
		NEUROLOGICAL		Macular degeneration	mm.
		Alzheimer's disease	q.	OTHER	
		Aphasia	r.	Allergies	nn.
		Cerebral palsy	s.	Anemia	oo.
		Cerebrovascular accident (stroke)	t.	Cancer	pp.
				Renal failure	qq.
		Dementia other than Alzheimer's disease	u.	*NONE OF ABOVE*	rr.

2.	INFECTIONS	*(If none apply, CHECK the NONE OF ABOVE box)*			
		Antibiotic resistant infection (e.g., Methicillin resistant staph)	a.	Septicemia	g.
				Sexually transmitted diseases	h.
		Clostridium difficile (c. diff.)	b.	Tuberculosis	i.
		Conjunctivitis	c.	Urinary tract infection **in last 30 days**	j.
		HIV infection	d.	Viral hepatitis	k.
		Pneumonia	e.	Wound infection	l.
		Respiratory infection	f.	NONE OF ABOVE	m.

3.	OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES	a. _____	| | | | . | |
		b. _____	| | | | . | |
		c. _____	| | | | . | |
		d. _____	| | | | . | |
		e. _____	| | | | . | |

SECTION J. HEALTH CONDITIONS

1.	PROBLEM CONDITIONS	*(Check all problems present in* ***last 7 days*** *unless other time frame is indicated)*			
		INDICATORS OF FLUID STATUS		Dizziness/Vertigo	f.
				Edema	g.
		Weight gain or loss of 3 or more pounds within a 7 day period	a.	Fever	h.
				Hallucinations	i.
				Internal bleeding	j.
		Inability to lie flat due to shortness of breath	b.	Recurrent lung aspirations in **last 90 days**	k.
		Dehydrated; output exceeds input	c.	Shortness of breath	l.
				Syncope (fainting)	m.
		Insufficient fluid; did NOT consume all/almost all liquids provided during **last 3 days**	d.	Unsteady gait	n.
				Vomiting	o.
		OTHER		*NONE OF ABOVE*	p.
		Delusions	e.		

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2.	PAIN SYMPTOMS	(*Code the **highest level of pain** present in the **last 7 days***) a. FREQUENCY with which resident complains or shows evidence of pain 0. No pain (***skip to J4***) 1. Pain less than daily 2. Pain daily b. INTENSITY of pain 1. Mild pain 2. Moderate pain 3. Times when pain is horrible or excruciating	
3.	PAIN SITE	(*If pain present, **check all sites** that apply in **last 7 days***) Back pain a. Bone pain b. Chest pain while doing usual activities c. Headache d. Hip pain e. Incisional pain f. Joint pain (other than hip) g. Soft tissue pain (e.g., lesion, muscle) h. Stomach pain i. Other j.	
4.	ACCIDENTS	(*Check all that apply*) Fell in **past 30 days** a. Fell in **past 31-180 days** b. Hip fracture in **last 180 days** c. Other fracture in **last 180 days** d. *NONE OF ABOVE* e.	
5.	STABILITY OF CONDITIONS	Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable—(fluctuating, precarious, or deteriorating) a. Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem b. End-stage disease, 6 or fewer months to live c. *NONE OF ABOVE* d.	

SECTION K. ORAL/NUTRITIONAL STATUS

1.	ORAL PROBLEMS	Chewing problem a. Swallowing problem b. Mouth pain c. *NONE OF ABOVE* d.	
2.	HEIGHT AND WEIGHT	*Record (a.) **height in inches** and (b.) **weight in pounds**. Base weight on most recent measure in **last 30 days**; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes* a. HT (in.) b. WT (lb.)	
3.	WEIGHT CHANGE	a. **Weight loss**—5 % or more in **last 30 days**; or 10 % or more in **last 180 days** 0. No 1. Yes b. **Weight gain**—5 % or more in **last 30 days**; or 10 % or more in **last 180 days** 0. No 1. Yes	
4.	NUTRITIONAL PROBLEMS	Complains about the taste of many foods a. Regular or repetitive complaints of hunger b. Leaves 25% or more of food uneaten at most meals c. *NONE OF ABOVE* d.	
5.	NUTRITIONAL APPROACHES	(*Check all that apply in **last 7 days***) Parenteral/IV a. Feeding tube b. Mechanically altered diet c. Syringe (oral feeding) d. Therapeutic diet e. Dietary supplement between meals f. Plate guard, stabilized built-up utensil, etc. g. On a planned weight change program h. *NONE OF ABOVE* i.	
6.	PARENTERAL OR ENTERAL INTAKE	(*Skip to Section L if neither 5a nor 5b is checked*) a. Code the proportion of **total calories** the resident received through parenteral or tube feedings in the **last 7 days** 0. None 3. 51% to 75% 1. 1% to 25% 4. 76% to 100% 2. 26% to 50% b. Code the average **fluid intake** per day by IV or tube in **last 7 days** 0. None 3. 1001 to 1500 cc/day 1. 1 to 500 cc/day 4. 1501 to 2000 cc/day 2. 501 to 1000 cc/day 5. 2001 or more cc/day	

SECTION L. ORAL/DENTAL STATUS

1.	ORAL STATUS AND DISEASE PREVENTION	Debris (soft, easily movable substances) present in mouth prior to going to bed at night a. Has dentures or removable bridge b. Some/all natural teeth lost—does not have or does not use dentures (or partial plates) c. Broken, loose, or carious teeth d. Inflamed gums (gingiva); swollen or bleeding gums; oral abcesses; ulcers or rashes e. Daily cleaning of teeth/dentures or daily mouth care—by resident or staff f. *NONE OF ABOVE* g.	

SECTION M. SKIN CONDITION

1.	ULCERS (Due to any cause)	(*Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during **last 7 days**. Code 9 = 9 or more.) **[Requires full body exam.]*** a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue. d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	Number at Stage
2.	TYPE OF ULCER	(*For each type of ulcer, **code for the highest stage in the last 7 days** using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4*) a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities	
3.	HISTORY OF RESOLVED ULCERS	Resident had an ulcer that was resolved or cured **in LAST 90 DAYS** 0. No 1. Yes	
4.	OTHER SKIN PROBLEMS OR LESIONS PRESENT	(*Check all that apply during **last 7 days***) Abrasions, bruises a. Burns (second or third degree) b. Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions) c. Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster d. Skin desensitized to pain or pressure e. Skin tears or cuts (other than surgery) f. Surgical wounds g. *NONE OF ABOVE* h.	
5.	SKIN TREATMENTS	(*Check all that apply during **last 7 days***) Pressure relieving device(s) for chair a. Pressure relieving device(s) for bed b. Turning/repositioning program c. Nutrition or hydration intervention to manage skin problems d. Ulcer care e. Surgical wound care f. Application of dressings (with or without topical medications) other than to feet g. Application of ointments/medications (other than to feet) h. Other preventative or protective skin care (other than to feet) i. *NONE OF ABOVE* j.	
6.	FOOT PROBLEMS AND CARE	(*Check all that apply during **last 7 days***) Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems a. Infection of the foot—e.g., cellulitis, purulent drainage b. Open lesions on the foot c. Nails/calluses trimmed during **last 90 days** d. Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) e. Application of dressings (with or without topical medications) f. *NONE OF ABOVE* g.	

SECTION N. ACTIVITY PURSUIT PATTERNS

1.	TIME AWAKE	(*Check appropriate time periods over last 7 days*) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Morning a. Afternoon b. Evening c. *NONE OF ABOVE* d.	
	(If resident is comatose, skip to Section O)		
2.	AVERAGE TIME INVOLVED IN ACTIVITIES	(**When awake and not receiving treatments or ADL care**) 0. Most—more than 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 3. None	
3.	PREFERRED ACTIVITY SETTINGS	(*Check all **settings** in which activities are **preferred***) Own room a. Day/activity room b. Inside NH/off unit c. Outside facility d. *NONE OF ABOVE* e.	
4.	GENERAL ACTIVITY PREFERENCES (adapted to resident's current abilities)	(*Check all PREFERENCES whether or not activity is currently available to resident*) Cards/other games a. Crafts/arts b. Exercise/sports c. Music d. Reading/writing e. Spiritual/religious activities f. Trips/shopping g. Walking/wheeling outdoors h. Watching TV i. Gardening or plants j. Talking or conversing k. Helping others l. *NONE OF ABOVE* m.	

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Resident _____ Numeric Identifier _____

5.	PREFERS CHANGE IN DAILY ROUTINE	*Code for resident preferences in daily routines* 0. No change 1. Slight change 2. Major change	
		a. Type of activities in which resident is currently involved	
		b. Extent of resident involvement in activities	

SECTION O. MEDICATIONS

1.	NUMBER OF MEDICATIONS	(*Record the number of different medications used in the last 7 days; enter "0" if none used*)	
2.	NEW MEDICATIONS	(*Resident currently receiving medications that were initiated during the last 90 days*) 0. No 1. Yes	
3.	INJECTIONS	(*Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used*)	
4.	DAYS RECEIVED THE FOLLOWING MEDICATION	(*Record the number of DAYS during last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly*) a. Antipsychotic; b. Antianxiety; c. Antidepressant; d. Hypnotic; e. Diuretic	

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

1.	SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS	a. SPECIAL CARE—*Check treatments or programs received during the last 14 days*	

TREATMENTS

Chemotherapy	a.	
Dialysis	b.	
IV medication	c.	
Intake/output	d.	
Monitoring acute medical condition	e.	
Ostomy care	f.	
Oxygen therapy	g.	
Radiation	h.	
Suctioning	i.	
Tracheostomy care	j.	
Transfusions	k.	
Ventilator or respirator	l.	

PROGRAMS

Alcohol/drug treatment program	m.	
Alzheimer's/dementia special care unit	n.	
Hospice care	o.	
Pediatric unit	p.	
Respite care	q.	
Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs)	r.	
NONE OF ABOVE	s.	

b. THERAPIES - *Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the last 7 calendar days (Enter 0 if none or less than 15 min. daily)*
[Note—count only post admission therapies]
(A) = # of days administered for 15 minutes or more
(B) = total # of minutes provided in last 7 days

	DAYS (A)	MIN (B)
a. Speech - language pathology and audiology services		
b. Occupational therapy		
c. Physical therapy		
d. Respiratory therapy		
e. Psychological therapy (by any licensed mental health professional)		

2.	INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS	(Check all interventions or strategies used in last 7 days—no matter where received)	
		Special behavior symptom evaluation program	a.
		Evaluation by a licensed mental health specialist in last 90 days	b.
		Group therapy	c.
		Resident-specific deliberate changes in the environment to address mood/behavior patterns—e.g., providing bureau in which to rummage	d.
		Reorientation—e.g., cueing	e.
		NONE OF ABOVE	f.

3.	NURSING REHABILITATION/ RESTORATIVE CARE	*Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the last 7 days (Enter 0 if none or less than 15 min. daily.)*	

a. Range of motion (passive)		f. Walking	
b. Range of motion (active)		g. Dressing or grooming	
c. Splint or brace assistance		h. Eating or swallowing	
TRAINING AND SKILL PRACTICE IN:		i. Amputation/prosthesis care	
d. Bed mobility		j. Communication	
e. Transfer		k. Other	

4.	DEVICES AND RESTRAINTS	(*Use the following codes for last 7 days:*) 0. Not used 1. Used less than daily 2. Used daily	
		Bed rails	
		a. — Full bed rails on all open sides of bed	
		b. — Other types of side rails used (e.g., half rail, one side)	
		c. Trunk restraint	
		d. Limb restraint	
		e. Chair prevents rising	
5.	HOSPITAL STAY(S)	Record number of times resident was admitted to hospital with an overnight stay **in last 90 days** (or since last assessment if less than 90 days) (*Enter 0 if no hospital admissions*)	
6.	EMERGENCY ROOM (ER) VISIT(S)	Record number of times resident visited ER without an overnight stay **in last 90 days** (or since last assessment if less than 90 days). (*Enter 0 if no ER visits*)	
7.	PHYSICIAN VISITS	In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (*Enter 0 if none*)	
8.	PHYSICIAN ORDERS	In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? *Do not include order renewals without change.* (*Enter 0 if none*)	
9.	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the **last 90 days** (or since admission)? 0. No 1. Yes	

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

1.	DISCHARGE POTENTIAL	a. Resident expresses/indicates preference to return to the community 0. No 1. Yes	
		b. Resident has a support person who is positive towards discharge 0. No 1. Yes	
		c. Stay projected to be of a short duration— discharge projected **within 90 days** (do not include expected discharge due to death) 0. No 2. Within 31-90 days 1. Within 30 days 3. Discharge status uncertain	
2.	OVERALL CHANGE IN CARE NEEDS	Resident's overall self sufficiency has changed significantly as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support	

SECTION R. ASSESSMENT INFORMATION

1.	PARTICIPATION IN ASSESSMENT	a. Resident:	0. No	1. Yes	
		b. Family:	0. No	1. Yes	2. No family
		c. Significant other:	0. No	1. Yes	2. None

2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:

a. Signature of RN Assessment Coordinator (sign on above line)

b. Date RN Assessment Coordinator signed as complete ___ Month ___ Day ___ Year

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Resident _____ Numeric Identifier _____

SECTION T. THERAPY SUPPLEMENT FOR MEDICARE PPS

1. SPECIAL TREATMENTS AND PROCEDURES

a. RECREATION THERAPY—*Enter number of days and total minutes of recreation therapy administered* (***for at least 15 minutes a day***) *in the* ***last 7 days*** (*Enter 0 if none*)

(A) = # of days administered for 15 minutes or more
(B) = total # of minutes provided in last 7 days

DAYS (A)	MIN (B)

Skip unless this is a Medicare 5 day or Medicare readmission/return assessment.

b. ORDERED THERAPIES—*Has physician ordered any of following therapies to begin in FIRST 14 days of stay—physical therapy, occupational therapy, or speech pathology service?*
0. No 1. Yes

If not ordered, skip to item 2

c. Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered.

d. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered?

2. WALKING WHEN MOST SELF SUFFICIENT

Complete item 2 if ADL self-performance score for TRANSFER (G.1.b.A) is 0,1,2, or 3 AND at least one of the following are present:

- Resident received physical therapy involving gait training (P.1.b.c)
- Physical therapy was ordered for the resident involving gait training (T.1.b)
- Resident received nursing rehabilitation for walking (P.3.f)
- Physical therapy involving walking has been discontinued within the past 180 days

Skip to item 3 if resident did not walk in last 7 days

(FOR FOLLOWING FIVE ITEMS, BASE CODING ON THE EPISODE WHEN THE RESIDENT WALKED THE FARTHEST WITHOUT SITTING DOWN. INCLUDE WALKING DURING REHABILITATION SESSIONS.)

a. **Furthest distance walked** without sitting down during this episode.

0. 150+ feet
1. 51-149 feet
2. 26-50 feet
3. 10-25 feet
4. Less than 10 feet

b. **Time walked** without sitting down during this episode.

0. 1-2 minutes
1. 3-4 minutes
2. 5-10 minutes
3. 11-15 minutes
4. 16-30 minutes
5. 31+ minutes

c. **Self-Performance in walking** during this episode.

0. *INDEPENDENT*—No help or oversight
1. *SUPERVISION*—Oversight, encouragement or cueing provided
2. *LIMITED ASSISTANCE*—Resident highly involved in walking received physical help in guided maneuvering of limbs or other nonweight bearing assistance
3. *EXTENSIVE ASSISTANCE*—Resident received weight bearing assistance while walking

d. **Walking support provided** associated with this episode (code regardless of resident's self-performance classification).

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist

e. **Parallel bars** used by resident in association with this episode.

0. No 1. Yes

3. CASE MIX GROUP

Medicare _____ State _____

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Numeric Identifier _____

SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY

Resident's Name:	Medical Record No.:

1. Check if RAP is triggered.
2. For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status.
   - Describe:
     - — Nature of the condition (may include presence or lack of objective data and subjective complaints).
     - — Complications and risk factors that affect your decision to proceed to care planning.
     - — Factors that must be considered in developing individualized care plan interventions.
     - — Need for referrals/further evaluation by appropriate health professionals.
   - Documentation should support your decision-making regarding whether to proceed with a care plan for a triggered RAP and the type(s) of care plan interventions that are appropriate for a particular resident.
   - Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, etc.).
3. Indicate under the Location of RAP Assessment Documentation column where information related to the RAP assessment can be found.
4. For each triggered RAP, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and RAPs).

A. RAP PROBLEM AREA	(a) Check if triggered	Location and Date of RAP Assessment Documentation	(b) Care Planning Decision—check if addressed in care plan
1. DELIRIUM	☐		☐
2. COGNITIVE LOSS	☐		☐
3. VISUAL FUNCTION	☐		☐
4. COMMUNICATION	☐		☐
5. ADL FUNCTIONAL/ REHABILITATION POTENTIAL	☐		☐
6. URINARY INCONTINENCE AND INDWELLING CATHETER	☐		☐
7. PSYCHOSOCIAL WELL-BEING	☐		☐
8. MOOD STATE	☐		☐
9. BEHAVIORAL SYMPTOMS	☐		☐
10. ACTIVITIES	☐		☐
11. FALLS	☐		☐
12. NUTRITIONAL STATUS	☐		☐
13. FEEDING TUBES	☐		☐
14. DEHYDRATION/FLUID MAINTENANCE	☐		☐
15. DENTAL CARE	☐		☐
16. PRESSURE ULCERS	☐		☐
17. PSYCHOTROPIC DRUG USE	☐		☐
18. PHYSICAL RESTRAINTS	☐		☐

B. _____
1. Signature of RN Coordinator for RAP Assessment Process

2. ☐☐ – ☐☐ – ☐☐☐☐ Month – Day – Year

_____
3. Signature of Person Completing Care Planning Decision

4. ☐☐ – ☐☐ – ☐☐☐☐ Month – Day – Year

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Randy Class, President
Michael J. Hammond, Interim Executive Director

Testimony to Medicaid Reform Task Force

February 24, 2003

Mr. Chairman and members of the Task Force, my name is David Johnson and I am the CEO of Bert Nash Community Mental Health Center in Lawrence. I appear before you today not only in my role at Bert Nash, but also as the Public Policy Committee Chair of the Association of Community Mental Health Centers of Kansas, Inc.

The Association represents 29 licensed Community Mental Health Centers (CMHCs) - providing mental health services in every county in over 100 locations. Each CMHC has a defined and discrete geographical service area. With a collective staff of over 4,000 professionals, the CMHCs provide services to Kansans of all ages with a diverse range of presenting problems. Together, this system forms an integral part of the total mental health system in Kansas.

Medicaid funding is a critical resource and cornerstone for the public mental health system in Kansas. Medicaid is now the largest payer of mental health services, representing 54% of our total funding from public sources. Virtually all Medicaid mental health services provided by a CMHC are optional services yet essential to the individuals we serve in providing the necessary support to enable them to remain in the community as productive citizens. It is these services which prevent greater reliance on more costly inpatient care and crisis services.

General Information about Mental Illness

About 5-7 percent of adults in a given year, have a serious mental illness, according to several nationally recognized studies. Serious mental illness is a term used in federal regulations for any diagnosable mental disorder that affects work, home, or other areas of social functioning. A similar percentage of children, about 5-9 percent, have a serious emotional disturbance. This term also comes from federal regulations, and it refers to any diagnosable mental disorder in a

child under age 18 that severely disrupts social, academic and emotional functioning. What this translates into is millions of adults and children across our nation disabled by mental illness. These disorders range from the relatively mild to the totally debilitating, may be transient or last for a lifetime, and may develop unnoticed for years or strike suddenly. Certain disorders are, of course, more serious than others, requiring longer or more intensive forms of care. The disability toll can be quantified in a way that cannot be ignored: when compared with all other diseases (such as cancer and heart disease), mental illness ranks first in terms of causing disability in the U.S., Canada and Western Europe, according to the World Health Organization. In the U.S., the economy's loss of productivity from mental illness amounts to $63 billion annually, according to the U.S. Department of Health and Human Services.

Community-Based Mental Health Services

Prior to the 1950s, individuals with severe mental illness were the primary recipients of mental health care which was provided in large state hospital settings. In the past 30 years, however, mental health care has expanded in communities making help more widely available outside the state hospital setting, both for individuals with serious disorders and for those suffering from milder mental health problems.

As part of licensing regulations, CMHCs are required to provide services to all Kansans needing it, regardless of their ability to pay. This often makes us the "safety net" for Kansans with mental health needs – target and non-target populations. The target population consists of adults who have a severe and persistent mental illness (SPMI) and children/adolescents who have a serious emotional disturbance (SED). The non-target population is basically everyone else who walks through the door of a CMHC. It is the target populations who are, for the most part, Medicaid eligible.

The CMHC system is one that is not self-contained, but rather one that crosses boundaries. For example, the correctional system is one that if you haven't broken the law, you don't get in their system. For community mental health, there aren't any boundaries. We integrate with systems such as education, juvenile justice, developmental disabilities, corrections, aging, child welfare, and the list goes on and on.

As the local Mental Health Authorities for community-based mental health services in Kansas, CMHCs provide the primary linkages between and among service agencies and transition from child to adult services.

<u>Meeting the Mental Health Needs of Kansans</u>

During the period from 1970 to 1997, the state hospital average daily census declined by more than 80 percent. Many of these former hospital patients now rely on CMHCs for mental health services to maintain their ability to live in their own community.

The number of severe and persistent mentally ill (SPMI) adults served by CMHCs has grown from 7,775 in FY92, to just under 13,000 in FY02. The same trend has occurred for

children/adolescents with a serious emotional disturbance (SED), having served 6,034 in FY92, compared to just under 13,000 in FY02. In FY02, CMHCs also served over 46,000 adults and over 16,000 children/adolescents who were not a part of the target populations.

The CMHCs have played a critical role in accomplishing significant bed reductions in state hospitals, declining from 1,003 in FY90 to 376 in FY02.

In FY90, the average length of stay (ALOS) for children/adolescents was 220 days, compared to 43 days at Rainbow Mental Health Facility (RMHF) and 91 days at Larned State Hospital (LSH) in FY02. For adults, the ALOS was 108 days in FY90, compared to 27 days at RMHF, 69 days at Osawatomie State Hospital (OSH), and 43 days at LSH for FY02.

Services to Adults with Severe and Persistent Mental Illness (SPMI)

Community Support Services (CSS) refers to the array of community based services that are provided to the adult targeted population, which consists of individuals who suffer with a severe and persistent mental illness (SPMI). A SPMI refers to a biological brain disorder, such as schizophrenia, that impairs an individual's ability to function throughout their life. However, individuals with severe mental illnesses that were once considered to be marked by lifelong deterioration are now energized by the message of hope and recovery offered by CSS programs.

The guiding philosophy of CSS programs are embodied in the work with consumers in promoting recovery and achieving their self-defined goals. The CSS model emphasizes using an individual's strengths, desires and aspirations to support and teach the skills individuals needs to be successful in the living, learning, working and social environments they choose. Community Support Service programs across the state provide a broad spectrum of services and activities to support some of the most at risk and vulnerable citizens of Kansas that suffer with a SPMI. These programs are built upon a case management model that promotes recovery and focuses on assisting consumers to live successfully in the community. Every individual served through a CSS program have access to case management services as well as psychosocial services, vocational services, attendant care services and medication management, if they desire it. All of these services facilitate the treatment process through direct interactions that assist consumers in understanding their symptoms and teach community living skills. Beyond focusing on symptoms management, recovery casts a much wider spotlight on quality of life, restoration of self-esteem and on attaining meaningful roles in society.

Kansas is a leader in the area of community mental health for the adult target population. Across the state model programs are being developed utilizing best practices in areas such as Supported Employment, Supported Education, Dual Recovery and Supported Housing. The successes of these programs are not only found in the improved quality of life but in the performance outcomes that are produced statewide.

Services to Children/Adolescents with Serious Emotional Disturbance (SED)

Community Based Services (CBS) programs serve children and youth who have been identified as having a SED and have demonstrated a need for interventions other than traditional outpatient mental health care. A fundamental goal of CBS is to help at risk children and youth remain in their home, school, and community. To help achieve this goal, children and their families may receive an array of individualized services and support. Strength based, family focused and family driven, culturally competent, and community-based are the core values that drive CBS programs. The core service of CBS is Case Management. Among other critical services includes Targeted Case Management, Community Psychiatric Support Treatment, Attendant Care, Wraparound, Home Based Family Therapy and Psychosocial Groups.

Medicaid and Optional Services

When Medicaid was enacted, its design was unfriendly to mental health care. It provided no specialty mental health benefits and no coverage for inpatient care in psychiatric facilities for persons age 21 to 64. Based on the U.S. General Accounting Office's 1977 criticism of federal inaction to support deinstitutionalization, and recommendations of the President's Commission on Mental Health headed by then First Lady Rosalynn Carter, optional specialty mental health benefits were added to Medicaid in the early 1980s. Today, Medicaid pays for a broad array of treatments for mental illness most of which are optional services.

It is impossible to compare one type of mental health service with another and say that one is more important than the other. Medications, counseling therapy, case management, attendant care, psychosocial groups, etc., are a package of services used in combination with each other to meet the needs of individual clients. If one of these services is removed, treatment either does not work or is severely compromised. These services are the most important because, in the absence of an extensive state hospital-based system of care, these particular children and adults are at the highest risk of emergency-related out of home placement, often involuntary and very disruptive, costly, and often not productive of the most desirable outcomes.

According to the Kansas Medicaid program, among the top ten medications paid for by Medicaid are three drugs for the treatment of mental illness. Psychotropic drugs have offered dramatic improvements in the capacity to treat a number of major disorders safely and effectively. In particular, new generations of antidepressants and anti-psychotic drugs have improved side-effect profiles and offer greater safety and ease of administration. Greater adherence to treatment regimens is the result.

We know from research that while these newer medications – antipsychotic drugs, may cost more than older treatments, they result in significant savings as patients require less acute treatment, fewer hospitalizations and show signs of recovery from the devastating symptoms of chronic and severe mental illness. One study found the use of such drugs resulted in 65% reduction in inpatient costs; 55% reduction in emergency room costs; 23% increase in outpatient care; and an overall mean costs savings of $170 per patient per month.

Ten Year Study of Medicaid by Kaiser Family Foundation

Over the past decade, the Kaiser Commission on Medicaid and the Uninsured has studies the Medicaid program and among their key findings include:

- ✓ Coverage matters for low-income populations, and Medicaid matters for coverage of these populations. The uninsured get less and later care than the insured get and have poorer health outcomes as a result.
- ✓ Medicaid helps provide improved access, comparable to private insurance, for many low-income people.
- ✓ When severed from its welfare ties, Medicaid is an effective vehicle for providing health coverage to low-income people.
- ✓ Medicaid provides coverage to the sickest and most disadvantaged in our society, at a good value. Medicaid is not an extravagant program. Its costs are high because medical care for the sickest and frailest in our society is expansive.
- ✓ Although Medicaid is a public program, it purchases private-sector health care services and is thus also a victim of rising health care costs.
- ✓ Because it is broader in scope than private insurance and is an open-ended matching program, states are able to draw down federal funds to fill in gaps in support for safety-net programs.
- ✓ Because Medicaid represents a large share of most state budgets, it is a target for cuts when the economy is poor. Yet cutting Medicaid spending can be penny-wise and pound-foolish for a state. Because of the federal matching payments, saving a dollar of state money can mean losing one to three dollars in federal federal matching funds.
- ✓ Most notably, Medicaid provides coverage for mental health and substance abuse services that fall outside the scope of private coverage.

Unintended Implications of Potential Policy Decisions

As a state reduces spending on Medicaid, more citizens will be left uninsured. A significant number of these people will go without needed care – with long-term consequences to their health and to their ability to contribute productively to the state's economy.

Research shows that, as low-income, uninsured individuals and families balance competing financial needs, they may delay seeking care until their condition grows more serious – even though it may then be more expensive to treat.

When low-income, uninsured people must find health care, they go to local public hospitals, local health departments, state and county health clinics, and other programs and services financed by the state when they are available. Thus, as states reduce the number of people served by the Medicaid program, the funding demands for other public programs go up and must be met by the state and local communities.

At a time when states across the country are facing severe budget crises, President Bush's plan to reform Medicaid is concerning to us. Because block grant funds would be capped, state funding would not be driven by the medical needs of the covered populations. We believe it would weaken the critical safety net program and force states and localities to abandon low-income people with mental illness whose very lives often depend on this program. A better alternative would be to increase federal funding for Medicaid through an increase in the Federal Medical Assistance Percentages.

State Medicaid programs are an important safety net for vulnerable children and families, senior citizens and people with disabilities. Medicaid provides millions of low-income people with critical mental health services that range from inpatient hospital care, to psychologist services, psychosocial rehabilitation and prescription drug coverage. Many of the services and benefits that Medicaid covers permit individuals to remain in their homes and communities and avoid the high costs of institutionalization.

Mr. Chairman, I appreciate the opportunity to share with you and members of this Task Force, information about CMHCs and the critical services we provide to some of the most vulnerable Kansans. I would be happy to entertain any questions at this time.

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TERRI ROBERTS J.D., R.N.
EXECUTIVE DIRECTOR

TO: Presidents Medicaid Task Force

FROM: Terri Roberts J.D., R.N.

DATE: February 24, 2003

SUBJ: Provider Input on Medicaid

Registered nurses (RN's) as the largest group of licensed health professionals in the state are impacted by Medicaid in many ways. As caregivers, RN's in many settings (school nursing, health departments, home health and indigent clinics) observe first hand the important safety-net that Medicaid provides to individuals who have no other source of health insurance. Unfortunately in today's economy, what we would have said to you two years ago compared to what we will be saying to you today are very different. It is no secret that reimbursement levels for services to Medicaid beneficiaries are very low and are a detriment to some categories of health professionals accepting/seeing Medicaid clients. Not now, but in time the disparity of reimbursement for medical services in hospitals, clinics, health departments and other areas must be addressed. This has an impact on the many staff nurses at the bedside in the state, as RN's wages and benefits packages are determined by profit/loss and income generation by hospitals, where 60% of RN's are employed.

In a lot of communities, Advanced Registered Nurse Practitioners (ARNP's) in indigent clinics, local health departments, mental health centers, and in physician offices are often responsible for the care of the Medicaid beneficiaries. The reimbursement received for the delivery of services by an ARNP as opposed to a physician is 85% of what the physician would be paid. For obstetrical services ARNP-Certified Nurse Midwives receive less than 85%, and that is not enough to compensate for services rendered for this special population, than in many cases have additional barriers to optimum health especially during pregnancy.

Medicaid is an essential safety-net for some of our most vulnerable Kansans. Being part of the provider community, this is a fact we must acknowledge. In January, Families USA released a report entitled "Medicaid: Good Medicine for State Economies". Using some fairly sophisticated data analysis and economic models, this report presents a case for maintaining Medicaid expenditures by states as a mechanism to avoid further erosion of healthcare services to vulnerable populations and the impact the federal draw down has on bringing revenue into a state, as well as the overall economic impact. It is well written and an easy read. While it is biased to preserving Medicaid expenditures at the state level, it does present arguments and data that otherwise not be considered by policy makers.

President's Task Force on
Medicaid Reform
February 24, 2003
Attachment 14-1

Thank you.

Medicaid:

Good Medicine For State Economies

A REPORT BY

Families USA

January 2003

14-2

INTRODUCTION

Nationally, Medicaid helped pay for essential health care services for an estimated 47 million people in 2002. However, as state policy makers struggle to balance strained budgets during the current economic downturn, Medicaid has become a prime target for spending cuts. In 2002, 45 states took actions to limit their Medicaid spending. In 2003, the budget crisis in the states will be more severe as state revenue growth continues to decline.

Medicaid is a target for spending cuts because it is the second largest item in most states' budgets, after elementary and secondary education. Indeed, the Medicaid program reaches people of all ages and from all economic classes. For low-income children and their parents, Medicaid pays for essential primary and preventive health care services that these families otherwise could not afford. For elderly and disabled people, Medicaid fills gaps in Medicare coverage by helping Medicare beneficiaries with their prescription drug costs as well as other essential services, such as hearing aids and dental care. Medicaid also is the nation's largest payer of nursing home care, and each year, Medicaid helps millions of families with the cost of home-based long-term care services. Clearly, any reduction in state Medicaid spending will jeopardize coverage for people who depend on these health care services.

Less understood is the unique role that Medicaid plays in stimulating state business activity and state economies. Every dollar a state spends on Medicaid pulls new federal dollars into the state—dollars that would not otherwise flow into the state. These new dollars pass from one person to another in successive rounds of spending. For example, health care employees spend part of their salaries on new cars, which adds to the income of employees of the auto dealership, enabling them to spend part of their salaries on washing machines, which enables appliance store employees to spend additional money on groceries, and so on. Economists call this the "multiplier effect." The magnitude of the multiplier varies from state to state, depending on how the dollars will be spent initially and on the economic structure of, and conditions in, the state. Because of the multiplier effect, the aggregate impact of Medicaid spending on a state's economy is much greater than the value of services purchased directly by the Medicaid program.

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To determine the aggregate impact of Medicaid spending on each state's economy, Families USA used the RIMS II input-output economic model created by the U. S. Department of Commerce, Bureau of Economic Analysis. The RIMS II model allowed us to capture the specific economic conditions in each state and then calculate the new economic activity that will be generated by Medicaid spending in the following three areas:

1. Business Activity (the increased output of goods and services);
2. Employment (the number of new jobs created); and
3. Employee Earnings (wage and salary income associated with these new jobs).

We analyzed state Medicaid spending and its economic impact in each state for two different years. First, we looked at the economic impact of actual state Medicaid spending in fiscal year 2001,[1] the most recent year for which expenditure data are available. Second, we provide readers with updated economic impact multipliers that can be used to predict the economic impact of potential state Medicaid spending increases or cuts in fiscal year 2003.

KEY FINDINGS

Spending on Medicaid Has a Significant Impact on a State's Economy

- Business Activity (Output of Goods and Services)
  - In fiscal year 2001, the 50 states spent a combined total of nearly $97.7 billion on Medicaid. This investment in Medicaid generated an almost three-fold return in state economic benefit—$279.3 billion in increased state-level output of goods and services from increased business activity (see Table 1).
  - In fiscal year 2001, the rate of return per dollar invested in Medicaid ranged from $6.34 in Mississippi to $1.95 in Nevada.
  - The 10 states with the highest rate of return for every state dollar spent on Medicaid in fiscal year 2001 were Mississippi ($6.34 in new state business activity per dollar of Medicaid spending), New Mexico ($5.76), Oklahoma ($5.46), Utah ($5.35), West Virginia ($5.25), Montana ($5.14), Arkansas ($5.11), South Carolina ($4.97); Alabama ($4.82), and Kentucky ($4.71).

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- In the remaining 40 states, a state dollar invested in Medicaid generated anywhere from $1.95 to $4.71 in increased state business activity.
  - Of these 40 states, 10 realized a return of at least $3.50 in increased state business activity for every dollar the state invested in Medicaid.
  - Another 10 of these 40 states realized a return of at least $3.00 in increased state business activity for every dollar the state invested in Medicaid.
- In fiscal year 2001, the average value of increased business activity generated from state Medicaid spending was nearly $6 billion per state. The total value of increased business activity generated by state Medicaid spending ranged from $33.9 billion in New York (from $16.1 billion in state Medicaid spending) to $298 million in Wyoming (from $92 million in state Medicaid spending).
- The 10 states with the largest increase in business activity attributed to state Medicaid spending were New York ($33.9 billion in increased state business activity), California ($31.5 billion), Texas ($17.8 billion), Pennsylvania ($14.0 billion), Ohio ($11.5 billion), Florida ($11.1 billion), Illinois ($10.2 billion), Michigan ($8.9 billion), North Carolina ($8.8 billion), and New Jersey ($8.4 billion).
- Even in the two states with the smallest Medicaid budgets, North Dakota and Wyoming, the new business activity attributed to Medicaid spending was valued at $555 million and $298 million, respectively—4.3 times North Dakota's Medicaid investment of $130 million and 3.2 times Wyoming's Medicaid investment of $92 million.

- Jobs and Wages
  - Fiscal year 2001 state Medicaid spending generated almost 3 million jobs with wages in excess of $100 billion in the 50 states (see Table 2). These jobs included Medicaid personnel, other employment in the health care sector, and jobs generated as the Medicaid dollars circulated through *different* sectors of the economy.

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- Jobs
  - The average number of jobs generated by state Medicaid spending was 58,785 per state. The number of jobs generated by state Medicaid spending ranged from 300,352 in New York to 3,949 in Wyoming.
  - The 10 states with the largest number of jobs generated by state Medicaid spending were New York (300,352), California (291,439), Texas (187,901), Pennsylvania (143,110), Florida (132,215), Ohio (132,028), North Carolina (100,353), Michigan (98,754), Illinois (98,435), and Tennessee (81,675).
- Wages
  - The average increase in employee wages attributable to state Medicaid spending was $2 billion per state. The increase in employee wages attributable to state Medicaid spending ranged from $11.7 billion in New York to $114 million in Wyoming.
  - The 10 states with the largest increase in wages attributable to state Medicaid spending were New York ($11.7 billion), California ($11.4 billion), Texas ($6.5 billion), Pennsylvania ($4.9 billion), Florida ($4.3 billion), Ohio ($4.1 billion), Illinois ($3.6 billion), Michigan ($3.3 billion), North Carolina ($3.2 billion), and New Jersey ($2.9 billion).
  - Even in the two states with the smallest Medicaid budgets, North Dakota and Wyoming, Medicaid spending generated significant numbers of jobs and corresponding wages: 7,248 jobs paying $200 million in wages in North Dakota and 3,949 jobs paying $114 million in wages in Wyoming.

The Economic Impact of a Change in State Medicaid Spending in Fiscal Year 2003 Will Be Significant and Predictable

In fiscal year 2003, the economic impact on business activity, jobs, and wages of state Medicaid spending will be comparable, but not identical, to the impact in fiscal year 2001 (see Table 3). The changes in impact from fiscal year 2001 to fiscal year 2003 are due to both changes in the federal-to-state Medicaid matching rates and changes in the economic factors and conditions in play in each state.

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- In fiscal year 2003, every million dollars a state invests in Medicaid will generate, on average, $3.4 million in new state business activity. The rate of return on the one million dollar investment will range from $6.25 million in Mississippi to $1.96 million in Delaware.
- The 10 states that will have the highest rate of return in new state business activity per million dollars of state Medicaid spending in fiscal year 2003 are Mississippi ($6.25 million), New Mexico ($5.72 million), Arkansas ($5.41 million), Utah ($5.27 million), West Virginia ($5.16 million), Oklahoma ($4.98 million), Alabama ($4.93 million), Montana ($4.90 million), Louisiana ($4.87 million), and South Carolina ($4.78 million).
  - Of the remaining 40 states, nine will realize a return of at least $3.50 million in increased state business activity for every million state dollars invested in Medicaid.
  - Another nine of these 40 states will realize a return of at least $3 million in increased state business activity for every million state dollars invested in Medicaid.
- The 10 states that will have the largest number of new jobs generated per one million dollars of state Medicaid spending are Mississippi (72), New Mexico (67), Arkansas (65), Montana (64), Oklahoma (62), Utah (60), West Virginia (57), Idaho (56), Louisiana (55), and Alabama (55).
- The 10 states that will have the largest amount of new wages per one million dollars of state Medicaid spending are Mississippi ($2.28 million), New Mexico ($2.14 million), Arkansas ($1.98 million), Utah ($1.92 million), Alabama ($1.83 million), Montana ($1.83 million), Oklahoma ($1.81 million), Louisiana ($1.77 million), West Virginia ($1.77 million), and Idaho ($1.74 million).

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Table 1

Return on State Investment in Medicaid: Economic Benefits* to State Economy, FY2001

State	State Medicaid Spending (in millions of dollars)	Business Activity Multiplier (Per $1 change in state Medicaid spending)[1]	New Business Activity (in millions of dollars)[2]
Alabama	$ 907	4.82	$ 4,373
Alaska	211	3.57	755
Arizona	938	4.30	4,035
Arkansas	536	5.11	2,738
California	12,366	2.55	31,477
Colorado	1,114	2.30	2,561
Connecticut	1,682	2.11	3,545
Delaware	310	1.97	612
Florida	3,925	2.82	11,084
Georgia	2,147	3.37	7,243
Hawaii	308	2.41	743
Idaho	223	4.51	1,008
Illinois	4,173	2.45	10,223
Indiana	1,606	3.36	5,399
Iowa	656	3.35	2,199
Kansas	714	3.10	2,214
Kentucky	1,014	4.71	4,777
Louisiana	1,286	4.71	6,052
Maine	478	3.73	1,782
Maryland	1,737	2.27	3,939
Massachusetts	3,430	2.21	7,595
Michigan	3,463	2.58	8,948
Minnesota	1,976	2.32	4,582
Mississippi	595	6.34	3,774
Missouri	1,925	3.46	6,655
Montana	142	5.14	730
Nebraska	495	3.08	1,525
Nevada	351	1.95	683
New Hampshire	456	2.03	929
New Jersey	3,653	2.29	8,355
New Mexico	403	5.76	2,320
New York	16,134	2.10	33,880
North Carolina	2,426	3.64	8,842
North Dakota	130	4.29	555
Ohio	3,645	3.15	11,493
Oklahoma	620	5.46	3,385
Oregon	1,148	3.08	3,540
Pennsylvania	5,233	2.67	13,988
Rhode Island	577	2.29	1,320
South Carolina	927	4.97	4,608
South Dakota	143	4.49	640
Tennessee	2,062	3.87	7,986
Texas	4,848	3.67	17,811
Utah	266	5.35	1,423
Vermont	244	3.11	757
Virginia	1,500	2.50	3,754
Washington	2,333	2.14	5,004
West Virginia	412	5.25	2,163
Wisconsin	1,704	2.93	4,986
Wyoming	92	3.25	298
Total	**$ 97,663**		**$ 279,288**

* Value of additional state business activity attributed to state Medicaid spending, measured in dollar value of goods and services produced.

[1] This economic impact multiplier incorporates both the federal matching multiplier and the RIMS II economic output multiplier. It predicts the total change in economic activity, measured in value of goods and services produced, per dollar change in state Medicaid spending.

[2] Total new business activity in this column may not equal the state Medicaid spending multiplied by the economic impact multiplier due to rounding. In addition, totals do not exactly sum due to rounding.

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Table 2

Return on State Investment in Medicaid: New Jobs and Wages Attributed to State Medicaid Spending, FY2001

State	State Medicaid Spending (in millions of dollars)	Total New Jobs Created[1]	Total Wages from New Jobs Created (in millions of dollars)[1]
Alabama	$ 907	51,558	$ 1,621
Alaska	211	7,718	277
Arizona	938	45,611	1,528
Arkansas	536	34,807	1,000
California	12,366	291,439	11,419
Colorado	1,114	28,612	967
Connecticut	1,682	33,422	1,338
Delaware	310	5,491	201
Florida	3,925	132,215	4,268
Georgia	2,147	75,173	2,633
Hawaii	308	7,784	282
Idaho	223	13,332	387
Illinois	4,173	98,435	3,554
Indiana	1,606	62,181	1,944
Iowa	656	28,671	817
Kansas	714	26,392	767
Kentucky	1,014	54,451	1,676
Louisiana	1,286	72,937	2,199
Maine	478	23,193	682
Maryland	1,737	40,341	1,395
Massachusetts	3,430	70,697	2,713
Michigan	3,463	98,754	3,331
Minnesota	1,976	52,654	1,742
Mississippi	595	46,118	1,375
Missouri	1,925	69,144	2,162
Montana	142	10,126	273
Nebraska	495	18,900	556
Nevada	351	6,998	269
New Hampshire	456	9,861	330
New Jersey	3,653	71,226	2,899
New Mexico	403	28,913	866
New York	16,134	300,352	11,746
North Carolina	2,426	100,353	3,206
North Dakota	130	7,248	200
Ohio	3,645	132,028	4,145
Oklahoma	620	44,720	1,228
Oregon	1,148	39,549	1,302
Pennsylvania	5,233	143,110	4,874
Rhode Island	577	14,280	467
South Carolina	927	52,258	1,673
South Dakota	143	8,642	242
Tennessee	2,062	81,675	2,837
Texas	4,848	187,901	6,459
Utah	266	17,130	519
Vermont	244	9,607	283
Virginia	1,500	39,824	1,325
Washington	2,333	52,223	1,865
West Virginia	412	25,298	742
Wisconsin	1,704	61,934	1,928
Wyoming	92	3,949	114
Total	**$ 97,663**	**2,939,236**	**$ 100,627**

[1] Total economic impact on jobs and wages in these columns may not equal the state Medicaid spending multiplied by the relevant multiplier due to rounding. In addition, totals may not sum due to rounding.

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Table 3

Economic Losses* for Each $1 Million Cut in State Medicaid Spending, FY2003

State	Business Activity Lost Per $1 Million Cut in Medicaid Spending[1]	Jobs Lost Per $1 Million Cut in Medicaid Spending	Employee Wages Lost Per $1 Million Cut in Medicaid Spending
Alabama	$ 4,930,000	54.66	$ 1,830,000
Alaska	2,570,000	24.70	940,000
Arizona	4,220,000	44.79	1,600,000
Arkansas	5,410,000	64.64	1,980,000
California	2,380,000	20.75	870,000
Colorado	2,290,000	24.02	860,000
Connecticut	2,110,000	18.66	790,000
Delaware	1,960,000	16.51	640,000
Florida	3,060,000	34.35	1,180,000
Georgia	3,350,000	32.66	1,220,000
Hawaii	2,900,000	28.55	1,100,000
Idaho	4,520,000	56.25	1,740,000
Illinois	2,440,000	22.05	850,000
Indiana	3,340,000	36.19	1,200,000
Iowa	3,460,000	42.35	1,280,000
Kansas	3,130,000	35.10	1,090,000
Kentucky	4,590,000	49.14	1,610,000
Louisiana	4,870,000	55.20	1,770,000
Maine	3,730,000	45.67	1,430,000
Maryland	2,270,000	21.86	800,000
Massachusetts	2,190,000	19.14	780,000
Michigan	2,510,000	25.99	930,000
Minnesota	2,200,000	23.75	840,000
Mississippi	6,250,000	71.78	2,280,000
Missouri	3,430,000	33.52	1,120,000
Montana	4,900,000	63.88	1,830,000
Nebraska	2,960,000	34.49	1,080,000
Nevada	2,070,000	19.96	810,000
New Hampshire	2,030,000	20.25	720,000
New Jersey	2,270,000	18.20	790,000
New Mexico	5,720,000	67.03	2,140,000
New York	2,090,000	17.41	720,000
North Carolina	3,640,000	38.80	1,320,000
North Dakota	3,880,000	47.58	1,400,000
Ohio	3,120,000	33.69	1,130,000
Oklahoma	4,980,000	61.78	1,810,000
Oregon	3,060,000	32.14	1,130,000
Pennsylvania	2,740,000	26.39	960,000
Rhode Island	2,420,000	24.65	860,000
South Carolina	4,780,000	50.95	1,740,000
South Dakota	3,570,000	45.28	1,350,000
Tennessee	3,990,000	38.35	1,420,000
Texas	3,570,000	35.37	1,290,000
Utah	5,270,000	59.67	1,920,000
Vermont	3,090,000	36.80	1,150,000
Virginia	2,280,000	22.73	800,000
Washington	2,080,000	20.36	770,000
West Virginia	5,160,000	56.70	1,770,000
Wisconsin	2,810,000	32.83	1,090,000
Wyoming	2,790,000	34.70	1,060,000
Average of 50 States	**$ 3,387,600**	**36.85**	**$ 1,235,800**

*Losses were calculated by employing economic impact multipliers that incorporate both the federal matching multiplier and the RIMS II economic output multiplier.

[1] "Business Activity Lost" predicts the total change in economic activity, measured in value of goods and services produced, per one million dollar change in state Medicaid spending.

14-10

DISCUSSION

Without question, the potential harm to people who rely on Medicaid should be the foremost consideration for any policy maker who faces tough choices about Medicaid spending. However, the impact on a state's economy is another important consideration. As policy makers consider their spending choices, they should be aware that increases or cuts in state Medicaid spending result in a gain or loss of federal dollars, which will have significant implications for the state's economy.

Medicaid: A State and Federal Partnership

The Medicaid program is a unique federal and state partnership. It gives states great flexibility to design their program and, thus, to control state spending commitments. Every state Medicaid program must cover certain very low-income children, pregnant women, and some elderly and disabled people and must provide them with a defined set of benefits. However, above these minimum requirements, states decide if they want to expand Medicaid to more people and/or to cover more services. At the same time, to entice states to cover more people and services, the federal government "matches" every dollar that a state invests in Medicaid. The matching rate varies from state to state, ranging from $1.00 to $3.28 in federal funds for each state dollar. In 2003, Medicaid spending will total an estimated $280 billion. Of this amount, about $121 billion will be state funds and $159 billion will be federal funds. In fact, Medicaid is the source of 43 percent of the total federal grant dollars given to the states.[2]

In this context of flexibility and federal matching funds, each state's policy makers make their own unique political calculations about who will be covered, what kinds of health care services will be provided, how much to spend, and where to ultimately place Medicaid among competing demands for limited state dollars. This balancing of spending priorities and state budget bottom lines became much more challenging for state policy makers when the national economic downturn began in 2001, and it continues to affect every state.

14-11

Medicaid: A Target for Cuts in Current State Budget Crises

There is no doubt that states are experiencing severe budget crises. With slowing economies and state tax cuts enacted during the 1990s, state tax revenues are falling dramatically (by 10 percent in the second quarter of 2002).[3] Compounding the problem, changes in the federal income tax code have also affected state revenues.[4] Most states are facing their third consecutive year of budget shortfalls. In the current fiscal year, states expect budget deficits to reach a combined $58 billion, with many states facing a budget gap greater than 10 percent of their total budget.[5] Unlike the federal government, all states (except Vermont) are prohibited by law from having budget deficits at the end of their fiscal year. Thus, the choices facing states are to cut spending, raise taxes, or spend reserve funds (if they have not already done so).

The size and rapid growth of state Medicaid budgets makes the program a prime target for budget cuts. In most states, Medicaid is the second-largest item in the state budget after elementary and secondary education and, on average, represents 20 percent of state expenditures.[6] In addition, Medicaid spending is growing faster than the spending on other state programs. Nationally, Medicaid spending grew 10.4 percent between fiscal years 2001 and 2002 and 10.0 percent between fiscal years 2000 and 2001. During this two-year period, state revenues grew about 5 percent.[7]

Forty-five states took action to reduce Medicaid spending growth in fiscal year 2002. At least 41 states report that they will act again this year to reduce their Medicaid spending. States report that they will continue to look for ways to reduce the use and cost of prescription drugs, limit payments to providers, eliminate covered benefits, and cut back eligibility.[8] While some savings might be identified that will not harm beneficiaries (states obtaining discounts on prescription drugs, for example), most cuts will directly harm the people who rely on Medicaid coverage for health care. What is more, Medicaid spending decisions also affect the health of a state's economy.

14-12

Medicaid: Good State Economic Policy

To generate *new* business activity, jobs, and wages in a state economy, money must be received from outside the state. For example, visits by out-of-state tourists or the sale of manufacturing products to customers outside the state bring new spending into the state, contributing to economic growth.

Buying health care services through Medicaid brings new money into the state in the form of federal matching dollars. This injection of new dollars has a positive and measurable impact on state business activity, available jobs, and aggregate state income.

Medicaid spending adds to state economies in both direct and indirect ways. Medicaid payments to hospitals, nursing homes, and other health-related businesses have a direct impact, paying for goods and services and supporting jobs in the state. These dollars trigger successive rounds of earnings and purchases as they continue to circulate through the economy. They create income and jobs for individuals not directly, or even indirectly, associated with health care. For example, health care employees spend part of their salaries on new cars, which adds to the income of employees of auto dealerships, enabling them to spend part of their salaries on washing machines, which enables appliance store employees to spend additional money on groceries, and so on. This ripple effect of spending is called the economic "multiplier effect."

Medicaid spending also provides a uniquely positive, counter-cyclical stimulus to a state's economy during a recession or downturn. State Medicaid spending has a greater economic impact than other state spending. Increases in state government spending on most programs do not have the same multiplier effect as Medicaid spending increases because most state government expenditures simply reallocate spending from one sector of the economy to another. When a state increases its spending on Medicaid, by contrast, new federal matching dollars are brought in to the state's economy.

14-13

Medicaid:
A Health Care Safety Net for Millions of People

- ✓ Medicaid helped to pay for the health care of an estimated 44.6 million people in 2001 and an estimated 47 million in 2002–**one in six Americans**.
- ✓ Medicaid is the most widespread type of health insurance among the poor: More than 40 percent of all people living below the federal poverty level rely on the program.
- ✓ Medicaid provides health coverage to more than one-fifth of the nation's children (16.5 million in 2001) and is the source of health coverage for more than 40 percent of low-income children (in families with incomes below $30,000 for a family of three).
- ✓ Medicaid is the nation's largest single purchaser of maternity care, paying for approximately 35 percent of all births in the nation.
- ✓ Medicaid is an important source of financial help for over seven million Medicare beneficiaries living in poverty–paying their Medicare Part B premiums and the costs of other essential services not provided by Medicare, including prescription drugs.
- ✓ Medicaid provides health insurance coverage to one in five noninstitutionalized, non-elderly people who have specific, chronic disabilities–approximately five million people. Medicaid assists seven out of 10 poor children with chronic disabilities and 41 percent of poor, working-age adults with disabilities.
- ✓ Medicaid is the nation's largest single purchaser of nursing home care, paying for about half of all nursing home care in this country.
- ✓ Although elderly and disabled people comprise one-quarter of Medicaid beneficiaries, because they need more expensive care, they account for two-thirds of total Medicaid spending.

Sources: Robert J. Mills, *Health Insurance Coverage: 2001* (Washington: U. S. Census Bureau, September 2002); The Kaiser Commission on Medicaid and the Uninsured, fact sheets on Medicaid available online at www.kff.org (visited on November 27, 2002).

14-14

The magnitude of Medicaid's unique positive impact varies from state to state based on *both* the size of the state's federal matching rate and the economic conditions in the state. The specific economic conditions in each state are captured by the RIMS II input-output economic model. The RIMS II model is built on Department of Commerce data that show the relationships among nearly 500 industries in the economy. These relationships are adjusted and updated to reflect a state economy's current industrial structure, trading patterns, wage and salary data, and personal income data.

Tables 1 and 2 show the positive impact of actual state Medicaid spending in fiscal year 2001 on each state's economy. These tables show the significant return—in increased business activity, new jobs, and additional wages—gained by states from their investment of dollars in the Medicaid program.

Table 3 presents the most current Medicaid economic impact multipliers available (based on federal fiscal year 2003), which state policy makers can use to calculate the economic impact of state Medicaid spending decisions. These multipliers can be applied to changes in state Medicaid spending to calculate the economic impact in fiscal year 2003. The fiscal year 2003 multipliers in Table 3 also can be used to estimate the economic impact of changes in fiscal years 2004 and 2005 since the federal matching rate and economic conditions in states do not change dramatically over one or two years.

For example, Table 3 can be used to estimate the impact of a hypothetical reduction in Texas state Medicaid spending on the overall Texas economy. In fiscal year 2001, Texas invested a total of approximately $4.85 billion in Medicaid. Taking into account even a very modest inflation factor, it is safe to say that Texas would need to spend *at least* $5 billion in fiscal year 2003 to maintain the same basic Medicaid program. If Texas were to reduce its spending on Medicaid by only 5 percent—a $250 million cut—the losses to the Texas economy can be calculated using Table 3: Texas would lose more than $892.5 million worth of state business activity (250 x $3,570,000), 8,843 jobs (250 x 35.37), and $322.5 million in wages paid to workers in Texas (250 x $1,290,000).

14-15

Many states are considering state Medicaid spending reductions that are greater than the 5 percent in the above hypothetical example. In addition, the impact of other state cuts may be greater per dollar than in Texas. In fact, 18 states have Medicaid spending multiplier effects greater than that in Texas. In other words, in 18 states, every dollar change in state Medicaid spending would have an even greater economic impact per dollar than the impact in Texas.

With Table 3, state policy makers and other policy stakeholders can estimate the economic impact—on business activity, jobs, and wages—of proposed Medicaid spending decisions in any state. Less quantifiable, of course, is the impact on the lives of state residents who rely on Medicaid as their only source of health care.

Medicaid: Health Care at a Discount Price for the States

As a state reduces spending on Medicaid, more state residents will be left uninsured. A significant number of these people will go without needed care—with long-term consequences to their health and to their ability to contribute productively to the state's economy.

Research shows that, as low-income, uninsured individuals and families balance competing financial needs, they may delay seeking care until their condition grows more serious—even though it may then be more expensive to treat. For example, the average cost of hospitalization is $25,000 for a heart attack and $7,300 for a severe asthma attack.

When low-income, uninsured people must find health care, they go to local public hospitals, local health departments, state and county health clinics, school health clinics, and other programs and services financed by the state when they are available. Thus, as states reduce the number of people served by the Medicaid program, the funding demands for other public programs go up and must be met by the state and local communities—*usually without federal financial assistance*.

The bottom line is that states really cannot avoid paying for at least some health care needed by its uninsured residents. By paying for that care through Medicaid, states can, in essence, buy these services at a 50 to 76.6 percent "discount" provided by the federal government through the federal-state matching formula. In any calculation of savings to a state budget from a Medicaid cut, the resulting increase in demands on state- and locally-funded programs must be part of the equation.

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CONCLUSION

Medicaid provides a vital health care safety net in every state. It is a lifeline to health care for children, people with disabilities or chronic illness, and low-income elderly people. Medicaid is the only source of financial help for millions of families struggling to pay for nursing home or other long-term care services for a parent or family member. Every Medicaid spending decision made by state policy makers affects people in very real, and often irrevocable, ways. At the same time, the economic downturn and state budget deficits are forcing state policy makers to confront hard choices about state spending priorities.

As state budget options are weighed and balanced, the equation should include recognition of the economic benefit of using state spending on Medicaid to pull in new federal dollars. These new federal dollars are a powerful stimulus to state economies. The federal dollars that flow into a state to match state Medicaid spending generate new business activity, increase output of goods and services, create new jobs, and increase aggregate state income. In turn, these positive effects increase state revenues, which can then support further state spending.

Thus, Medicaid spending is good medicine—both for the health of state residents and for an ailing state economy.

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ENDNOTES

[1] Data in this report are based on federal fiscal years 2001 and 2003. All references to fiscal year 2001 and 2003 refer to the federal fiscal years that begin on October 1 of the preceding year (October 1, 2000 and October 1, 2002, respectively). State fiscal years vary. Forty-six states begin their fiscal years in July and end them in June. The exceptions are Alabama and Michigan, with October-to-September fiscal years; New York, with an April-to-March fiscal year; and Texas, with a September-to-August fiscal year. Additionally, 20 states operate on a biennial budget cycle.

[2] Vernon Smith, et al., *Medicaid Spending Growth: Results from a 2002 Survey* (Washington: Kaiser Commission on Medicaid and the Uninsured, September 2002).

[3] Ibid. From 1995 to 2001, states cut taxes by $36 billion, with the largest single annual cut—$9.9 billion—occurring in 2000. Corina Eckl and Arturo Perez, *State Budget and Tax Actions 2002: Preliminary Report* (Washington: National Conference of State Legislatures, August 28, 2002).

[4] For example, states may lose more than $14 billion unless they act to de-link their tax code rules that govern business depreciation deductions for new equipment from new federal rules. Business interests who want the advantage of the new rules in both federal and state tax treatment make this a hard fix to make at the state level. Nicholas Johnson, *States Can Avoid Substantial Revenue Loss by Decoupling from New Federal Tax Provision* (Washington: Center on Budget and Policy Priorities, April 30, 2002).

[5] National Association of State Budget Officers, *NASBO Analysis: Medicaid to Stress State Budgets Severely into Fiscal Year 2003* (Washington: NASBO, March 15, 2002).

[6] Ibid.

[7] Ibid and National Association of State Budget Officers, *2001 State Expenditure Report* (Washington: NASBO, Summer, 2002). Both are available online at (www.nsbo.org/Publications/PDFs/nasbo2001exrep.pdf). Medicaid spending is growing rapidly for three main reasons. First and foremost, Medicaid costs are increasing because health care costs are increasing. In fact, private health insurance premiums grew faster than the cost of Medicaid: 12.7 percent in 2002. Like private insurance, Medicaid is affected by rising prescription drug prices, higher hospital and inpatient and outpatient costs, and increased demand for and cost of new medical technologies. Second, Medicaid enrollment is increasing in the current economic downturn as more people become income-eligible for Medicaid. In addition, enrollment is increasing because of some state eligibility expansions enacted in recent years. Third, the increasing cost of and demand for nursing home and other long-term care is an important factor driving up Medicaid spending.

[8] Vernon Smith, et al., op. cit.

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METHODOLOGY

In order to measure and quantify the role of Medicaid in the states' economies, Families USA retained Richard Clinch, Director of Economic Research at the Jacob France Institute of the Merrick School of Business at the University of Baltimore, to conduct an economic input-output analysis of the impact of state-level cuts in the Medicaid program on the economies of the 50 states.

The economic input-output analysis is based on the RIMS II economic input-output model created by the U.S. Department of Commerce, Bureau of Economic Analysis. The RIMS II model is built on Department of Commerce data that show the relationships among nearly 500 industries in the economy. These relationships are adjusted and updated to reflect a state economy's current industrial structure, trading patterns, wage and salary data, and personal income data.

Events or programs have an economic impact by attracting new spending that would otherwise not exist in a state. A new source of spending from outside a state creates a larger impact on a state economy than the amount of new spending alone through what economists call "multiplier effects." An economic multiplier quantifies the total impact on a state economy of successive rounds of spending that occur as the new spending is earned by state businesses and residents who then spend these earnings on purchases from other state firms or residents who in turn make other purchases, creating successive rounds of earnings and purchases. However, these successive rounds of spending do not continue endlessly because, in each round of spending, a portion of purchases is made from outside the state. These multiplier effects are measured by the RIMS II economic model. The RIMS II model allows economists to estimate three economic impacts:

- **Economic output**, or the value of goods and services produced in the state;
- **Employment**, or the number of jobs in the state; and
- **Employee earnings**, or the wage and salary income associated with the affected jobs.

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In fiscal year 2003, the federal match for Medicaid assistance ranged from a low of 50 percent (in twelve states) to a high of 76.6 percent (in Mississippi). This federal spending represents a new source of spending to a state economy because it supports health care expenditures that would otherwise not occur or need to be taken from other sources of spending. The total level of federal Medicaid matching funds flowing into a state is determined by the level of state Medicaid spending. When a state increases or decreases state spending on Medicaid, federal matching dollars are gained or lost.

Because the level of state Medicaid spending determines the level of this federal support, changes in state Medicaid budgets can have a significant impact on the overall level of health care spending and related health care sector employment and earnings. Furthermore, these changes in spending influence the broader economy through the multiplier effects discussed above.

The comparative economic advantage of state Medicaid spending over other state spending options is the substantial size of the federal matching rate for state Medicaid spending. Medicaid has a *net* positive economic impact when compared to state spending on other programs because it pulls a large (or larger) infusion of new federal dollars into the economy from outside the state. The magnitude of this unique net positive impact on a state's economy differs from state to state based on both the size of the state's federal matching rate and the state's economic multipliers (which reflect economic conditions in the state).

This report analyzes state Medicaid spending and its economic impact in each state for two different years:

- The report first looks at the economic impact of actual state Medicaid spending in fiscal year 2001, the most recent year for which expenditure data are available.
- The report then provides policy makers with the relevant economic impact multipliers needed to predict the economic impact of potential state Medicaid spending changes in fiscal year 2003.

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The economic impact of actual state Medicaid spending in fiscal year 2001 and the economic impact multipliers for fiscal year 2003 are based on *federal* fiscal years 2001 and 2003. All references in the report to fiscal year 2001 and 2003 refer to the federal fiscal years that begin on October 1 of the preceding year (October 1, 2000 and October 1, 2002, respectively). State fiscal years vary among states. Forty-six states begin their fiscal years in July and end them in June. The exceptions are Alabama and Michigan, with October-to-September fiscal years; New York, with an April-to-March fiscal year; and Texas, with a September-to-August fiscal year. Additionally, 20 states operate on a biennial budget cycle. The fiscal year 2003 economic impact multipliers present in this report can be applied to changes in state Medicaid spending to calculate the economic impact in any state's 2003 fiscal year, and these multipliers can be used to estimate the economic impact of changes in state fiscal years 2004 and 2005, since the federal matching rate and the economic conditions of the state do not change dramatically over several months or even over a period of one or two years.

Although we also did an analysis of the District of Columbia, the data are not presented in the report. As an economic system or unit, the District of Columbia is more like a city than a state. When new dollars flow into the District of Columbia and generate successive rounds of spending, a relatively high portion of purchases are made from outside of the city limits (in the Maryland and Virginia suburbs). Therefore, comparisons of the economic multipliers in the District of Columbia to state economic multipliers are misleading. Data from the analysis of the District of Columbia are available from Families USA upon request.

Analysis 1:
The Economic Impact of Fiscal Year 2001 State Medicaid Spending

The first analysis measures the economic impact of state Medicaid spending in fiscal year 2001 for the 50 states. Fiscal year 2001 data on actual state and federal Medicaid expenditures, the most recent data available, were obtained from the CMS-64 reports published by the Centers for Medicare and Medicaid

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Services, U.S. Department of Health and Human Services. The economic impact of federal Medicaid expenditures was calculated by multiplying the total federal assistance and administrative expenditures by the appropriate RIMS II multiplier to yield the economic output, employment, and employee compensation impacts. The fiscal year 2001 state spending and economic impact multiplier was derived by dividing the total economic impact—which included both federal matching and economic multiplier effects—by the level of state spending.

Table 1 shows the impact of state Medicaid spending on total state economic output. Table 2 shows the impact of state Medicaid spending on jobs and the wages associated with these jobs.

Analysis 2:
The Fiscal Year 2003 Economic Impact Multipliers for State Medicaid Spending

The first analysis was based on Medicaid spending in fiscal year 2001. In order to analyze the impact of future cuts, when the level of state and federal spending is not yet known, economic impact multipliers for each dollar of state Medicaid spending were developed. These multipliers measure the change in economic activity per dollar cut in state Medicaid spending. The economic impact multiplier was derived in a similar two-step process.

The first step was the development of a federal matching multiplier for the total amount of federal matching funds for each dollar of state funds. Again, this was derived using the basic formula: (1 / [1 – Federal Match Percentage] – 1). The federal match percentage used in this formula for medical assistance payments is the published fiscal year 2003 Federal Medical Assistance Percentage.* The federal match percentage used in the formula for each state's administrative costs was the actual federal match rate from fiscal year 2001 expenditures. This administrative match percentage was used because administrative match rates do not change from year to year, but certain administrative activities have different matching rates. Each state has a unique mix of these different administrative activities. We assumed that

* Source: (http://aspe.hhs.gov/health/fmap.htm).

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the mix of activities will not change substantially from fiscal year 2001 to fiscal year 2003. The final federal matching multiplier is a weighted average of the federal matching multiplier for medical assistance payments and the state-specific administrative matching multiplier. The weighting of medical assistance to administrative expenditures is based on the allocation to each category in fiscal year 2001 for the relevant state.

The second step was the derivation of the economic impact multiplier for state Medicaid expenditures by multiplying the state federal matching multiplier by the relevant economic impact (output, employment, and earnings) from the RIMS II model. The resulting multiplier yields the total economic impact per dollar change in state Medicaid spending. For economic output and earnings impact, the multiplier measures the change in state economic output and earnings per $1 million change in state spending. The state employment multiplier is expressed in terms of jobs per $1 million change in state Medicaid spending.

The Medicaid economic impact multipliers for fiscal year 2003 are presented in Table 3.

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Medicaid: Good Medicine for State Economies

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Senator Stan Clark, Chair
President's Task Force on Medicaid Reform
Committee of the Kansas Legislature

Senator Clark and Committee Members
I am pleased to be able to give testimony regarding the problems with the current Medicaid program as experienced by a Home Health Agency Provider.

I represent the Douglas County Visiting Nurses Association in Lawrence, Kansas. We have been a not-for-profit licensed home health agency for over thirty years, providing services since 1969. In July of 2001 we made our one-millionth visit. VNA provides comprehensive home health services throughout the life span from birth to death. Our Hospice program provides bereavement services for one year following death.

The problems listed below are putting home health agencies under undue financial stress and are placing the medically indigent citizens of Douglas County and the State of Kansas at risk for institutionalization.

PROBLEM

1. **The Prior Authorization process for new patients and every 60-day reauthorization is cumbersome and costly to the Agency.**
   - All skilled visits for "waiver" patients must be Prior Authorized by Medicaid. The PA process takes 5-7 days and requires the agency to make an initial visit to complete the OASIS assessment and fax with other required reports to Medicaid. (Avg. number of pages faxed = 15 per patient. In one instance we had to fax over 30 pages)
   - During the 5-7 days the agency is waiting for PA, visits are made according to the physician's orders on "good faith" that they will be authorized. The average cost to VNA for daily nursing visits for 5-7 days is $480 to $672 per patient. VNA has an average caseload of 30 patients on the HCBS/PD Waiver. **The financial risk to the agency is $14,400 - $20,160 every 60 days.** If visits are ordered twice daily this risk doubles.

   SOLUTION

   Reimburse home health agencies on a "per episode" basis like Medicare does. This puts the responsibility of providing the care within the pre-set fee, on the home health agency.

PROBLEM

2. **The Prior Authorization process for PRN (unscheduled visits) is not practical and is costly to the agency.**
   - After visits are authorized a patient may need an extra visit due to a medication change and agency clinicians are expected to call Medicaid for PA. Clinicians make 10-12 visits a day and spend valuable patient care time being put on "hold" and waiting for the Medicaid staff person to review the case and give approval.

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Clinicians usually make the visit in order to carry-out physicians change of orders. Then they must remember to notify the office to call Medicaid for approval. If the PA in not approved within 5 days of the PRN visit, the Agency is not paid.

- Medicaid authorizes payment for medication set-ups two times a month and only a 30-day supply of medications. When medications run out before the next visit is due, a PRN visit is needed so the patient will have their medications.
- A patient with an indwelling catheter may develop a leak and need a new catheter to be inserted, which requires an extra PRN visit.

SOLUTION

Medicaid could Prior Authorize up to a certain number of PRN visits at the start of care.

PROBLEM

3. **There is a significant increase in VNA administrative time/cost due to codes and authorization numbers required for billing.**
   - The authorization numbers are different for different billing codes. The electronic billing format does not allow for more than one authorization number so bills with more than one must be done manually. **Billing partly electronically and partly manual is an administrative nightmare for both parties.**

SOLUTION

A "per episode" reimbursement system would eliminate the need for these differing authorization numbers.

PROBLEM

4. **If a patient is discharged and then needs to be readmitted, the PA's for both episodes are blended together and the agency does not know which visits are authorized.**
   - In one VNA case there were five different authorizations on the same patient and it took 30 minutes on the telephone to resolve.

SOLUTION

A "per episode" reimbursement system would eliminate the need for PA's.

PROBLEM

5. **Staff turnover at Medicaid results in inconsistent PA's being given, depending** where **the staff person is at in the learning curve.**

SOLUTION

The "per episode" reimbursement system is more clearly defined and provides more consistency for both Medicaid staff and the agency.

I will be happy to answer any questions.

Jan Jenkins, Executive Director February 24, 2003

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Explicit Criteria for Determining Potentially Inappropriate Medication Use by the Elderly

An Update

Mark H. Beers, MD

This study updates and expands explicit criteria defining potentially inappropriate medication use by the elderly. Additional goals were to address whether adverse outcomes were likely to be clinically severe and to incorporate clinical information on diagnoses when available. These criteria are meant to serve epidemiological studies, drug utilization review systems, health care providers, and educational efforts. Consensus from a panel of 6 nationally recognized experts on the appropriate use of medication in the elderly was sought. The expert panel agreed on the validity of 28 criteria describing the potentially inappropriate use of medication by general populations of the elderly as well as 35 criteria defining potentially inappropriate medication use in older persons known to have any of 15 common medical conditions. Updated, expanded, and more generally applicable criteria are now available to help identify inappropriate use of medications in elderly populations. These criteria define medications that should generally be avoided in the ambulatory elderly, doses or frequencies of administrations that should generally not be exceeded, and medications that should be avoided in older persons known to have any of several common conditions.

Arch Intern Med. 1997;157:1531-1536

In 1991, researchers[1] at the University of California, Los Angeles published the first explicit criteria identifying inappropriate medication use in nursing home residents. Thus, the criteria were designed to apply to only the frailest and sickest elderly populations. Those criteria were meant to serve researchers evaluating the quality of prescribing, drug utilization review systems, and educational efforts. They were designed to evaluate medication use in the absence of clinical information on diagnoses because of the relative inaccuracy of such information in nursing home records. The criteria have now been used as the basis for several research studies.[2-6]

At the time they were created, the criteria filled a void in pharmacoepidemiological methods.[6] However, even when they were first published, the authors cautioned that updating and expansion would be needed. The growing need for such criteria has led to their application in ways that they were never intended to be used. For example, although the original criteria were developed for the frailest elderly—those residing in nursing homes—they have been used to evaluate prescribing in noninstitutionalized elderly populations.[4-6] Additionally, the original criteria have been modified by most who have used them. Some have selected a subset of the criteria that they believed identified the most serious prescribing problems, since the criteria did not rate the potential severity of outcomes. Since the creation of the criteria, new medications have come to the marketplace that were not considered during the original development process and new scientific information has become available about the effects and side effects of many medications in older populations. Finally, the availability of clinical information in drug utilization review and research databases has increased so that accurate information on concurrent diagnosis is sometimes available. For all these reasons, the criteria must be reevaluated.

From the Division of Geriatric Medicine, Allegheny University of the Health Sciences, Presidential City, Philadelphia, Pa.

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Explicit criteria defining inappropriate drug use are an important tool in the evaluation of prescribing to populations.[7] The alternative, implicit review, is a less satisfactory evaluation method that introduces biases that are difficult to identify. When applied in the clinical setting, drug utilization review criteria are not meant to limit appropriate prescribing and should not be used as the basis for punitive interventions. They are not substitutes for careful clinical consideration by prescribers and pharmacists. Rather, they are a mechanism for alerting prescribers and pharmacists to the likelihood that a prescription is inappropriate.

Without measuring outcomes, criteria cannot determine whether adverse outcomes have occurred; they can only determine that they are more likely to occur. Thus, some people prefer to say that such criteria define potential inappropriate prescribing rather than actual inappropriate prescribing. However, the definition of inappropriate prescribing is based in the probability of desired and undesired outcomes; it is generally stated that the use of a drug (or any intervention) is inappropriate when its potential risk outweighs its potential benefit. These criteria were developed to predict when the potential for adverse outcomes is greater than the potential for benefit.

There were 4 goals of this project: (1) to reevaluate the criteria to include new products and incorporate new information available in the scientific literature, (2) to generalize the criteria to a population of persons older than 65 years regardless of their level of frailty or their place of residence, (3) to assign a relative rating of severity to each criterion, and (4) to identify additional alerts that apply when clinical information on diagnoses is available.

METHODS

I identified literature published since the original literature review in 1991 that established the first set of criteria. I included literature in the English language that described guidelines for the use of medications in elderly persons.[8-27] The literature review included review articles and opinion articles as well as controlled trials. I used the results of this literature review and the original set of criteria developed by Beers et al[1] to construct statements or guidelines on the inappropriate use of medications by older people. These statements tried to summarize the specific cautions and concerns regarding use of each drug or class of drug in elderly persons that were made in the literature. The statements were not verbatim extracts from any one source and do not quote prescribing guidelines prepared by manufacturers. The statements were of 3 types: (1) medications or medication categories that should generally be avoided because they are either ineffective or because they pose unnecessarily high risk for elderly persons; (2) doses, frequencies, or durations of therapies that generally govern the appropriate use in elderly persons of some medications; and (3) medications that should not be used in persons known to have specific medical conditions, even though their use in the general population of elders might be appropriate.

Reviewers rated the validity of each statement on a 5-point Likert scale,[28] in which a score of 1 meant they strongly agreed, 3 meant they were equivocal, and 5 meant they strongly disagreed. If they agreed that the statement was true (rated 3 or below), the panelist was further asked to rate the severity of any problems that might arise because of use of the medication as stated. Severity was defined conceptually as a combination of both the likelihood that an adverse outcome would occur and the clinical significance of that outcome should it occur.

I asked 6 nationally recognized experts in geriatric care and pharmacology to evaluate the criteria (Jerry Avorn, MD, Richard W. Besdine, MD, Gary W. Erwin, PharmD, Carl Salzman, MD, Brian L. Strom, MD, MPH, and Robert E. Vestal, MD). The panel included expertise in general geriatrics, clinical pharmacology, pharmacoepidemiology, clinical pharmacy, and psychopharmacology. I used a modified Delphi method to reach consensus on the criteria.[29] The first round of evaluation was conducted by a written survey sent and returned by mail. Participants were asked to add additional statements for consideration in the second round. The second round of evaluation was conducted at a face-to-face full-day meeting moderated by the author, who did not vote on assessing the validity of the proposed criteria. Each participant was told his or her rating of each statement as well as the mean and 90% confidence intervals (CIs) around the mean of responses by the group. Several new statements were added either in writing during the first round or at the face-to-face meeting. Each statement was discussed fully and participants then rerated both their assessment of the validity of the statement and its severity.

I computed the mean response and 90% CIs for each statement. I rejected all statements for which the 90% CIs were above 3. I also computed the mean response and 90% CIs for ratings of severity. I defined as severe those potential adverse outcomes whose CIs of severity ratings were 3 or below.

For several medications or categories of medications, the panelists modified statements to broaden or tighten their application. Such criteria were evaluated in addition to the original one. Thus, for some medications or categories of medications, the panel rated 2 or more statements. For example, the panelists rated both the inappropriateness of hydrochlorothiazide dose more than 25 mg daily and more than 50 mg daily; they rated both the appropriateness of any use of meprobamate and the appropriateness of only newly prescribed meprobamate (first prescription). If the panel included both the broader and more narrowly focused statement we added only the broader statement to the final criteria list.

RESULTS

At the face-to-face meeting, the panelists reviewed 38 statements regarding the use of medications when clinical data on diagnoses are not available. They also reviewed 59 scenarios of medication use that might be considered inappropriate only when any of 17 medical conditions were known to exist.

Table 1 and **Table 2** list those statements that the panel

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Table 2. Final Criteria Considering Diagnoses

Disease and Condition	Drug†	Alert	Severity
Heart failure	Disopyramide	Negative inotrope. May worsen heart failure.	Yes
	Drugs with high sodium content (such as sodium alginate, bicarbonate, biphosphate, citrate, phosphate, salicylate, and sulfate)	Large sodium load, leading to fluid retention. May worsen heart failure	No
Diabetes	β-Blockers (limited to people with diabetes taking oral hypoglycemics or insulin)	May block hypoglycemic symptoms in people with diabetes receiving treatment.	No
	Corticosteroids (limited to recently started use)	May worsen diabetic control.	No
Hypertension	Diet pills: amphetamines	May elevate blood pressure.	Yes
Chronic obstructive pulmonary disease	β-Blockers	May worsen respiratory function in persons with chronic obstructive pulmonary disease.	Yes
	Sedative/hypnotics	May slow respirations and increase carbon dioxide retention in persons with severe chronic obstructive pulmonary disease.	Yes
Asthma	β-Blockers	May worsen respiratory function in persons with chronic obstructive pulmonary disease.	Yes
Ulcers	NSAIDs	May exacerbate ulcer disease, gastritis, and GERD.	Yes
	Aspirin (>325 mg)	May exacerbate ulcer disease, gastritis, and GERD.	No
	Potassium supplements (all)	May cause gastritic irritation with symptoms similar to ulcer disease.	No
Seizures or epilepsy	Clozapine, thorazine, thioridazine, and chlorprothixene	Lower seizure threshold.	No
	Metoclopramide	May worsen peripheral arterial blood flow and precipitate claudication.	Yes
Peripheral vascular disease	β-Blockers	May worsen peripheral arterial blood flow and precipitate claudication.	Yes
Blood-clotting disorders, limited to those receiving anticoagulant therapy	Aspirin	May cause bleeding in those using anticoagulants.	Yes
	NSAIDs	May cause bleeding in those using anticoagulants.	Yes
	Dipyridamole and ticlopidine	May cause bleeding in those using anticoagulants.	Yes
BPH	Anticholinergic antihistamines	Anticholinergic drugs may impair micturation and cause obstruction in persons with BPH.	Yes
	Gastrointestinal antispasmodic drugs	Anticholinergic drugs may impair micturation and cause obstruction in persons with BPH.	Yes
	Muscle relaxants	Anticholinergic drugs may impair micturation and cause obstruction in persons with BPH.	No
	Narcotic drugs (including propoxyphene)	Narcotic drugs may impair micturation and cause obstruction in persons with BPH.	No
	Flavoxate, oxybutynin	Bladder relaxants may cause obstruction in persons with BPH	No
	Bethanechol	Anticholinergic bladder relaxants may cause obstruction in persons with BPH.	No
	Anticholinergic antidepressant drugs	Anticholinergic drugs may impair micturation and cause obstruction in persons with BPH.	Yes
Incontinence	α-Blockers	α-Blockers relax the external bladder sphincter and may cause incontinence.	No
Constipation	Anticholinergic drugs	Will worsen constipation.	No
	Narcotic drugs	Will worsen constipation.	No
	Tricyclic antidepressant drugs	May worsen constipation.	Yes
Syncope or falls	β-Blockers	Negative chronotrope and inotrope. May precipitate syncope in susceptible persons.	No
	Long-acting benzodiazepine drugs	May contribute to falls.	Yes
Arrhythmias	Tricyclic antidepressant drugs	May induce arrhythmias.	Yes if started recently‡
Insomnia	Decongestants	May cause or worsen insomnia.	No
	Theophylline	May cause or worsen insomnia.	No
	Desipramine, SSRIs, methylphenidate, and MAOIs	May cause or worsen insomnia.	No
	β-Agonists	May cause or worsen insomnia	No

*It is important to note that most package circulars produced by drug manufacturers do not include language identical to the statements presented he Although the adverse effects that these drugs can produce are generally listed in the package circulars, these as well as warnings and contraindicat approved by regulatory agencies and in general are not based on consensus or surveys. NSAIDs indicates nonsteroidal anti-inflammatory dru gastroesophageal reflux disease. BPH, benign prostatic hyperplasia; SSRIs, selective serotonin reuptake inhibitors, and MAOIs, monoam

†Dose limits are total daily dose.

‡Panelists believed that the severity of adverse reaction would be substantially greater when these drugs were recently started. In ge would be within about a 1-month period

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Table 1. Final Criteria: Independent of Diagnoses* (cont)

Summary of Prescribing Concern	Applicable Medications†	High Severity
Diphenhydramine is potently anticholinergic and usually should not be used as a hypnotic in the elderly. When used to treat or prevent allergic reactions, it should be used in the smallest possible dose and with great caution.	Diphenhydramine (Benadryl)	No
Hydergine (ergot mesyloids) and the cerebral vasodilators have not been shown to be effective, in the doses studied, for the treatment of dementia or any other condition.	Ergot mesyloids (Hydergine), cyclospasmol	No
Iron supplements rarely need to be given in doses exceeding 325 mg of ferrous sulfate daily. When doses are higher, total absorption is not substantially increased, but constipation is more likely to occur.	Iron supplements, >325 mg	No
Barbiturates cause more side effects than most other sedative or hypnotic drugs in the elderly and are highly addictive. They should not be started as new therapy in the elderly except when used to control seizures.	All barbiturates except phenobarbital	Yes if recently started‡
Meperidine is not an effective oral analgesic and has many disadvantages to other narcotic drugs. Avoid in the elderly.	Meperidine	Yes
Ticlopidine has been shown to be no better than aspirin in preventing clotting and is considerably more toxic. Avoid in the elderly.	Ticlopidine	Yes

**It is important to note that most package circulars produced by drug manufacturers do not include language identical to the statements presented herein. Although the adverse effects that these drugs can produce are generally listed in the package circulars, these as well as warnings and contraindications must be approved by regulatory agencies and in general are not based on consensus or surveys. SIADH indicates syndrome of inappropriate antidiuretic hormone.*

†Dose limits are total daily dose.

‡Panelists believed that the severity of adverse reaction would be substantially greater when these drugs were recently started. In general, the greatest risk would be within about a 1-month period.

considered valid. These tables also indicate whether the panelists believed that the use of the medication was of a more serious nature. The final criteria describe the use of 28 medications or classes of medications that apply to all older patients. Adverse outcomes of 14 of these were considered severe. The criteria also identify 35 drugs or categories of drugs that are inappropriate in persons with any of 15 known medical conditions. Outcomes of 17 of these were considered severe. One of the diseases, glaucoma, was eliminated from consideration by the panel. The panel believed that under most circumstances, closed-angle glaucoma could not be distinguished from open-angle glaucoma from typical data sources, and, therefore, medication problems could not be adequately evaluated. No statements on medication use were considered valid for persons with dementia.

These results now serve as criteria defining inappropriate medication use in 2 settings. The first apply in general to all older persons. The second are disease specific and apply to older persons in whom clinical information is available on known diagnoses.

COMMENT

Explicit criteria provide useful tools for assessing the quality of prescribing to older persons. They may be used in drug utilization review, as the basis for educational materials, and to assess the quality of prescribing and potential risk from prescribing in populations. They are meant to apply to elderly populations in general and like any evaluation test have limitations in both sensitivity and specificity. These criteria do not identify all cases of potentially inappropriate prescribing and sometimes identify appropriate prescribing as inappropriate. The latter case is particularly likely when physicians, nurses, and pharmacists carefully adjust medication regimens for the individual needs of individual patients. Clinical evaluation of an individual patient is essential in clinical care but cannot usually be accomplished in drug utilization review and research studies. In the best opinion of several of America's leading experts on medication use in the elderly as supported by the published literature, these criteria are current, inclusive, and accurate.

These new criteria are more limited than those published previ-

ously. They are meant to apply to th general population of elderly per sons rather than just the frailest an sickest residing in nursing homes Thus, some medications that migh not be appropriate for those frailes elderly populations may appropri ately be used in other elderly popu lations.

These criteria not only incor porate recent scientific informa tion about the use of medication in the elderly but also add usefu features. First, they categorize a criteria as to whether their advers outcomes are less or more seriou This evaluation is relative and i not meant to establish absolut guidelines. The issue is also com plex, combining 2 related but di fering concepts. To be severe, ou panelists considered that a adverse outcome was both likel to occur and, if it did occu would likely lead to a clinicall significant event.

These criteria also attempt t include information on clinic diagnoses. While implicit evalu tions of medication use have ofte evaluated clinical informatio most explicit drug utilizatio review criteria have avoided suc considerations. These new criter take a first step at incorporatin

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Table 2. Final Criteria Considering Diagnoses

Disease and Condition	Drug†	Alert	Severity
Heart failure	Disopyramide	Negative inotrope. May worsen heart failure.	Yes
	Drugs with high sodium content (such as sodium alginate, bicarbonate, biphosphate, citrate, phosphate, salicylate, and sulfate)	Large sodium load, leading to fluid retention. May worsen heart failure.	No
Diabetes	β-Blockers (limited to people with diabetes taking oral hypoglycemics or insulin)	May block hypoglycemic symptoms in people with diabetes receiving treatment.	No
	Corticosteroids (limited to recently started use)	May worsen diabetic control.	No
Hypertension	Diet pills: amphetamines	May elevate blood pressure.	Yes
Chronic obstructive pulmonary disease	β-Blockers	May worsen respiratory function in persons with chronic obstructive pulmonary disease.	Yes
	Sedative/hypnotics	May slow respirations and increase carbon dioxide retention in persons with severe chronic obstructive pulmonary disease.	Yes
Asthma	β-Blockers	May worsen respiratory function in persons with chronic obstructive pulmonary disease.	Yes
Ulcers	NSAIDs	May exacerbate ulcer disease, gastritis, and GERD.	Yes
	Aspirin (>325 mg)	May exacerbate ulcer disease, gastritis, and GERD.	No
	Potassium supplements (all)	May cause gastritic irritation with symptoms similar to ulcer disease.	No
Seizures or epilepsy	Clozapine, thorazine, thioridazine, and chlorprothixene	Lower seizure threshold.	No
	Metoclopramide	May worsen peripheral arterial blood flow and precipitate claudication.	Yes
Peripheral vascular disease	β-Blockers	May worsen peripheral arterial blood flow and precipitate claudication.	Yes
Blood-clotting disorders, limited to those receiving anticoagulant therapy	Aspirin	May cause bleeding in those using anticoagulants.	Yes
	NSAIDs	May cause bleeding in those using anticoagulants.	Yes
	Dipyridamole and ticlopidine	May cause bleeding in those using anticoagulants.	Yes
BPH	Anticholinergic antihistamines	Anticholinergic drugs may impair micturation and cause obstruction in persons with BPH.	Yes
	Gastrointestinal antispasmodic drugs	Anticholinergic drugs may impair micturation and cause obstruction in persons with BPH.	Yes
	Muscle relaxants	Anticholinergic drugs may impair micturation and cause obstruction in persons with BPH.	No
	Narcotic drugs (including propoxyphene)	Narcotic drugs may impair micturation and cause obstruction in persons with BPH.	No
	Flavoxate, oxybutynin	Bladder relaxants may cause obstruction in persons with BPH	No
	Bethanechol	Anticholinergic bladder relaxants may cause obstruction in persons with BPH.	No
	Anticholinergic antidepressant drugs	Anticholinergic drugs may impair micturation and cause obstruction in persons with BPH.	Yes
Incontinence	α-Blockers	α-Blockers relax the external bladder sphincter and may cause incontinence.	No
Constipation	Anticholinergic drugs	Will worsen constipation.	No
	Narcotic drugs	Will worsen constipation.	No
	Tricyclic antidepressant drugs	May worsen constipation.	Yes
Syncope or falls	β-Blockers	Negative chronotrope and inotrope. May precipitate syncope in susceptible persons.	No
	Long-acting benzodiazepine drugs	May contribute to falls.	Yes
Arrhythmias	Tricyclic antidepressant drugs	May induce arrhythmias.	Yes if started recently‡
Insomnia	Decongestants	May cause or worsen insomnia.	No
	Theophylline	May cause or worsen insomnia.	No
	Desipramine, SSRIs, methylphenidate, and MAOIs	May cause or worsen insomnia.	No
	β-Agonists	May cause or worsen insomnia	No

*It is important to note that most package circulars produced by drug manufacturers do not include language identical to the statements presented he Although the adverse effects that these drugs can produce are generally listed in the package circulars, these as well as warnings and contraindicat approved by regulatory agencies and in general are not based on consensus or surveys. NSAIDs indicates nonsteroidal anti-inflammatory dru gastroesophageal reflux disease; BPH, benign prostatic hyperplasia; SSRIs, selective serotonin reuptake inhibitors; and MAOIs, monoam

†Dose limits are total daily dose.

‡Panelists believed that the severity of adverse reaction would be substantially greater when these drugs were recently started. In ge would be within about a 1-month period.

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this additional complexity in a way that will be most useful to persons designing research studies and drug utilization review systems. We recognize that considering clinical information is a complex issue that requires additional work, and their application may be befuddled by inaccuracies in clinical data.

Continued development of explicit criteria governing the use of medication by older persons is important to clinical medicine and health services research. Further refinements must address the needs of subpopulations of the elderly and attempt to incorporate additional clinical information. All criteria must be reviewed periodically to be sure that they are up-to-date and comprehensive. Ultimately, careful outcomes research will help define the accuracy of such criteria and determine the severity of events related to medication use by the elderly.

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Behavior Changes Challenging for Caregivers

Combative, agitated behavior

Changes in behavior may be caused by

- Physical discomfort
- Over-stimulation
- Unfamiliar or confusing surroundings
- Complicated tasks
- Frustrating interactions or communication problems

Managing aggressive or unsafe behaviors

- Have familiar objects, such as items in a memory box, immediately available to reassure and distract the person.
- Ask for the person's help but do not rush, criticize, or make demands.
- Offer a snack or treat to divert the person's attention.
- Remove potentially dangerous or confusing items, such as sharp objects.
- Learn the person's nonverbal sings of increasing agitation (e.g., red face, clenched fists, rapid searching with the eyes, or waving hands in the air).
- Learn verbal signs of escalating anger such as cursing, using a loud voice, and muttering.
- Change the environment or move to a quiet, smaller space.
- Reduce expectations by allowing more time to accomplish fewer activities/tasks.
- Slow down your actions as the person speeds up. Your nonverbal and verbal slowing can have a calming effect.
- Never surround or gang up on someone who is about to lose control. If the person feels cornered or overwhelmed, it can prompt a "fight or flee" response. Physical restraints are not effective in reducing aggressive behavior.
- Do not make any assumptions about what is safe.

Identifying underlying physical causes

Modifying the environment

Assisting with personal care

- Delay personal care when the person is upset.
- Move to the side or out of the person's direct vision when helping with bathing or personal care. The person is less likely to fell attacked if the caregiver stays at his her eye level and is nonconfrontational.
- The person may need real physical reassurance through hugs or hearing that you are there to protect his or her safety.

- If the person grabs your arm or wrist, stroke the lower arm of the grabbing hand or place your hand over the grabbing hand and squeeze firmly.
- If threatened with an object like a cane or chair, grab a safe object like a pillow that can stop the threatening object without causing harm.

Communicating after an aggressive incident

- Use short, simple phrases or sentences as well as familiar words.
- Do not argue with the individual.
- Approach the person calmly from the front, move to the side, and speak slowly in a low-pitched voice.
- Give the person time to respond.
- Pay attention to the person's nonverbal messages as well as what they say verbally. Facial expressions and body language can sometimes provide additional information on how the person is feeling.
- Respond to the feelings behind the words or body language.
- Keep noise and distractions to a minimum.
- Always remind the person who you are and what you are attempting to do.
- Offer guided choices such as, "Would you prefer to wear the blue shirt or the red shirt?"

February, 22, 2003

Dear Committee,

As an RN in an emergency room, I see numerous patients with a variety of complaints. Throughout my six years in an ER, it is obvious that many patients use an ER for convenience and as their primary care support. The majority of these patients are on Medicaid or the equivalent. Our society as a whole is impatient and wants immediate results and cures, even for the common cold. This is not only impossible but it burdens our ER and taxpayers as a whole.

As a taxpayer and an RN, I resent the fact that my tax dollars pay for people on Medicaid who don't take responsibility for themselves or their children. We are inundated with complaints that are months old "I decided to come in today", to the "he just felt hot so I brought him in". I believe the bulk of the problem lies with the patient not planning ahead or making good decisions. I also believe our current state of entitlements must change so that it isn't so easy for people to abuse the Medicaid system. My insurance has regulations that are enforced and so must Medicaid's. (These findings are not limited to only Medicaid patients, although they occur at a significantly higher percentage than those with private insurance)

Here are common comments/problems we encounter on a daily basis.

- Most medicaid patients don't have an assigned doctor or clinic on their card. They use ER's as their primary care area. This provides them with no continuity of care. Why haven't they been assigned to a doctor?

- If they do have an assigned doctor most of the patients or parents of patients, do not attempt to contact the doctor prior to heading straight to the ER.
- They may have an assigned doctor on their card but have never been to that doctor to establish care with that doctor. This only takes a phone call.
- Many doctors don't want to accept Medicaid patients due to reimbursement issues. That is also why some Medicaid recipients have trouble finding a clinic that will accept them so they can be locked in to that doctor.
- Once they come to the ER medicaid patients often return to the ER instead of contacting their assigned doctor for their follow up appointment as we advise them to do upon dismissal.

- "I've got a medical card, I don't need a regular doctor!" is a frequent comment.
- Medicaid patients using EMS to bring them in because they couldn't find a ride that day to get to a doctor. Many times their complaint has been going on for weeks.

- Over 95% of adult patients on medicaid smoke at least one pack of cigarettes a day

- Over 90% of pediatric patients on medicaid are around second hand smoke on a regular basis.

President's Task Force on
Medicaid Reform
February 24, 2003
Attachment 16-1

- Many medicaid patients expect free medication samples or ask us for money to buy prescriptions when they are somehow able to buy their cigarettes every day.
- Many recipients of medicaid don't speak English. This means we have to stop our assessment, call an interpreter service–at the hospital's expense–before we can care for this patient. Why aren't recipients of Kansas tax dollars asked to speak the national language?
- Medicaid patients often use the ER as a convenience. It is amazing the amount of patients that drop by after work instead of calling their doctor during working hours. Then when they have to wait a while because we are busy taking care of a person with a heart attack, they get impatient, rude, demanding to be taken care of immediately.
- Many medicaid patients rush their children into the ER without attempting any home remedies. "He got a fever so I brought him right in!" They don't give any fever reducing medication, they don't wait a day to see if the child improves, they don't realize colds last 7-10 days and don't require an antibiotic. This involves education. If a person gets a medical card they need to be provided with and educated on the types of conditions that truly are an emergency. If it isn't an emergency then provide them with a list of cares they can do on their own or encourage them to call their clinic doctor.
- Many doctors offices routinely tell patients to go to the ER when they can't fit them in on that day. These offices need to provide educated people other than receptionists to answer patients questions and help determine if the patient's complaint can wait until an appointment is available or truly needs to be referred to the ER.

This is by no means a complete list of all the problems we regularly incur. But complaining and getting frustrated is not a solution. That is why I have some ideas I'd like to share. I am not an expert in social work, and I don't know the budget for Medicaid but I do believe changes have got to be made. Here are some ideas.

1. All medicaid recipients must be assigned to a doctor or clinic

When they get a card for the first time OR are getting a new monthly card, allow the cardholder 30 days to establish an appointment with their assigned facility. If they haven't done this in 30 days do not give them the next month's card. Advise them that if they need care within the next 30 days that they must pay for it themselves. A few times of getting billed directly and being made to be responsible for the bill and they should learn how it works.

This would require a paper or phone trail to ensure the patients are being truthful that they have in fact made an appointment. This would alleviate the common responses, "I have a doctor on my card but I have never been there", "the office won't see me because I've never been there before", "I don't have a doctor to go to", etc.

Along with an initial appointment, advise/encourage the importance of continuity of care. Once they go to the doctor all their records are in one place. They should have all follow up care at that facility. Present this as a positive that they can rely on.

For those that need assistance finding a doctor or making an appointment services should be available. I try and help people leaving the ER make an appointment so they leave with a place to follow up.

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2. All recipients must show proof of citizenship before they can qualify for a card.

This is common sense. I am not paying taxes to support illegal aliens. NOONE should be offended by this. They should take pride in the fact that they are Americans.

3. All recipients should eventually speak English.

This is not the trend with all the technology giving people the choice to "press one for English". However from a healthcare provider standpoint, it is extremely frustrating and time consuming and expensive for us to get an interpreter. I don't understand why we make it so easy for people NOT to have to learn English. We need to emphasis this as a positive. If we can't understand them, we can't treat them adequately.

4: Educate Educate Educate!!!

When a person qualifies for a card they need to be provided and discussed with a list of when to call the doctor or seek medical treatment. Specific information on what a fever is, what medication to give and how much, the symptoms of a common cold and that their children don't need to see a doctor the minute they develop a fever or a runny nose.

Have someone at each office designated to field phone calls to answer patients questions. Explain to callers that it may take a few hours to return their call but that they will get a response. This can help avoid, "I called the doctor's office 30 minutes ago and they haven't called me back yet so I just brought her in here".

Even if a new position (Education Specialist?) has to be created to field all these questions it has to be cheaper than paying for unnecessary emergency room visits. Not more bureaucracy but to streamline help for people who have questions.

5: Why should taxpayers pay for a person's healthcare when they continue to smoke?????

When a person signs up to receive Medicaid, ask them if they smoke and how much. The average person I care for smokes 1 pack per day. The average cost of a pack of cigarettes is $3.00. That is $90.00/month per person, $180.00/month per couple in a household.

Advise them if they smoke, the amount they spend on cigarettes will be deducted from any benefits they receive. It still gives them a choice. We wouldn't tell them they can't smoke to get the card but if they do their benefits will be reduced. Statistically smokers cost insurance companies more to care for. It only makes sense to encourage them not to smoke. Without any incentives to quit why should they?

Parents who smoke around their children should receive or attend a class on the hazards of second hand smoke. We see children who are barely breathing when they come in with an asthma attack. Their and their parents clothes reek of cigarette smoke. A common response is, "It's not like I blow it in his face!" Children who are around cigarette smoke show a much higher incidence of asthma, colds, ear infections, pneumonia, sore throats, etc. **It is amazing how many times children return with the same complaints, sometimes life threatening, yet their parents continue to abuse them by exposing**

them to smoke. They need to hear it over and over until they get the point!

6: Eliminate prescription coverage for adult medicaid recipients.

There are seniors who must choose between buying food or their medication because Medicare doesn't offer any prescription coverage. Yet medicaid recipients get their prescriptions free or at a reduced cost. This isn't right.

7: Have a reviewer look through charts billed to medicaid.

If a complaint was non emergent or even non urgent, bill cost not covered by medicaid directly to the patient. This would help promote them going to their regular doctor if they knew they had to pay out of their own pockets. I think this is already being done but I can't imagine the continued frequent visits to our ER by some patients if they had truly been billed for previous visits.

Many medicaid patients come to the Emergency Room several times a month. These patients need to be singled out and counseled to determine how to help them prioritize their healthcare. Hospital social workers need to work with the case managers with social services to see how best to address each case. I think this is already being done but I can't imagine the continued frequent visits to our ER by some patients if they had truly been billed for previous visits.

8. Require adult medicaid recipients to have a job. Obviously stay at home mom's should have that option, but others should have a job. They shouldn't have to choose between getting welfare or Medicaid and getting job.

9. Eliminate any marriage penalties. Going back to #8. There should not be any reduction in available resources if someone gets married. We should reward couples who choose to marry versus single parent households.

10. Contraceptives, including vasectomies and tubal ligations, should be covered. Preventing unwanted pregnancies has got to be cheaper than paying for a child on medicaid. This may already be covered but according to my resources it isn't.

11. Have a limit on amount benefits are increased based on the number of children a woman has. Rewarding multiple births just to get more support is defeating for everyone.

12. If these changes or others are made, these recipients may need budget counseling. This is probably already offered but if not it should be considered. It will be an adjustment financially as well as psychologically, if their benefits decrease.

I think our state and our country as a whole has gotten out of control with entitlements. Instead of rewarding hard work, getting an education and taking responsibility for oneself, the trend seems to be to "take care" of everyone. I went to college, got degrees and made a life for myself and my family. I take pride in my achievements and would consider it a defeat if I accepted handouts. There are times when some people need short term help, but this country was not founded and maintained and grown by the government supporting all the people. Let's make Kansas an example of a success, not a state losing money year after year because it can't "support" its entitlements.

I am not harsh, I am realistic. I will do anything to save a person's life when they are sick, or at least make them as comfortable as possible while I care for them. I will spend time trying to educate people on their condition,

medications, and what they should do when they leave the ER. I treat all people the same regardless of insurance or lack there of. I enjoy my job very much, and I am good at it. I care and that is why I am trying to make things better.

Thank you very much for your time and effort into the process of reform. I will continue to help in anyway I can.

Sincerely,

Rexanne K. Beauchamp, RN CCRN

16-5

TESTIMONY OF
MARTHA L. HEGARTY

MEDICAID REFORM TASK FORCE
SENATOR STAN CLARK, CHAIRMAN
February 24, 2003

Good afternoon Chairman Clark and members of the subcommittee. My name is Martha Hegarty and my friends call me Marty. I am extremely honored to appear before you to discuss the crisis in long term care Medicaid reimbursement and the important role you must play in beginning to solve the problem.
Let me tell you about myself and the people in my care in Easton. My daughter and I own and operate a 52-bed skilled nursing facility called Country Care. My daughter is the administrator and we have 55 dedicated caregivers who care for our 50 residents.

Easton is representative of rural KS and Country Care is representative of the small nursing homes that provide care 24 hours a day, 365 days a year. Country Care is also representative of the many nursing homes across Kansas who have seen the number of private pay residents dwindle to less than fifty percent. In the past our home was one of the lucky ones that had sixty- percent private pay and forty percent Medicaid. This has changed drastically and we now have 63 percent Medicaid. When the Medicaid rate doesn't cover all of our costs this can have an impact on quality of care and ultimately, quality of life. This is not an option that I am willing to take and not one that would be in the best interest of the State. We must work together to assure that the residents who are in our care receive the quality of care they deserve.

As you are well aware, there is a nation wide shortage of caregivers, especially those on the front line of caregiving. In rural KS this problem is made worse by the trend called depopulation. While the number of elderly in KS is exploding, the people who would provide that care are leaving in droves. I compete for workers with two hospitals, the VA medical center in Leavenworth, numerous nursing homes as well as the riverboat gambling, which is only 30 miles from Easton. Working in a nursing home is hard work and the rewards are measured in the smile of a resident rather than a big paycheck. One of the ways that I think we could improve the situation is to have more healthcare classes offered in high school. A certified nurses aide class could be offered as the credit for Health.

The last two years has seen a dramatic increase in the cost of liability insurance. It went from a range of five to ten thousand to forty to eight thousand in yearly premiums. Some nursing homes in the state are unable to even receive insurance either because of the cost of the premiums or because they had what the insurance companies felt was not a good enough survey. The money I spend on insurance could be better spent on something that would benefit the residents. However, I don't feel that I can not have coverage.

Surveys might be an area that could be looked at to see if the current process does indeed assure better care for the residents. Surveys should be outcome oriented. If your sample of residents are well, hydrated, no weight loss and happy, surveyors should not feel they have to "dig" until they find a "system" that they feel could cause or has the potential for a problem. This can lead to a subjective survey rather than objective and that means more time spent in a facility that has good resident care and outcome.

In a good nursing home you will find all nurses, LPN's as well as RN's giving direct resident care if or I should say when the occasion arises. The way the survey process is carried out now, more emphasis is put on paperwork than resident care. It is understandable that if the survey team comes in on a complaint that they will look more closely at policies and procedures. In our facility, we write our policies and procedures as simply as possible but it works for us. Even in good facilities the survey team may stay four to five days. On our last survey we received three deficiencies and it took up six type written pages. On another survey I was told the surveyors would be back to do the exit interview early afternoon. I wanted certain supervisors to attend so I asked them to stay late. The exit interview took place at almost seven in the evening. This is not making good use of my money or tax dollars. Surveyors should get in and out quickly if no problems are found. They could spend longer time helping a facility that has a problem. What we don't need is someone telling us we have a problem and not giving us an idea of how to solve that problem. In the 70's and 80's that was exactly what happened. The survey process was a learning tool. Who better to share ideas than a surveyor who has seen something in another facility that helped improve quality of life? Health care workers from the administrator on down are busy being sure that the resident is being taken care of in a homelike atmosphere where they may enjoy the quality of life they deserve. What we don't need is the threat of a fine if something happens. Why can't the money the fine would generate be put back into something that would benefit the resident? I a resident wanders away from a facility wouldn't all residents benefit if the home had to spend $10,000 on a new door monitoring system rather than the money going to the state?

Ten or twelve years ago I was privileged to attend a seminar in Washington on Restraint Free Nursing Homes. Administrators, DON's and Legislators from all states were present. After the wonderful presentation the question and answer session began with the questions, "What about law suits concerning falls?" "Will we get a deficiency because a resident falls?" We were assured that falls don't kill but

restraints do. We were assured that we wouldn't get a deficiency when a resident fell. We all went back to our facilities and wanted to be the first "Restraint Free" home in our state. The medical supply companies were busy selling us products that would reduce the number of falls. My favorite is the Merry Walker, which is a walker with a seat. Residents could walk around and then sit down when tired. There was also the Lap Buddy, a padded cushion that fit around the arms of the wheelchair.

I imagine you know the rest of the story. The surveyors decided that the Merry Walker and the Lap Buddy were restraints unless of course the resident could get out by himself or herself. I had a resident who could undo his seatbelt but of course he wouldn't do that when the surveyor asked him . We may still use these devices but the amount of paperwork involved is unbelievable. Even a bed rail is considered a restraint even when the resident requests it to use for positioning. My two RN's told me last week that they were just overwhelmed with everything they have to do with paperwork. In my small 52-bed nursing home on the 6-2 shift I have two RN's 80 hours a week . With a payroll of eighty five to ninety thousand a month I don't know how I can have more hours for paper compliance.