Approved: 3-14-03
Date

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

The meeting was called to order by Chairperson Senator Stan Clark at 9:30 a.m. on March 5, 2003 in Room 231-N of the Capitol.

All members were present except: Senator Barnett, excused

Committee staff present: Emalene Correll, Legislative Research
Jim Wilson, Revisor of Statutes
Ann McMorris, Secretary

Conferees appearing before the committee:
Bob Day, SRS
Laura Howard, Dept. Of Aging

Others attending: See attached list

Information provided to the committee -

1. Policy Options Discussion Guide - Health Care Policy by Laura Howard, Asst. Secretary for Health Care, SRS (Attachment 1)
2. Kansas Department on Aging cost containment strategies - Janis DeBoer (Attachment 2)
3. Caring Hearts of Wichita - written testimony by Brenda Carver (Attachment 3)
4. Article - "What's it gonna cost, Doc? By Tom Simpson, MD (Attachment 4)
5. Medicaid Long Term Care Spending FY 2001 chart (Attachment 5)
6. Letter of March 3, 2003 from Janet Schalansky, Secretary, SRS (Attachment 6)
7. Fact Sheet - State Health Care Partnership Allotment (Attachment 7)

Robert Day of SRS spoke on abuse of drugs, chemical restraint and drugs not covered by Medicaid. The drugs not covered could be waivered in but are not mandated, usually inexpensive but are they good. Some of the drugs that aren't covered are in the valium family and there are 8 or 9 of these. Mr. Day had data on the 2000 top beneficiaries for Medicaid in FY2002. He didn't supply this list to the committee due to confidential information it contained. He shared the information that the top beneficiary had cost $533,000; the second - $530,000; the third $481,000; the fourth $426,000; the fifth $268,000. These claims covered various health problems. Inpatient expense is a big driver of cost. Discussion on how to determine care management. There is a need for a program to deal with conditions where people have more than one chronic disease.

Several ideas were discussed - paying primary care physicians' extra; pilot program in Sedgwick County to set up case management; long term care factors; medicare legislation; use of 20 or more drugs by one person; managed care success; rural health care needs.

Laura Howard, Assistant Secretary of Health Care, SRS, distributed a Policy Options Discussion Guide on Health Care Policy (Attachment 1). She discussed the adjustments included in the Governor's Budget recommendations for SRS - p.40; current comparison of economic benefits by state - p.28-29; Medicaid mandatory and optional coverage groups - p.32-33; comparison of most common optional medical services for adults - p.34; current comparison of medical eligibility by state - p.35; description of service or population- p.3-24. She referred to long term care, estate planning and legislative suggestions. Some discussion on residency requirements in Kansas and other states. Kansas has no residency requirements.

The next meeting of the Task Force on Medicaid Reform is on March 5, at 3:30 p.m.

Respectfully submitted,

Ann McMorris, Secretary

Attachments - 7

President's Task Force on Medicaid Reform

DATE: MARCH 5, 2003 9:00AM

Name	Representing
James A. Bour	KDoA
Christy Lane	KDOA
Gov. Shelby	Post Cabinet
Mike Hammond	Assoc. of Cmtys
Jason Atkinson	Cabinet
Vicki Hutfles	Ks. Governmental Consulting
Bob Corkins	KLEAR, Inc.
Bob Williams	Ks. Pharmacists Assoc.
Bob Alderson	KPSC
Vicki Whitaker	Ks Health Care Assn.
Larry Hecht	Hecht Law Firm
Jim Sergeant	Wesley Medical Center
Lou Howard	SRS

Kansas Department of

Social and Rehabilitation Services

Janet Schalansky, Secretary

President's Task Force on Medicaid Reform

March 5, 2003

9:30 a.m. 519-S

Policy Options Discussion Guide

Health Care Policy

Laura Howard, Assistant Secretary for Health Care

For additional information contact:

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Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

President's Task Force on Medicaid Reform 519-S
March 5, 2003

Policy Options Discussion Guide

Senate Ways and Means Committee members have requested the department identify savings in major discretionary expenditures. This document is intended to facilitate a discussion on these options. The information represents neither the priorities nor opinions of the Governor and the department. Although an extensive list of savings is submitted, there are undoubtably additional policy options that could be added to this document.

Use of Policy Option Savings. The use of the savings estimates must be accompanied with an awareness that several options overlap or may have interrelated impacts. Consequently, the savings are not necessarily additive and the selection of any set of options will require a refinement in the savings estimate. Also, the estimated savings are based on a year's savings to illustrate the full impact of the option. The first year of savings for a chosen option would hinge on the actual implementation date.

Organization of Policy Options. The savings options are categorized by "Services" and "Populations." Each of these categories has been further defined by groupings such as "Regular Medical Services to Adults", "Regular Medical Services to Children", "Populations Covered by Medicaid", etc. Each option contains a description of the population or the service, an estimate of savings below the Governor's budget recommendation, the changes required to implement the option, the number of persons affected by the reduction, and the potential implications. Options impacting programs included in the consensus caseload estimating process are noted by an asterisk.

Factors to Consider when Discussing Options. The following considerations should be made when reviewing the savings options:

- The population groups served by the Department are among Kansas' most needy whose resources must already have been spent before qualifying for any of these programs. The majority of the adult clients are working, or are unable to work due to disability. Many of the services provided to children help keep parents in the workforce.

- Kansas ranks 29th in the nation in the amount of TAF cash benefits and 4th in our six-state region. Colorado, Iowa, and Nebraska provide higher benefits while Missouri and Oklahoma provide lower benefits.

- Increases in the Medicaid program are reflective of increases in health care costs across the country.

- Elimination of certain programs may cause exceptional hardship to some long term clients who will have no means to develop a way to compensate for the lost benefit. Some consideration may need to be given to "grandfathering" in these clients.
- Selection of an option may shift costs to other categories or programs. Costs may also be shifted to communities.
- Some services have been based on long term strategic investments. Eliminating HCBS waiver services, for example, may cause a greater number of people to enter institutions at a greater expense.
- Decisions could adversely affect the service delivery infrastructure and make it difficult to reintroduce those services if it proves to be affordable in the future.
- All estimates are for a full year based on data as of February 2003. If a specific implementation date is chosen, savings would be recalculated based on the new date.

The appendix to this document contains attachments which elaborate on the department's services and which provide a comparison of the department's services across our six-state region. The attachments are listed in the following table:

1-4

Description of Service or Population	Estimated Reduction Below FY 2004 GBR (in millions) State Funds	AF	Type of Change Required to Implement	Estimated Number of People Affected	Consequences or Implications
OPTIONAL REGULAR MEDICAL **SERVICES** FOR CHILDREN - **Dollar amounts and numbers of persons duplicate those in Optional Populations Section**					
Incontinence Supplies* This benefits covers incontinence supplies for children over the age of five who, due to a variety of disabilities or medical conditions, do not use the bathroom. Option reflects total elimination of the service. Coverage for diapers was eliminated in the FY03 allotment and reinstated in the FY04 GBR.	($0.24)	($0.60)	Amend State Medicaid Plan	513	Parents would be required to purchase incontinence supplies for their children.
Attendant Care for Independent Living (ACIL)* This benefit covers health related services for children who are medically fragile and medicaid eligible. Skilled nursing includes such things as tube feeding, suctioning and delivery of medications by I.V. The medicaid HCBS waiver for children requiring technology assistance (TA) qualifies children to access these services. All direct services for children on the TA waiver are accessed through ACIL.	($5.76)	($14.19)	Amend State Medicaid Plan	300	Children who are medically fragile would no longer receive this service.
OPTIONAL REGULAR MEDICAL **SERVICES** FOR ADULTS - **Dollar amounts and numbers of persons duplicate those in Optional Populations Section**					

1-5

Description of Service or Population	Estimated Reduction Below FY 2004 GBR (in millions) State Funds	AF	Type of Change Required to Implement	Estimated Number of People Affected	Consequences or Implications
Pharmacy for Adults* This benefit covers prescription drugs for adults. At the direction of the 2002 legislature, reductions were implemented involving reimbursement rates for pharmaceuticals, dispensing fees, co-pay and the development of a preferred formulary. This additional option reflects total elimination of the service. The GBR makes targeted reductions to pharmacy through a variety of policy changes. **Reductions in GBR:** **SGF** **AF** Reduce Pharmacy from AWP-11% to AWP-13% ($1.2) ($3.1) Limit the # of branded prescriptions ($5.3) ($13.5) Limit prescription supply to 31 days ($.2) ($.5) PA Access to Cox 2 Drugs ($.6) ($1.5) **TOTAL** **($7.3)** **($18.6)**	($76.97)	($180.71)	Amend State Medicaid Plan	75,600	Eliminating access to pharmaceuticals will likely increase use of inpatient care and physician visits.
Vision Services for Adults* This benefit covers eye exams and eye glasses for adults once every four years. Option reflects total elimination of the service. Vision services were eliminated by the FY03 allotment and reinstated in the FY04 GBR.	($0.37)	($0.91)	Amend State Medicaid Plan	10,600	Persons needing glasses would have to obtain them using other means.

OPTIONAL REGULAR MEDICAL **SERVICES** FOR ADULTS - **Dollar amounts and number of persons duplicate those in Optional Populations Section** (continued)

Description of Service or Population	Estimated Reduction Below FY 2004 GBR (in millions) State Funds	AF	Type of Change Required to Implement	Estimated Number of People Affected	Consequences or Implications
Dental Services for Adults* This benefit covers only emergency dental care that affects the overall health of the person. The service is limited to teeth extraction. Option reflects total elimination of the service.	($0.22)	($0.53)	Amend State Medicaid Plan	2,300	Untreated persons are likely to need more intensive emergency care as the infected teeth affect overall health.
Audiology Services for Adults* This benefit covers audiology testing and hearing aids for adults every four years and very limited hearing aid repairs and maintenance. Option reflects total elimination of the service. Audiology services were eliminated by the FY03 allotment and reinstated in the FY04 GBR.	($0.14)	($0.33)	Amend State Medicaid Plan	1,300	Persons needing hearing aids would have to obtain them through other means.
Therapy Services for Adults* This benefit covers physical therapy, occupational therapy, and services for speech, hearing, and language disorders. Therapy provided is only rehabilitative in nature on a limited, short term basis. The FY03 appropriation reflects the estimated savings that will result from improving edits and processing of therapy claims for assessments so provider billing errors are greatly reduced. This additional option reflects total elimination of the service.	($0.06)	($0.13)	Amend State Medicaid Plan	360	Eliminating therapy could limit people returning to work and decrease self-sufficiency. Could increase the demand for VR services.

OPTIONAL REGULAR MEDICAL **SERVICES** FOR ADULTS - **Dollar amounts and number of persons duplicate those in Optional Populations Section** (continued)

1-7

Description of Service or Population	Estimated Reduction Below FY 2004 GBR (in millions) State Funds	AF	Type of Change Required to Implement	Estimated Number of People Affected	Consequences or Implications
Durable Medical Equipment for Adults* This benefit covers durable medical equipment and supplies such as oxygen equipment, wheelchairs, diapers, and ostomy supplies. Option reflects total elimination of the service. The FY03 allotment eliminated coverage for diapers, but the FY04 GBR reinstates this coverage.	($2.56)	($6.13)	Amend State Medicaid Plan	10,000	Would likely result in increased nursing home and hospital treatment. Could increase the demand for VR services.
Transplants for Adults* This benefit covers kidney, cornea, liver and bone marrow transplants. Medicare frequently covers most of the costs of these Medicaid allowable transplants. Medicaid is the last payer. Option reflects total elimination of the service.	($0.33)	($0.82)	Repeal Regulations Amend State Medicaid Plan	27	Life span of people needing critical transplants will be shortened. Discontinuing non-critical transplants will greatly diminish quality of life.
Alcohol and Drug Abuse Services for Adults* This benefit covers drug and alcohol treatment for adults such as acute detox, intermediate inpatient care, and day treatment. Option reflects total elimination of Medicaid services. It does not include grant funding for this service.	($1.33)	($3.34)	Amend State Medicaid Plan	2,060	Could possibly increase the demand on state only funded services.

OPTIONAL REGULAR MEDICAL **SERVICES** FOR ADULTS - **Dollar amounts and number of persons duplicate those in Optional Populations Section** (continued)

1-8

Description of Service or Population	Estimated Reduction Below FY 2004 GBR (in millions) State Funds	AF	Type of Change Required to Implement	Estimated Number of People Affected	Consequences or Implications
Hospice for Adults* This benefit covers skilled nursing services for persons who have been determined to have less than six months to live. The FY03 appropriation budget eliminated hospice for persons on PD waiver. This additional option reflects total elimination of the service.	($2.99)	($7.44)	Amend State Medicaid Plan	1,350	Would likely result in increased inpatient hospitalization and nursing home placements.
Federally Qualified Health Clinics for Adults* This benefit provides federal funding for Federally Qualified Health Clinics. (Note: Rural Health Clinics are a mandated service). Option reflects total elimination of the service.	($0.29)	($0.58)	Amend State Medicaid Plan	4,000	Persons would likely seek services from other Medicaid providers. These clinics would no longer be eligible for Medicaid reimbursement. Decreased availability of medical services especially where access to physicians is limited.
OPTIONAL REGULAR MEDICAL **SERVICES** FOR ADULTS - **Dollar amounts and number of persons duplicate those in Optional Populations Section** (continued)					

Description of Service or Population	Estimated Reduction Below FY 2004 GBR (in millions) State Funds	AF	Type of Change Required to Implement	Estimated Number of People Affected	Consequences or Implications
Local Health Department Services for Adults* This benefit covers services provided by county health departments. Option reflects total elimination of the service.	($0.05)	($0.15)	Repeal Regulations Amend State Medicaid Plan	2,700	County Health Department funding would be decreased. Decreased availability of medical services especially where access to physicians is limited.
Nursing (ARNP) Services for Adults* This benefit covers the services provided by an advanced registered nurse practitioner such as pain management and obstetrics. Option reflects total elimination of the service.	($0.04)	($0.10)	Repeal Regulations Amend State Medicaid Plan	1,200	Decreased availability of medical services, especially where access to physicians is limited.
OPTIONAL **POPULATIONS** COVERED BY MEDICAID - **Dollar amounts and persons listed duplicate those under Optional Services Sections**					

Description of Service or Population	Estimated Reduction Below FY 2004 GBR (in millions) State Funds	AF	Type of Change Required to Implement	Estimated Number of People Affected	Consequences or Implications
MediKan Program* The persons covered by this program are adults who are applying for federal disability benefits. Medikan is a more limited services package than Medicaid. SRS receives retroactive federal funding for persons ultimately found eligible for Medicaid. This additional option reflects total elimination of services to this population. The GBR limits this program to 24 months with the first month counting toward the limiting as January 2002, resulting in estimated savings of $2.2 million. The GBR also lowers Medikan $1.4 million by reducing reimbursement rates to Community Mental Health Centers. **Reduction in FY2004 GBR:** **SGF** **AF** GA MediKan ($2.2) ($2.2) CMHC MediKan ($1.4) ($1.4) **TOTAL** **($3.6)** **($3.6)**	($14.80)	($14.80)	Repeal Regulations	3,410	Significant increase in indigent care especially at hospitals that can not turn away patients in need of emergency care.Additional uncompensated care at CMHC's for mentally ill consumers.
Expanded Breast and Cervical Cancer Coverage* Persons covered by this program are women with cervical or breast cancer who qualify for the Kansas Breast and Cervical Cancer program. These women have income less than 250% of the federal poverty level. Federal funds are provided at an enhanced match rate of 72%. Option reflects total elimination of services to this population.	($0.28)	($1.00)	Amend State Medicaid Plan	45	Women in this group would go untreated or secure treatment through other means.

OPTIONAL **POPULATIONS** COVERED BY MEDICAID - **Dollar amounts and persons listed duplicate those under Optional Services Sections** (continued)

Description of Service or Population	Estimated Reduction Below FY 2004 GBR (in millions) State Funds	AF	Type of Change Required to Implement	Estimated Number of People Affected	Consequences or Implications
Working Healthy* Persons covered by this program are disabled with incomes up to 300% of the federal poverty level, and who are working. Certain income levels are assessed premiums. This additional option reflects total elimination of services to this population.	($1.38)	($3.45)	Amend State Medicaid Plan	495	Persons would purchase their own health insurance if it was available and affordable. Elimination of this program could discourage people from seeking employment and cause them to remain on waivers.
Medically Needy Aged, Blind, and Disabled* Persons covered by this program are elderly, or disabled who may have income above the SSI level of $516/month. These persons must spend down their income to become eligible for Medicaid coverage much the same as paying an insurance deductible. Calculations exclude reductions in HCBS and LTC and includes Working Healthy with the disabled population. Option reflects total elimination of services to this population.	($80.80)	($216.1)	Amend State Medicaid Plan	27,940	Loss of health insurance coverage which could result in an increase in indigent care. Eliminates Medicaid coverage of prescriptions for persons on Medicare.
Aged	($34.2)	($86.7)		16,370	
Disabled/Blind	($46.6)	($129.4)		11,570	

OPTIONAL **POPULATIONS** COVERED BY MEDICAID - **Dollar amounts and persons listed duplicate those under Optional Services Sections** (continued)

Description of Service or Population	Estimated Reduction Below FY 2004 GBR (in millions) State Funds	AF	Type of Change Required to Implement	Estimated Number of People Affected	Consequences or Implications
Medically Needy Pregnant Women and Children* Families covered by this program must have income above the established income levels, have catastrophic medical expenses, and also spend down their income to become eligible. This program can not be eliminated until the medically needy aged/blind and disabled program is eliminated. Option reflects total elimination of services to this population.	($1.24)	($3.32)	Repeal Regulations Amend State Medicaid Plan	1,160	These persons would lose health insurance coverage thereby increasing indigent care.
STATE CHILDREN'S HEALTH INSURANCE PROGRAM					
HealthWave (SCHIP) Premiums This program covers health care costs for uninsured children whose families' income is less than 200% of the federal poverty level (FPL). These families originally paid monthly premiums of either $10 or $15 per month. This option would triple the amount of premiums the average family must pay. The FY 03 allotment set premiums at $30 and $45 per month, triple the original premium amount effective 2/1/03. The FY 04 GBR lowered the premiums to $20 and $30 per month, double the original amount.. **Reduction in FY2004 GBR:** SGF ($.4) AF ($1.3)	($0.3)	($1.2)	Change Regulations Amend Title XXI State Plan	6,208 families 11,111 children	Some families may choose to leave the program leaving their children without medical coverage.

Description of Service or Population	Estimated Reduction Below FY 2004 GBR (in millions) State Funds	AF	Type of Change Required to Implement	Estimated Number of People Affected	Consequences or Implications
Eligibility for HealthWave (SCHIP) from 200% to 150% of Federal Poverty Level This program covers health care costs for uninsured children whose family income is less than 200% of FPL. This option reduces that income eligibility to 150% of FPL. The eligibility change would occur at the child's next review date. **Option SGF All Funds Children** Lower 185% ($.30) ($1.01) 1,160 Lower 150% ($2.69) ($9.75) 11,111	($2.7)	($9.8)	Change Regulations Amend Title XXI State Plan	11,111 children	The number of uninsured children could rise significantly. Could jeopardize the viability of the managed care program. Reduce the number of people served. Cost per person would likely increase as population served decreased.
FACILITY-BASED SERVICES					
Nursing Facilities for Mental Health* Nursing Facilities for Mental Health (NF/MH) provide residential care and treatment for persons who are primarily severely and persistently mentally ill (SPMI). This option reflects total elimination of this service to this population. **SGF AF** **Reduction in FY2004 GBR:** ($0.81) ($1.19) The GBR includes a reduction in the caseload estimate based on SRS's projection that fewer people will be served in NF/MH's as a result of the decision to only serve persons who are SPMI and the implementation of pre-admission screening for new applicants to ensure they need this level of care.	($8.9)	($13.1)	Repeal Regulations Amend State Medicaid Plan	604 beds	Services to people displaced by this option would be assumed by state hospitals, community based settings or nursing homes.

Description of Service or Population	Estimated Reduction Below FY 2004 GBR (in millions) State Funds	AF	Type of Change Required to Implement	Estimated Number of People Affected	Consequences or Implications
Intermediate Care Facilities for the Mentally Retarded This optional Medicaid service provides private institutional services to persons who are severely developmentally disabled (DD). This option reflects total elimination of this service to this population. Note: The cost of this optional service has declined significantly as a result of the closure of several large private facilities. The savings from these closures was shifted to the DD waiver to pay the costs of services for persons moved from these facilities. SGF AF Reduction in FY2004 GBR: (0.78) (1.99)	($6.67)	($16.95)	Repeal Regulations & State Medicaid Plan	300	Federal funds for private ICFsMR would be lost. Demand for DD waiver services could expand greatly. If savings were not transferred to community DD programs, those leaving ICFs/MR would be left without services.

Description of Service or Population	Estimated Reduction Below FY 2004 GBR (in millions) State Funds	AF	Type of Change Required to Implement	Estimated Number of People Affected	Consequences or Implications
HOME AND COMMUNITY BASED SERVICES (HCBS WAIVERS)					
Home and Community Based Services Waivers HCBS waivers fund home and community based services for persons who are eligible for ICF/MR placement. All HCBS waivers are optional services. This option reflects total elimination of this service to these populations.	($100.7)	($280.7)	Withdraw Federal Waivers	10,982	All persons served by the HCBS waivers will lose long term supports. There may result in a substantial increase in the demand for institutional services.
State Funds AF					
Developmental Disability Waiver ($72.63) ($201.07)				5,792	
Physical Disability Waiver ($19.62) ($58.19)				3,900	
Head Injury Waiver ($2.35) ($5.96)				150	
Technology Assistance Waiver ($0.06) ($0.21)				40	
Serious Emotional Disturbance Waiver ($6.08) ($15.28)				1,100	
The FY03 allotment reduced the waivers by lowering the protected income level, reducing reimbursement rates, and raising the level of care score for the PD waiver to 30. The FY04 GBR reinstates these reductions.					
Reduction in FY2004 GBR: ($3.15) ($8.01) The GBR includes reductions of PD waiver by removing from service those people who were "grandfathered" in when the level of care score (LOC) was raised from 16 to 25. The GBR also reduces the DD waiver for in-home family supports.					

Description of Service or Population	Estimated Reduction Below FY 2004 GBR (in millions) State Funds	AF	Type of Change Required to Implement	Estimated Number of People Affected	Consequences or Implications
Protected Income Level (PIL) Eligibility Persons whose services are funded by the HCBS waivers have protected income levels (PIL) higher than other persons served by Medicaid. This higher protected income is used to pay for these persons rent, utilities, food, transportation, and other living expenses. Their PIL is $716 per month compared with the minimum PIL of $475 per month. This option reduces PIL to $525 per month. The PIL was reduced to $645 as part of the November allotment in FY 03, but was restored to $716 in FY04. **Option** **SGF** **All Funds** **People** Lower to $645 ($0.74) ($1.88) 2,434 Lower to $585 ($1.54) ($3.87) 3,111 Lower to $525 ($2.51) ($6.31) 3,574	($2.5)	($6.3)	Amend Regulations & Federal Waiver	3,574 persons	People in the "spend down group" would need to pay significantly higher amounts for the cost of their care and would have fewer dollars available for non medical expenses.

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Description of Service or Population	Estimated Reduction Below FY 2004 GBR (in millions) State Funds	AF	Type of Change Required to Implement	Estimated Number of People Affected	Consequences or Implications
Accessing the Medicaid Waiver for Persons with Physical Disabilities Eligibility to the PD waiver requires a level of care score (LOC) of at least 26 on a standardized assessment instrument that measures the persons' ability to care for themselves. This option raises the minimum LOC score needed to access services from 26 to 34. This option assumes that persons currently being served by the PD waiver would be removed from services: **Options SGF AF People** 30 or lower ($5.88) ($14.95) 933 34 or lower ($8.26) ($21.39) 1,335 **SGF AF** GBR Reduction: (1.48) (3.77)	($8.3)	($21.39)	Change in the nursing home admission criteria through KDOA and a change in policy and procedures.	1,335 people	This assumes that existing persons receiving services are removed from services. If these persons receiving services were "grandfathered" in, there would be no first year savings, but the service access management (waiting) list would be reduced. Of the 779 people on the waiting list as of January 1, 2003 15% of the persons on the waiting list, or 116 people, have a score of 30 or less; an additional 19% or 147, have a score between 31 and 34. Raising the score would mean that 263 people currently waiting for services would no longer be eligible. If these services are not available, additional persons may choose to enter nursing homes or may enter nursing homes sooner than they normally would.

Description of Service or Population	Estimated Reduction Below GBR (in millions) SGF	All Funds	Type of Change Required to Implement	Estimated Number of People Affected	Consequences or Implications
DIRECT FINANCIAL ASSISTANCE					
General Assistance* General Assistance provides a small cash benefit to very low-income, physically and mentally disabled adults who are applying for federal disability benefits. This option would eliminate 1) cash assistance for this state-funded program, 2) disability advocacy funding which is used to represent claimants, and 3) enhanced funding for intensive services to clients who are at risk of meeting the 24-month time limit. A related consequence of the program elimination is the loss of SRS fee funds received from the Social Security Administration for the reimbursement of SRS assistance during the disability determination period. The following details the savings: GA cash assistance: SGF $7,305,261; All Funds $7,305,261 Disability advocacy contract: SGF 236,992; All Funds 640,000 Intensive services: SGF 334,400; All Funds 500,000 Total expenditures: SGF $7,876,653; All Funds $8,445,261 SRS Fee Fund Revenue: SGF (1,717,676); All Funds (1,717,676) Net Savings: SGF $6,158,977; All Funds $6,727,585 **Reduction in FY2004 GBR:** SGF ($.49); All Funds ($.49) The reduction reflects savings from the 24-month, time-limited General Assistance program. Clients will begin to lose eligibility on January 2004.	($6.2)	($6.7)	Amend Regulations. Cancel KLS contract	3,904 monthly persons	General Assistance recipients would need to rely on other means of financial support and seek federal disability on their own. FY 2003. The disability advocacy contract was reduced by $200,000 in FY 2003. This reduction was restored in FY 2004.

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Description of Service or Population	Estimated Reduction Below GBR (in millions) SGF	All Funds	Type of Change Required to Implement	Estimated Number of People Affected	Consequences or Implications
TAF Benefits* TAF provides financial assistance to very low-income families to meet essential needs. The average monthly benefit for families in Fiscal Year 2003 is $307. This reduction would reduce the monthly cash benefit to families receiving cash assistance. Benefit reduction options follow: Monthly Reduction in Family Cash Benefit / % Reduction From Current Monthly Benefit / Savings SGF / Savings All Funds $10 / 3.2% / $0.0 / $1,908,760 25 / 8.0% / 0.0 / 4,772,400 50 / 16.0% / 0.0 / 9,554,800	($0.0)	($9.5)	Amend regulations. Amend state plan.	15,908 monthly families 41,650 monthly persons	May compromise the ability of some families in paying rent, utility bills, or generally meeting basic living needs. Demands on local helping agencies may increase. Note: A state maintenance of effort (MOE) is required in the TANF program. Any deficit in the MOE must be made up dollar for dollar in the subsequent year. Consequently, no state fund savings are considered.
CHILD CARE SERVICES					

Description of Service or Population	Estimated Reduction Below GBR (in millions) SGF	All Funds	Type of Change Required to Implement	Estimated Number of People Affected	Consequences or Implications
Child Care Subsidies Subsidies for child care are provided to families below 185% of the poverty level using a sliding fee scale. Selected income limit reduction options follow: Income Limit (FPL%) / Families Losing Child Care / Children Losing Child Care / Savings SGF / Savings All Funds 150 / 1,219 / 1,980 / $2,418,616 / $6,069,300 130 / 2,352 / 3,888 / 4,941,145 / 12,399,360 110 / 3,524 / 5,973 / 7,836,134 / 19,664,076 FY 2003. The income limit for Child Care subsidies was reduced from 185 percent of the federal poverty level to 150 percent of the federal poverty level for the period February - June 2003. The income limit was restored to 185 percent of the federal poverty level in FY 2004.	($7.8)	($19.7)	Amend state plan	3,524 monthly families 5,973 monthly children	Child care is a basic support for employment, thus, this reduction may create an increase in cash assistance.

A-1

Description of Service or Population	Estimated Reduction Below GBR (in millions) SGF	All Funds	Type of Change Required to Implement	Estimated Number of People Affected	Consequences or Implications
Kansas Early Head Start Program The Kansas Early Head Start program provides enhanced supports to children and families to encourage appropriate development and success in school for low income children ages 0 to 4 years old. Most children who receive these services would qualify for subsidized child care. This option reflects total elimination of services to this population. It is assumed that the families presently served by the Early Head Start program would apply for child care subsidies. Savings SGF / All Funds Kansas Early Head Start $3,144,013 $7,889,618 Less funding for child care (1,121,876) (2,815,248) Net Savings $2,022,137 $5,074,370 FY 2003. The Early Head Start program was reduced by $300,000 in FY 2003. The reduction was restored in FY 2004.	($2.0)	($5.1)	Grants would not be issued	825 monthly families 825 monthly children	These at-risk families would not have these supportive services available.

CHILD WELFARE SERVICES

Description of Service or Population	Estimated Reduction Below GBR (in millions) SGF	All Funds	Type of Change Required to Implement	Estimated Number of People Affected	Consequences or Implications
Foster Care Statutory Changes Children aged 16 and older would no longer be considered children in need of care except in circumstances of abuse, neglect or abandonment. This would mainly impact children who currently come into the custody of the Secretary due to their own behaviors. This option reflects the total elimination of services to non-abuse and neglect clients age 16 and older who are not in custody on their 16th birthday. **Reduction in FY2004 GBR:** SGF ($3.27) All Funds ($4.76) The GBR includes a 5 percent reduction in foster care contract rates.	($1.6)	($4.3)	Statutory changes	264 youth	Responsibility for dealing with troubled youth aged 16 and older would remain with the family and/or local community.
Adoption Subsidy Program This program provides cash and medical subsidies to families who adopted a special needs child from SRS. 90% to 95% of all children placed for adoption by SRS qualify for an adoption subsidy. This option provides for no growth in the program. Savings SGF / All Funds Cash Subsidy $0.70 / $1.49 Medical Subsidy 0.16 / 0.68 Total $0.86 / $2.17	($0.9)	($2.2)	No new subsidy agreements would be originated	430 children	Adoption contracts may grow significantly as the number of children being adopted could be significantly reduced.

Description of Service or Population	Estimated Reduction Below GBR (in millions) SGF	All Funds	Type of Change Required to Implement	Estimated Number of People Affected	Consequences or Implications
Family Preservation Services This is a contracted service which provides intensive, short-term intervention for families whose children are at imminent risk of removal from the family home and placement in foster care. This option reflects total elimination of these services. **SGF All Funds** **Reduction in FY2004 GBR:** ($3.00) ($3.02) A number of adjustments affected this budget: 1. The base budget was reduced by $1.0 million relative to the FY 2003 approved as a result of the first allotment. 2. An additional reduction of $1.75 million resulted from the second allotment and reflected in the GBR. 3. A 2.5 percent contract rate reductions saving $255,489. FY 2003. Family Preservation reductions in FY 2003 were similar to the FY 2004 reductions as follows: 1. The base budget was reduced by $1.0 million relative to the FY 2003 approved as a result of the first allotment. 2. An additional reduction of $1.75 million resulted from the second allotment and reflected in the GBR. 3. A 2.5 percent contract rate reduction effective February 2003, saving $106,454.	($0.3)	($10.0)	Contracts for family preservation services would be cancelled.	2,574 families	More children may be removed from their homes and placed in foster care.

Description of Service or Population	Estimated Reduction Below GBR (in millions) SGF	All Funds	Type of Change Required to Implement	Estimated Number of People Affected	Consequences or Implications
Community Support and Family Services These programs fund services to families whose children are at risk of being removed from the home and placed in foster care. These services support families in maintaining their children in the family homes. This option reflects total elimination of services. Community Support: Families Served 8,859; Savings SGF $0.0; All Funds $2.6 Family Services: Families Served 403; Savings SGF 1.3; All Funds 3.4 Total: Families Served 9,262; Savings SGF $1.3; All Funds $6.0 FY 2003. In FY 2003, Community Support and Family Services were reduced by $663,993. This reduction was restored in FY 2004.	($1.3)	($6.0)	Grants and allocations would not be issued	9,262 families	More children could be removed from their homes and placed in foster care.

CHILD SUPPORT ENFORCEMENT SERVICES

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Description of Service or Population	Estimated Reduction Below GBR (in millions) SGF	All Funds	Type of Change Required to Implement	Estimated Number of People Affected	Consequences or Implications
Child Support Enforcement Fees - Those not Receiving SRS Aid Currently a fee is charged for every child support payment handled by SRS for a family not receiving TAF, Food Stamps, Medicaid, or a Child Care subsidy from SRS. SRS keeps 34% of this revenue, the remaining two-thirds goes to the federal government. At the present time this fee is 4% of the payment. It could be raised, however, families will withdraw as the fee increases. Raising this monthly fee to the following levels would produce the following revenue but would create competition with Court Trustees who charge 5% or less: **5%** - $42,500 **6%** - $65,000 Note: Above 6% it is estimated enough cases will close so as to actually decrease revenues.	$0.07	($0.0)	Amend regulations. Amend state plan.	3,000 families	Less money is available to the parent to meet household expenses. The state retains 1/3rd of this loss of family revenue, while the federal government receives 2/3rds of it.

Targeted Rate Reductions

An option to target provider groups for rate reductions is available. There are implications to consider before making this decision. Generally, when rates are reduced, the number of providers willing to participate in programs decreases which impacts access to services and continuity of care. Reductions to contracts may have legal implications, but minimally may require services to be prioritized and reduced which will instill a greater responsibility to more efficiently provide services. The ability of community partners and providers to maintain their fiscal integrity must also be considered. Communities may be affected by reduced revenues flowing to the community and greater burdens being shifted to local social service providers.

The FY 04 GBR includes rate reductions for the Foster Care, Family Preservation, and Adoption contracts, the Physical Disability (PD), Head Injured (HI), and Developmental Disability (DD) waivers, inpatient acute care hospital reimbursements, medical transportation reimbursements, MediKan reimbursements to Community Mental Health Centers (CMHCs), and the Pharmacy Average Wholesale Price (AWP). These rate reductions total $5.0 million SGF, $9.1 million all funds for FY 03 and $13.0 million SGF, $26.1 million all funds in FY 04.

Federal Policy Issues

Over one billion dollars, or 60.2% of SRS funding comes from federal sources. Federal funding is integral in meeting the needs of our customers. Increased flexibility in federal funding would improve the Department's ability to more effectively serve customers. The ability to affect change in many programs is impacted by federal regulations. A longer term strategy might include working toward changing federal policies.

Federal funding is often used to meet state priorities. Elimination or reduction of a service or population may result in a state general fund savings, but the corresponding loss of federal funds is disproportionately high and must be considered.

Targeted Federal Policies:

- SOBRA regulations re provision of emergency medical services to illegal aliens.
- Spousal Impoverishment - federal law allows the surviving spouse assets of up to $87,000 to be protected.
- DSH -limited access for use in state psychiatric hospitals.

Some Medicaid expenditures are the result of deliberate efforts to maximize federal resources for services that would otherwise been paid for entirely with state funds. The table below identifies some of these expenditures.

Optional Medicaid Services Used to Draw Down Federal Medicaid to Fund State Priorities		
	SGF	AF
Local Education Agencies This benefit provides federal funding to schools for services provided that are medically related. This service provides significant federal Medicaid funds to defray the cost of special education services.	$0.00	$27.68
Early Childhood Intervention This benefit covers health and developmental services for children with developmental delays and disabilities. Nearly all of these funds are federal Medicaid funds that supplement the early child intervention program administered by Health and Environment.	$0.35	$1.16
Community Mental Health Services for Adults This benefit covers mental health services and supports primarily for persons with severe and persistent mental illnesses. These federal funds provide increased federal funding for community mental health services.	$5.62	$35.41
Behavior Management This benefit covers behavioral health services primarily for children in the custody of the Secretary of SRS and JJA.. This optional service allows Kansas to draw down federal Medicaid funds to pay for required services to children in the custody of the state.	$6.84	$19.14

Appendix A

Poverty Guidelines
Annual Income Guidelines for 1-5 Member Households (HH)

Selected SRS Services	% of 2002 FPL*	HH-1	HH-2	HH-3	HH-4	HH-5
TAF and GA-Cash & Medical	32%	$2,853	$3,844	$4,836	$5,828	$6,819
Elderly/Disabled Persons on SSI-Medical	72%	6,372	8,587	10,802	13,017	15,232
Children 6-18 Medicaid and Medicaid Waivers**	100%	8,860	11,940	15,020	18,100	21,180
Food Assistance and Energy Assistance	130%	11,518	15,522	19,526	23,530	27,534
Children Age 1-5 - Medicaid	133%	11,784	15,880	19,977	24,073	28,169
Pregnant Women & Infants - Medicaid	150%	13,290	17,910	22,530	27,150	31,770
Child Care Subsidy***	185%	16,391	22,089	27,787	33,485	39,183
Children's Health Insurance Program	200%	17,720	23,880	30,040	36,200	42,360

*FPL is the Federal Poverty Level.
**For the remaining months of FY 2003, the % of 2002 FPL for Medicaid Waiver is 87.4%.
*** For the remaining months of FY 2003, the % of 2002 FPL for the Child Care Subsidy is 150%

Appendix B

Current Comparison of Economic Benefits by State

BENEFITS	KANSAS	MISSOURI	OKLAHOMA	IOWA	NEBRASKA	COLORADO
TANF-Cash (average benefit)	$288 (32% FPL)	$245 (23% FPL)	$202 (23% FPL)	$319 (35% FPL)	$332 (29% FPL)	359 (28% FPL)
Food Stamps (maximum benefit for 3)	$366	$366	$366	$366	$366	$366
Medical Limits • TANF Family	34% FPL ($4,836)	77% FPL ($11,565)	25% FPL ($3,755)	35% FPL ($5,257)	50%FPL ($7,510)	31% FPL ($4,656)
• Pregnant Women	150% FPL ($22,530)	185%FPL ($27,787)	185% FPL ($27,787)	200% FPL ($30,040)	185% FPL ($27,787)	133% FPL ($19,976)
• Children Under 1	150% FPL ($22,530)	185% FPL ($27,787)	185% FPL ($27,787)	200% FPL ($30,040)	185% FPL ($27,787)	133% FPL ($19,976)
• Child 1- 5	133% FPL ($19,976)	133% FPL ($19,976)	185% FPL ($27,787)	133% FPL ($19,976)	185% FPL ($27,787)	133% FPL ($19,976)
• Child 6 - 18	100% FPL ($15,020)	100% FPL ($15,020)	185% FPL ($27,787)	133% FPL ($19,976)	185% FPL ($27,787)	100% FPL ($15,020)
• Children's Health Insurance Program	200% FPL ($30,0400)	300% FPL ($45,060)	185% FPL ($27,787)	200% FPL ($30,040)	185% FPL ($27,787)	185% FPL ($27,787)
Child Care Income Limit	150% FPL ($22,536) Reduced from 185% FPL February to June 2003	118% FPL ($17,784)	190% FPL ($28,524)	140% FPL ($20,484)	120% FPL ($17,556) Reduced from 185% FPL eff. 7/02	County Adm. Min 130% FPL ($19,536) Max 225% FPL ($33,804)
• Monthly Fee For TANF Family	0	$1/year	0	0	0	$36
• Monthly Fee at 100% of Poverty	$58	$43	$44	$22	$18	$96

Appendix C

BENEFITS FOR NON-CITIZENS

COVERED NON-CITIZEN GROUP	BENEFITS AVAILABLE			
I. Legal - Entered U.S. on or Before 8-22-96	**CASH**	**MEDICAL**	**FOOD STAMPS**	**CHILD CARE**
• Refugees	Yes	Yes	Yes	Yes
• Asylees	Yes	Yes	Yes	Yes
• Deportation has been Withheld	Yes	Yes	Yes	Yes
• Cuban/Haitian Entrants	Yes	Yes	Yes	Yes
• Amerasians	Yes	Yes	Yes	Yes
• Granted Parole or Conditional Entry Status	Yes	Yes	No	Yes
• Lawful Permanent Residents	Yes	Yes	Yes, effective 4/1/03, once the person has resided legally in U.S. for 5 years.	Yes
• Certain Battered Spouses/ Children	Yes	Yes	Yes	Yes
• Veterans or Active Duty Status (includes spouses and dependent children)	Yes	Yes	Yes	Yes
• Non-citizens who are: - receiving blindness/ disability benefits - 65 years of age or older - under age 18	No	No	Yes	No

II. Legal - Entered U.S. after 8-22-96	CASH	MEDICAL	FOOD STAMPS	CHILD CARE
• Refugees	Yes	Yes, 8 months	Yes	Yes
• Asylees	Yes	Yes	Yes	Yes
• Cuban/Haitian Entrants	Yes	Yes	Yes	Yes
• Amerasians	Yes	Yes	Yes	Yes
• Deportation has been Withheld	Yes	Yes	Yes	Yes
• Granted Parole or Conditional Entry Status	No, until in the U.S. for 5 years	No, until in the U.S. for 5 years*	No, until in the U.S. for 5 years	No, until in the U.S. for 5 years
• Lawful Permanent Residents	No, until in the U.S. for 5 years	No, until in the U.S. for 5 years*	No, until in the U.S. for 5 years	No, until in the U.S. for 5 years
• Certain Battered Spouses/ Children	No, until in the U.S. for 5 years	No, until in the U.S. for 5 years*	No, until in the U.S. for 5 years	No, until in the U.S. for 5 years
• Veterans or Active Duty Status (includes spouses and dependent children)	Yes	Yes	Yes	Yes
• Victims of Human Trafficking	No, until in the U.S. for 5 years	Yes, 8 months	Yes	Yes
• American Indians Born in Canada	No, until in the U.S. for 5 years	Yes	Yes	No
• Certain Members of Hmong and Laotian Tribes	No, until in the U.S. for 5 years	No	Yes	No

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	CASH	MEDICAL	FOOD STAMPS	CHILD CARE
III. Other Legal Non-citizens (regardless of how long in U.S.)	No	*Yes, for emergency medical coverage only (SOBRA)	No	No
IV. Illegal or Undocumented Non-citizens	No	*Yes, for emergency medical coverage only (SOBRA)	No	No

* The individual must meet Medicaid eligibility criteria except for their non-citizen status. Emergency services are defined as services required because of a medical condition manifesting itself by acute symptoms of sufficient severity such that absence of immediate medical attention could result in:

- Placing the patient's health in serious jeopardy
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part.

Labor and delivery are defined as emergency services. Coverage is only for care sufficient to take care of the emergency.
Persons ineligible due to the 5 year bar may also receive coverage for emergency services.

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Appendix D

Medicaid Mandatory and Optional Coverage Groups

In addition to defining the population within the group, Medicaid rules also specify a level of eligibility for coverage. This specific level of coverage is usually selected by the State from an allow able range of incomes. The minima l level of coverage must be provided or Medicaid funding may be sacrificed. If an optional group is selected the conditions of the coverage group often depend upon a minimal level of coverage as well. These required levels are also included below:

MANDATORY COVERAGE GROUPS	OPTIONAL COVERAGE GROUPS
Temporary Assistance for Families (TAF) - Must cover families below 32% FPL ▸ Low-income families with children, eligible at TAF income levels ▸ Families moving from TAF to work ▸ Families moving from TAF to child support	**HCBS waivers** - The protected income level cannot be lower than the medically needy standard: ▸ Expanded coverage through higher protected income level of $716.00 per month ▸ Required disregard of parental income and resources
Poverty Level Eligibles - PLE - Must cover pregnant women and children of specific ages at 1989 levels ▸ Pregnant Women up to 150% ▸ Children at the following levels ▸ birth to one year up to 150% ▸ one to five years up to 133% ▸ six to eighteen up to 100% FPL	**Medically Needy** - Minimal protected income level is $475/month; through a spenddown, persons contribute to the cost of care: ▸ Pregnant women and children ▸ Elderly, disabled and blind persons
Foster Care/Adoption Support - Must cover children in custody under IV-E: ▸ foster care ▸ adoption ▸ juvenile justice	**Women with Breast or Cervical Cancer** - Must cover at level of the FREE to Know program ▸ Uninsured persons up to age 65 ▸ Income level is currently 250% FPL
Supplemental Security Income Recipients - Must cover all SSI recipients ▸ Persons who are disabled or blind ▸ Persons who are elderly	**Working Healthy** - Must cover persons with disabilities with incomes up to 300% of FPL
Medicare Savings Plans (QMB/LMB) - required to cover Medicare premiums and other cost sharing	**MediKan Coverage** - State funded group for persons who are receiving General Assistance or seeking federal disability benefits

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Appendix E

Medicaid Mandatory and Optional Services

The following table compares adult Medicaid beneficiaries only. It is inappropriate to include children in these comparisons because federal regulations of Early Periodic Screening, Diagnostic, and Treatment (EPSDT) preclude significant reduction or elimination of medically necessary services for children. Kansas, like other states provides EPSDT coverage for children to age 20.

Federally Mandated Services[1]	State Option Services
• Emergency Medical Services for Alien Individuals	• Alcohol and Drug Abuse Treatment
• Family Planning Services and Supplies	• Attendant Care for Independent Living
• Home Health Services	• Audiological Services
• Inpatient General Hospital Services	• Behavior Management
• Laboratory and X-Ray Services	• Community Mental Health Center and Psychological Services
• Medical Transportation	• Dental Services. Limited to KAN Be Healthy consumers (children), except for medically necessary extractions.
• Outpatient General Hospital Services	• Durable Medical Equipment, Medical Supplies, Orthotics, and Prosthetics
• Physician Services. This includes pregnancy related services, and some physician extender (i.e., nurse-midwife and nurse practitioner) services.	• Early Childhood Intervention
	• Health Clinics
	• Home or community-based services
	• Hospice Services
	• Inpatient Psychiatric Services. For individuals under age 21
	• Intermediate care facility (ICF/MR) services
	• Local Education Agencies
	• Local Health Department Services
	• Nursing Services (ARNP)
	• Physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders.
	• Prescribed Drugs
	• Pediatric Services
	• Respiratory care for ventilator-dependent individuals.
	• Services for Special Disorders
	• Targeted Case Management for Assistive Technology
	• Vision Services

[1] Federal rules require that when services are reduced or eliminated, they must be reduced or eliminated for all adults covered by Medicaid. However, federal rules for Early Periodic Screening, Diagnostic, and Treatment do not allow for significant reduction or elimination of medically necessary services for children.

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Each service is provided only when medically necessary to the beneficiary. In addition, each provided service must be defined in the Kansas State Plan.

Appendix F

Comparison of Most Common Optional Medical Services for Adults

Optional Services	Kansas	Colorado	Missouri	Nebraska	Oklahoma
Dental Services	Very limited	Very limited	Very Limited	Yes	No
Clinic services.	Yes	Yes	Yes	Yes	Yes
Pharmacy	Yes	Yes	Yes	Yes	Yes, limit to 5 prescriptions per month for HCBS recipients
Optometrist services and eyeglasses.	Eliminated in FY03 Allotment Limited FY04	Limited	Exams; No glasses	Yes	Limited
Transportation services.	Limited	Yes	Yes	Yes	Yes
Rehabilitation and physical therapy services.	Limited to 6 months of rehabilitative care only	Limited to 30 visits per diagnosis per year	Yes	Yes, but limited to restoration of lost function due to illness or injury	Yes
Audiology	Eliminated in FY03 Allotment Yes in FY04	Limited to hearing aids for congenital & traumatic injury hearing loss	Yes	Yes	na
Durable Medical Equipment (DME)	Yes	Limited	Yes	Yes	Yes
Transplants	Limited	Limited	Yes	na	na
Podiatry	Yes	na	Yes	Yes	Yes

Appendix G

Current Comparison of Medical Eligibility by State

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	MANDATORY GROUPS - States must cover certain populations. Some states have different minimal requirements than Kansas because coverage levels for certain groups were frozen at different points over the past several years. In most instances, the level of coverage at the time had to be maintained. Coverage may be expanded for most groups and limitations for reductions are noted.							
	Category	**Minimal Requirements KS Options**	**Kansas**	**Nebraska**	**Missouri**	**Iowa**	**Oklahoma**	**Colorado**
1.	Family Medical under 1931 - (TAF)	AFDC rules in effect 07-16-96	TANF Limit-32% FPL	50% FPL	77% FPL	TANF Limit-35% FPL	TANF Limit-25% FPL	TANF Limit-31% FPL
2.	Transitional Medical - ineligible for 1931 due to excess earnings	Required; income test for 2nd 6 mos effective FY2004	Up to 12 months	Up to 12 months	Up to 12 months; Addtl 12 mos for uninsured parents <100% FPL	Up to 12 months	Up to 12 months	Up to 12 months
3.	Extended Medical - ineligible for 1931 for child/spousal support	Required to cover 4 months	Yes - 4 months	Yes-4 months	Yes	Yes - 4 months	Yes	Yes
4.	Pregnant Women	KS frozen at 150%	150% FPL	185% FPL	185% FPL*	200% FPL	185%FPL	133% FPL*^
5.	Newborns under 1 yr	KS frozen at 150%	150% FPL	185% FPL	185% FPL*	200% FPL	185% FPL	133% FPL*^
6.	Children under 6	KS frozen at 133%	133% FPL	185% FPL	133% FPL*(185)	133% FPL	185% FPL	133% FPL*^
7.	Children under 19	KS frozen at 100%	100% FPL	185% FPL	100% FPL*(185)	133% FPL	185% FPL	100%

	Category	Minimal Requirements KS Options	Kansas	Nebraska	Missouri	Iowa	Oklahoma	Colorado
8.	SSI Recipients and deemed recipients	No options for Kansas - SSI is 75% FPL (1 hh)	yes; current FBR: $552 - single $829 - couple	yes	*** 80% FPL-single $829 - couple	yes	*** more restrictive	yes
9.	Medicare Cost Savings(QMB/LMB)	No options for Kansas	yes	yes	yes	yes	yes	yes
10.	Protected Groups (SSI related-e.g. Pickle)	No options for Kansas	yes	yes	yes	yes	yes	yes
11.	IV-E Foster & Adoption Support	KS expanded, see 15 below	yes	yes	yes	yes	yes	yes

	Category	Minimal Requirements KS Options	Kansas	Nebraska	Missouri	Iowa	Oklahoma	Colorado
12.	SOBRA - Coverage for non-citizens	No options for Kansas	yes	yes	yes	yes	yes	yes
	OPTIONAL GROUPS							
13.	Home and Community Based Services (HCBS) Waivers.	Optional. If an obligation is determined, must not be < 1 person med needy standard	Standard is $645.00 for all waivers	Standard is $738.00 for all waivers, except assisted living - 1 person SSI FBR ($552/month)	For most waivers, standard is $952.00	300% SSI ($1656). Not elig if income > than limit, except Empyd People w/Disabilities waiver - 250% FPL ($1845/mo)	Standard is $259 + $325 allowance for spouse	300% SSI limit for all waivers ($1656). Not elig if income > than limit
14.	Katie Beckett Kids		no	yes	yes	yes	yes	yes
15.	Reasonable Classifications of children < 21	Optional, but many persons would be picked up in other groups	Children in custody Children in institution Adoption sbsdy	Adoption sbsdy	FC children in PLE group Some temp absent children Adoption sbsdy	Children in institution Adoption sbsdy	All children < 21 in custody Adoption sbsdy	All children < 18 in custody Adoption sbsdy
16.	Chafee/ Foster Care Independence Act		no	unknown	no	no	unknown	no
17.	Optional SSI State Supplement	States are required to cover 1972 conversion only	conversion only	yes, expanded	yes, expanded; supp nursing care (res care, non-Mcd facilities) & blind	yes, expanded	yes, expanded	yes, expanded

	Category	Minimal Requirements KS Options	Kansas	Nebraska	Missouri	Iowa	Oklahoma	Colorado
18.	Aged-blind-disabled Poverty Level Group	Levels between SSI and 100% FPL	no	100% FPL Asset Test- $4000 - 1 hh $6000 - 2 hh	no	no	100% FPL	no
19.	Special Institutional Level for NF coverage	If chosen, 300% SSI is maximum	300% SSI	no	no	300% SSI	300% SSI	300% SSI
20.	COBRA Eligibles		no	no	no	no	no	no
21.	Institutional Hospice		no	no	yes	no	no	no
22.	HMO for < min period		no	unknown	no	no	yes	yes
23.	Breast and Cervical Cancer (BCC)	Financial elig limits of the CDC screening program	yes	yes	yes	yes	no	yes
24.	Tuberculosis		no	no	no	no	yes	no
25.	Working Disabled (BBA or TWIAA)		yes	yes	April, 2002	yes	no	no
26.	Medically Needy preg women, aged, children, blind, caretakers, disabled	Yes. If chosen pregnant women and children < 18 must be included	pw, children, aged blind, disabled $475- 1 hh $475- 2 hh person	all groups $392 - 1 hh $392 - 2 hh	No, SPNDWN*** a, d, b; 80% FPL $573 - 1 hh $750 - 2 hh	all groups $483 - 1 hh $483 - 2 hh	no	no
	OTHER OPTIONAL GROUPS/POLICIES							

	Category	Minimal Requirements KS Options	Kansas	Nebraska	Missouri	Iowa	Oklahoma	Colorado
27.	Continuous Eligibility (children)	Periods up to 12 months	12 months	12 months	no	no	12 months	no
28.	Presumptive Eligibility	PW, kids, BCC only	no	PW, kids, BCC	PW, kids, BCC	PW, BCC	PW	PW
29.	SCHIP	Yes. Medicaid MOE	200% FPL	185% FPL	300% FPL*	200% FPL	185% FPL**	185% FPL

Notes:
*Missouri has utilized a Medicaid expansion program for children up to 300% FPL, but imposes nominal cost sharing on families over 185% and expanded cost sharing on families over 225%

***Missouri and Oklahoma are 209(b) states able to set more restrictive criteria. Missouri does not have a medically needy program, but does apply spenddown rules to other groups through 209(b) status

*^Colorado had differing eligibility levels at the time the freeze was implemented, thus setting the minimal threshold below that of Kansas.

Appendix H

Department of Social and Rehabilitation Services

Adjustments included in the Governor's Budget Recommendation

Description	FY 2003 SGF	FY 2003 All Funds	FY 2004 SGF	FY 2004 All Funds
OPTIONAL REGULAR MEDICAL SERVICES FOR CHILDREN				
Incontinence Supplies (see Optional Services for Adults)	--	--	--	--
OPTIONAL REGULAR MEDICAL SERVICES FOR ADULTS				
Pharmacy for Adults • Reduce Pharmacy Reimbursement rate to Average Wholesale Price - 13% • Limit the Number of Branded Prescriptions covered by Medicaid to 5/mo • Limit prescription drug supply to 31 days • Require prior authorization to access Cox II anti-inflammatory drugs	(2,010,267)	(5,158,333)	(7,330,450)	(18,600,000)
Vision Services for Adults • Eliminate coverage	(208,333)	(458,333)	0	0
Audiology Services for Adults • Eliminate coverage	(83,333)	(166,667)	0	0
Durable Medical Equipment • Eliminate coverage for incontinence supplies to adults and children	(166,667)	(416,667)	0	0
OPTIONAL POPULATIONS COVERED BY MEDICAID				
MediKan Program • Move start date for two year limit to 1/1/02 • Reduce MediKan rate to Community Mental Health Centers	(466,667)	(466,667)	(3,598,417)	(3,598,417)
STATE CHILDREN'S HEALTH INSURANCE PROGRAM				
HealthWave (SCHIP) Premiums • Raise premiums	(91,628)	(328,650)	(359,150)	(1,288,200)
FACILITY BASED SERVICES				
Nursing Facilities for Mental Health	0	0	(810,939)	(1,191,000)
Intermediate Care Facilities for the Mentally Retarded • Reduce ICFs/MR rates by 10%	0	0	(784,973)	(1,994,848)
HOME AND COMMUNITY BASED SERVICES (HCBS WAIVERS)				

Description	FY 2003 SGF	FY 2003 All Funds	FY 2004 SGF	FY 2004 All Funds
Home and Community Base Services Waivers • Reduce additional funding for Head Injury waiver • Reduce PD waiver funding approved for the PD waiver waiting list • Reduce family support for DD waiver • Reduce PD, HI, and DD waiver rates	(3,132,787)	(7,860,075)	(3,157,750)	(8,007,538)
Protected Income Level (PIL) Eligibility • Reduce PIL for waivers to $645	(186,635)	(468,931)	0	0
Accessing the Medicaid Waiver for Persons with Physical Disabilities (LOC score) • Eliminate grandfathering for those whose PD waiver Level of Care score is between 16 and 25 • Raise PD waiver LOC score to 30 but grandfather those in service	(382,476)	(960,150)	(1,481,551)	(3,765,060)
DIRECT FINANCIAL ASSISTANCE				
General Assistance • Move start date for two year limit to 1/1/02 • Reduce the TAF and GA disability advocacy contract	($74,060)	($200,000)	($494,729)	($494,729)
Child Care Subsidies • Reduce eligibility from 185% of federal poverty level to 150% FPL	($831,798)	($2,089,944)	$0	$0
Kansas Early Head Start Program • Reduce grants	($119,400)	($300,000)	$0	$0
CHILD WELFARE SERVICES				
Foster Care Statutory Changes • Reduce contract rate by 5%	(1,797,282)	(1,950,637)	(3,273,750)	(4,761,818)
Family Preservation Services • Reduce additional funding for services • Eliminate additional funding for services • Reduce contract rate by 2.5%	(1,948,891)	(2,869,933)	(3,002,091)	(3,018,968)
Community Support and Family Services • Reduce services • Eliminate the emergency shelter case management funding	(632,639)	(663,993)	0	0
OTHER SERVICE REDUCTIONS				
Improve Medicaid Management of Payments	(2,300,000)	(5,778,894)	(2,300,000)	(5,778,894)

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Reduce Inpatient acute care hospital reimbursement rates	(614,840)	(1,544,724)	(4,997,450)	(12,700,000)
Reduce Medical transportation reimbursement rates	(497,500)	(1,250,000)	(1,180,500)	(3,000,000)
Reduce Grants • Early Learning Grants • Prevention grants • Medical policy grant • Mental Health grants • Developmental Disability grants • Rehabilitation grants	(1,029,710)	(2,159,459)	(1,722,724)	(2,940,519)
Reduce Community Mental Health Center State Aid	(2,500,000)	(2,500,000)	(1,500,000)	(1,500,000)
Reduce Community Developmental Disability Organization State Aid	(1,996,500)	(1,996,500)	(1,500,000)	(1,500,000)
Reduce Adoption Contract rates	(247,853)	(360,458)	(618,120)	(900,000)
Tighten eligibility for TAF transitional medical program	0	0	(865,700)	(2,200,000)
ADMINISTRATIVE REDUCTIONS AND FUNDING SHIFTS				
Workforce reductions • Increase SRS Central Office shrinkage rate to 17% • Eliminate Protection Report Center • Increase SRS Field Office shrinkage to 12% • Reduce State Hospital workforce	(4,602,150)	(9,104,607)	(2,314,450)	(4,894,459)
Redesign of the delivery of field services	(97,675)	(206,500)	(294,680)	(623,000)
Grant and Contract reductions • Savings from Child Support Enforcement contracts • Reduce Information Technology contracts • Reduce Human Resource training contract • Reduce EES professional development contract • Reduce ISD Commodities contract • Reduce the foster parent training and recruitment contract • Reduce the disability advocacy contract which assists in obtaining federal disability for children • Reduce Substance Abuse Prevention and Treatment administrative grants • Reduce CDDO administration contract • Reduce other DD contracts	(4,402,301)	(12,204,119)	(3,057,331)	(8,207,965)
Other Administrative Reductions • Reduce State Hospital OOE • Reduce SRS Travel and Supplies • Misc. Reductions	(1,433,100)	(2,269,261)	(660,518)	(1,446,040)

1-43

Funding Shifts • Replace SGF with IGT funding • Replace TANF SGF used for MOE with federal funds (use increase in EITC for MOE) • Replace SGF with federal Mental Health and Substance Abuse Block Grant funding • Replace OSH SGF with one-time Medicare funding • Other Misc shifts	(11,552,023)	(15,500,000)	(10,491,404)	(15,500,000)

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KANSAS
DEPARTMENT ON AGING

PAMELA JOHNSON-BETTS, SECRETARY

KATHLEEN SEBELIUS, GOVERNOR

March 4, 2003

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

Dear Senator Clark:

Thank you for the opportunity to present the Task Force on Medicaid Reform with information on some of the cost-containment strategies that the Kansas Department on Aging (KDOA) has implemented in our Medicaid programs in the recent past.

First, the Department on Aging continually monitors the cost of nursing facility care and Home and Community Based Services for the Frail Elderly (HCBS/FE) waiver. The chart in **Attachment A** reflects the comparison on an annual basis. In addition, the Department of Social and Rehabilitation Services conducted a study to determine the impact of Home and Community Based Services for the Frail Elderly (HCBS/FE) on nursing facility utilization (see **Attachment B**). The results from that study support KDOA's finding that HCBS/FE is a cost-effective alternative to nursing facility placement.

Second, in 2001 the Department on Aging began its' first Program for All Inclusive Care for the Elderly (PACE) in Wichita at Via-Christi. The Federal Balanced Budget Act of 1997 authorized PACE as an optional Medicaid service. The provider accepts a capitated rate in the form of a monthly "premium" that covers all primary, acute and long-term care. Most PACE participants use both Medicare and Medicaid programs. The provider assumes the risk for PACE participants. Most PACE sites are similar to Adult Day Care facilities, providing social activities and meals during the day, and assisting with activities of daily living and medication administration. The sites have a primary care clinic and sometimes provide dental and optometrist services, as well. Therapy can be provided on-site, as needed, as well as transportation to and from the site. However, PACE providers are not allowed to disenroll a participant, except for limited and specific causes. **Attachment C** is a summary of the PACE program.

President's Task Force
on Medicaid Reform
March 5, 2003 #1
Attachments 2- 1

NEW ENGLAND BUILDING, 503 S. KANSAS AVENUE, TOPEKA, KS 66603-3404
Voice 785-296-4986 Fax 785-296-0256 http://www.agingkansas.org/kdoa/

Third, in 2001 the Secretary of Aging created an advisory committee to make recommendations on how KDOA could implement cost containment in our nursing home reimbursement methodology. The Department on Aging has submitted the attached report (**Attachment D**) from that committee to the 2003 Kansas Legislature. The recommendations are on page 6.

Please feel free to contact me if you have further questions or comments at 296-0365. Thank you very much.

Sincerely,

Janis DeBoer
Deputy Secretary

cc: Doug Farmer
Juanita Lewis
Sheli Sweeney
Christy Lane

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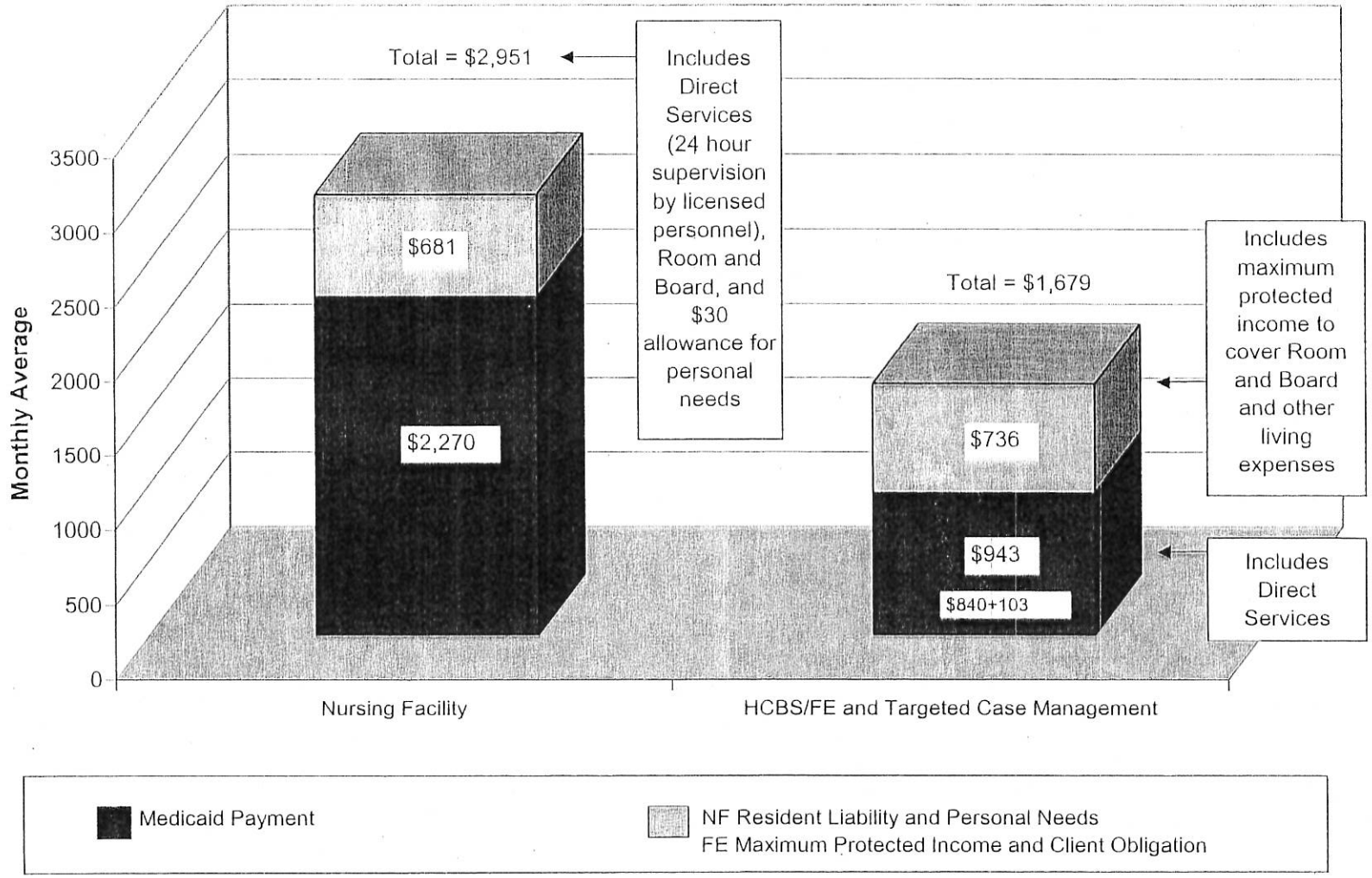
ATTACHMENT A

Average Monthly Expenditures for Medicaid Customers Based on FY 2002 Actual



ATTACHMENT B

Kansas Department of Social and Rehabilitation Services study to determine the impact of HCBS/FE on nursing facility utilization.

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

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

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

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

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

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

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

ATTACHMENT C

Program of All-Inclusive Care for the Elderly (PACE)

PACE is a unique capitated managed care benefit for the frail elderly, featuring a comprehensive medical and social service delivery system. It uses a multidisciplinary team approach in an adult day health center supplemented by in-home and referral service in accordance with participants' needs. Through PACE, today's fragmented health care financing and delivery system comes together to serve the unique needs of each individual in a way that makes sense to seniors with chronic care needs, their informal caregivers, health care providers, and policy makers.

Purpose

PACE provides pre-paid, capitated, comprehensive health care services designed to meet the following objectives:

1. Enhance the quality of life and autonomy for frail, older adults.
2. Maximize dignity of, and respect for, older adults.
3. Enable frail, older adults to live in the community as long as medically and socially feasible.
4. Preserve and support the older adult's family unit.

Eligibility

PACE serves individuals who are:

- aged 55 or older,
- certified by the state to need nursing home care,
- able to live safely in the community at the time of enrollment, and
- live in a PACE service area.

Although all PACE participants must be certified to need nursing home care to enroll in PACE, only about seven percent of PACE participants reside in a nursing home nationally. If a PACE participant does need nursing home care, the PACE program pays for it and continues to coordinate his or her care.

Services

PACE delivers all needed medical and supportive services, the program is able to provide the entire continuum of care and services to seniors with chronic care needs while maintaining their independence in their homes for as long as possible. Care and services include:

- Adult day care that offers nursing; physical, occupational and recreational therapies; meals; nutritional counseling; social work and personal care
- Medical care provided by a PACE physician familiar with the history, needs and preferences of each participant
- Home health care and personal care
- All necessary prescription drugs
- Social services
- Medical specialists such as audiology, dentistry, optometry, podiatry, and speech therapy
- Respite care
- Hospital and nursing home care when necessary

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Key features of the PACE model of care

Flexibility – PACE creatively coordinates the care of each participant enrolled in the program based on his or her individual needs with the goal of enabling older individuals to remain living in the community.

All-inclusive Care – PACE programs provide, coordinate, and oversee all needed preventative, primary, acute, and long-term care including hospital, adult day care, transportation and home care services.

Interdisciplinary Teams – PACE teams that are comprised of physicians, nurse practitioners, nurses, social workers, therapists, van drivers, aides and others, meet regularly to exchange information and solve problems as the conditions and needs of PACE participants changes.

Capitated Payment – The Medicare and Medicaid capitation rates are designed to result in cost savings relative to expenditures that would otherwise be paid for a comparable nursing-facility eligible population not enrolled under the PACE program. The PACE program's capitated payment arrangement allows participants to avoid costly and often preventable nursing home and hospital stays by expanding the range and intensity of services provided. The PACE organization assumes full financial risk for the participant. A participant cannot be disenrolled from PACE because the cost of their care increases.

Perspectives on PACE

For payers, PACE provides:

- Cost savings and predictable expenditures
- Comprehensive service package emphasizing less expensive preventive care
- A model of choice for older individuals focused on keeping them at home and out of institutional care

For health care organizations, PACE provides:

- The freedom from traditional fee-for-service reimbursement restrictions
- The ability to provide a full range of services
- The only fully integrated model of care for frail elderly individuals

For consumers, PACE provides:

- Caregivers who listen to and respond to their individualized care needs
- The ability to continue living in the community as long as possible
- One-stop shopping for all health care services

Additional information regarding PACE is available on the Centers for Medicare and Medicaid Services (CMS) website http://cms.hhs.gov/pace and the National PACE Association home page, http://www.npaonline.org.

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REPORT TO THE 2003 KANSAS LEGISLATURE

by the

Kansas Department on Aging

COST CONTAINMENT ALTERNATIVES FOR KANSAS NURSING FACILITY REIMBURSEMENT

January 13, 2003

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This report, Cost Containment Alternatives for Kansas Nursing Facility Reimbursement, is in response to the 2002 Legislative directive as follows: "The secretary of aging shall present a report to the committee on ways and means of the senate and the committee on appropriations of the house of representatives during the 2003 regular session of the legislature on cost containment alternatives for nursing facility reimbursements for consideration prior to the publication of the proposed reimbursement rules and regulations for the fiscal year ending June 30, 2004."

HISTORY

In 2001, the Secretary of the Kansas Department on Aging (KDOA) established an advisory committee to review and discuss Medicaid reimbursement to nursing facilities in Kansas. The advisory committee consisted of six participants from the nursing facility industry (both for-profit and not-for-profit), two participants from the hospital association, one from the administrator's association, one from the consumer advocacy group, and one staff person from the Kansas Department of Health and Environment (KDHE) and the Kansas Department of Social and Rehabilitation Services (SRS), in addition to three KDOA staff. Trained facilitators from SRS were asked to participate in the group's meetings to assist with the open discussion.

Five meetings were held. A purpose statement was provided as follows: The purpose of these Advisory Committee meetings is to review the methodology for determining Medicaid reimbursement for nursing facilities. Since this will be an advisory committee, decisions made by the committee will not be binding upon the State. We will not request that votes be taken. However, we welcome and appreciate any input you have with regard to Medicaid nursing facility reimbursement.

Two objectives were also established as follows: Our objective is to review and consider modifications to the current system. All discussions and modifications need to ensure: 1) Quality of care for Kansas seniors who choose nursing facility care as an option, and 2) Access to quality nursing facility care for Medicaid recipients.

The group provided feedback and input on changes to the methodology, over the course of several months. KDOA staff reviewed the input and made recommendations to the Secretary. A final meeting was held on January 16, 2002, with the Advisory Committee and information was provided to the group which reflected the decisions made by the Department with regard to changes to the methodology, to be effective July 1, 2002 (see Attachment 1). The changes were budget-neutral.

During the Legislative session and also during the public comment period, there was additional feedback regarding the elimination of the 85% rule, which is one component of the rate setting methodology. In summary, the 85% rule applies an occupancy minimum to the formula to calculate the per diem rate. If the 85% occupancy minimum is not met, the percent is applied regardless, which in turn, reduces the amount received by the nursing facility in the per diem rate. The decision had been to eliminate the rule from all costs, except administrative and plant operating expenses. However, based on additional feedback, it was decided to eliminate the 85% occupancy rule only from those costs that most directly impact resident care. The rule will exempt the direct

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health care costs (i.e., nurses and nurse aides), food, and utility costs. It will still be applied to the administrative, plant operating, and indirect health care costs.

Regulations were changed and the Kansas State Plan was modified to implement the changes in the methodology, to be effective July 1, 2002. During the 2002 Legislative session, however, the Department was directed to reduce its nursing facility budget by $9 million dollars (all funds). In response, the Department proposed a Phase I and Phase II implementation of the new rate setting methodology. The Phase I rates would provide for a 2.937% increase to all nursing facilities across the state. The Phase II rates would include the changes to the methodology, as reflected in the modified State Plan and the regulations. The Phase II rates would be implemented sometime between January 1, 2003, and June 30, 2003. Advance notice would be provided to the nursing facility industry of the implementation date, in addition to the information that was published in the Kansas register in June 2002, which provided the Phase II proposed rate for each nursing facility in Kansas.

COST CONTAINMENT

Specific to the Legislative directive regarding cost containment, the Secretary on Aging reconvened the Nursing Facility Advisory Committee to discuss cost containment options.

The advisory committee met on Tuesday, September 10, 2002. In attendance were representatives from the Kansas Association of Homes and Services for the Aging, the Kansas Health Care Association, Kansas Advocates for Better Care, Kansas Adult Care Executives, the Long-Term Care Ombudsman Office, the Kansas Department of Health and Environment, and the Kansas Department on Aging. Also invited were representatives from the Kansas Hospital Association, and the Kansas Department of Social and Rehabilitation Services.

The group was provided a copy of the language from the 2002 session, as noted above and as follows: "The secretary of aging shall present a report to the committee on ways and means of the senate and the committee on appropriations of the house of representatives during the 2003 regular session of the legislature on cost containment alternatives for nursing facility reimbursements for consideration prior to the publication of the proposed reimbursement rules and regulations for the fiscal year ending June 30, 2004."

Discussion was held on cost containment, incentives, and other options.

COST CONTAINMENT ALTERNATIVES

A base-year model was proposed by staff from KDOA (with mechanisms for pass-throughs and incentives). A base-year model is used in several other states. In essence, it eliminates the use of annual reported costs by the nursing facility industry when determining the rates each year. Instead, a base-year is established, using actual allowable costs as reported by the nursing facility industry, desk reviewed by KDOA auditors, and subject to the upper payment limits. Once the base-year is established, current and future rates are calculated using inflation indexes. Actual reported costs are not considered in future years until it is determined that costs need to be reconsidered or "rebased."

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The advisory group discussed whether the upper payment level or the actual rate should be inflated forward. The committee discussed how often to rebase rates from a cost report submission. Every three years was suggested. There was discussion about the inflation factor and which costs should be included. There were comments that salaries and benefits should not be trended forward from a base year but instead be rebased annually.

INCENTIVES

Coupling an incentive program with a base-year model was also discussed, and the Iowa Accountability Measures model was presented by several members of the advisory committee. The Iowa model applies a point system to ten accountability measures. For a facility to qualify for additional Medicaid reimbursement, it must achieve a minimum score of 3 accountability measures points (Attachment 2). The following indicators are used in the accountability measures:

1. Deficiency Free Survey – Based on the latest annual survey completed and any subsequent surveys completed between specified dates.

2. Substantial Compliance with Survey – Based on the latest annual survey completed and any subsequent surveys completed between specified dates.

3. Nursing Hours Provided – Based on a nursing facility's Case Mix adjusted nursing hours per patient day.

4. Resident Satisfaction – Measured using a Resident Opinion Survey.

5. Resident Advocate Committee Resolution Rate – Nursing facilities that have a resident advocate committee resolution rate of 60% or greater.

6. High Employee Retention Rate – Nursing facilities that have an employee retention rate at or above the 50th percentile.

7. High Occupancy – Nursing facilities with occupancy at or above 95%.

8. Low Administrative Costs and Low Utilization of Contracted Nursing – Nursing facilities with per patient day administrative costs and contracted nursing costs at or below the 50th percentile.

9. Special Licensure Classification – Nursing facilities with units licensed for the care of residents with chronic confusion or dementing illness.

10. High Medicaid Utilization – Nursing facilities with Medicaid utilization at or above a set percentage.

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The committee, overall, supported indicators #2, 3, 4, 5, 6, 8, and 10 with modifications, as needed. Indicators #1 and 7 may also require modification and #9 did not appear applicable. An additional indicator was added, #11, to encourage Medicare utilization.

OTHER ALTERNATIVES

There was also discussion on:

- Promoting Long-Term Care insurance to increase payor sources.
- Encouraging CMS to shift InterGovernmental Transfer and provider bed tax dollars to Federal Financial Participation dollars. This would require action at the federal level.
- Increasing education by KDHE for certified nurse aides and enhancing the CNA curriculum. Also, begin working with the National Association of Geriatric Nurse Aides and state paraprofessionals and the Kansas Medical Society to recruit health care staff.
- Establishing criteria for authorization of new nursing home construction and increased bed authorization.
- Promoting family participation and volunteerism. This would require checking labor laws and liability issues. Also, it was noted volunteers and family members cannot be used to replace staff.

During the meeting, the Legislative Post Audit report was also reviewed. This included discussion on the Level of Care scores for functional eligibility, long term care insurance, and Medicaid eligibility, fraud, abuse and estate recovery.

It was determined by the advisory committee that a second meeting was not required to discuss cost containment alternatives. However, it should be noted that one additional meeting was convened in August 2002 with several members of the Nursing Facility Advisory Committee and other members of the industry, by the Secretary on Aging, to discuss potential revenue enhancements. Revenue enhancement options included discussion on a provider bed tax and establishing a voluntary bed closure program.

SUMMARY

In summary, there has been significant discussion with the nursing home industry representatives and other stakeholders, including the advocacy group representing nursing home residents and families, during the past two years. Progress has been made. The rate setting system has been reviewed and revisions will be implemented using the Phase II methodology. A base-year model is being proposed with this report.

It should also be noted in this report that during FY03, there were two allotment directives received by KDOA. The nursing facility caseload budget was included in the directive. As a result, the Department recommended a reduction to the nursing facility budget of $11 million (all funds) in FY03. The reduction reflects the delay in implementation of the Phase II rates until June 30, 2003.

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RECOMMENDATIONS

1. **Implement the Phase II methodology**. The Phase II methodology, as reflected in the Medicaid updated regulations and State Plan, should be implemented. The changes made to the reimbursement methodology "update" the system and strengthen the various components. The Phase II methodology will complement a base-year model, as recommended below.

2. **Move to a base-year model**. A base-year model, as noted earlier, will eliminate the consideration of costs, as reported by the nursing facility industry, in the rate setting system on an annual basis. It will be necessary to require that costs be reported each year in order to have current costs available for rebasing purposes. In other words, costs will continue to be reported on an annual basis, but an inflation factor will be used to trend the rates forward each year until it is determined a "rebasing" of costs needs to be established which will set a new base-year. A standard practice with a base-year model is to not inform the nursing facility providers of the year the costs will be rebased. Instead, a range (i.e., 3 to 7 years) is used.

3. **Allow for incentives and pass-through mechanisms to be included in a base-year model**. The incentives proposed by Iowa could prove to be very attractive in Kansas in that positive behaviors would be recognized and rewarded in the rate setting system. With regard to a pass-through, this option would allow the State to recognize that certain mandates or costs may exceed the rate of inflation and funding could be passed through as a "add-on" amount to the per diem rate, as deemed appropriate. An example of this activity is the OBRA requirement in 1987 which required 24 hour supervision by licensed nursing personnel.

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ATTACHMENT 1

Kansas Department on Aging
Proposed Changes for Nursing Home Reimbursement

1) Reorganize cost centers and establish new percentage add-ons for the upper payment limit calculations. The cost centers will be Operating, Indirect Health Care, and Direct Health Care.

2) Remove the 85% minimum occupancy rule from Indirect Health Care and Direct Health Care cost centers. Utilities will be included in the Indirect Health Care cost center.

3) Use version 5.12 of the Resource Utilization Group classification logic. This version is used by Medicare and includes added allowances for cognitive impairments.

4) Use Medicaid acuity only to determine the case mix index (CMI) used to adjust the direct health care component of the rates. Do not reset the statewide average CMI to 1.0.

5) Use more "snapshots" or day weighting for the CMI calculations and adjust the Direct Health Care portion of the rates quarterly as opposed to adjusting only the upper payment limit.

6) Split the real and personal property fee from the plant operating costs and inflate the fee. Set an upper payment limit for the real and personal property fee.

STATE OF IOWA

ATTACHMENT 2

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

To: All Medicaid Certified Nursing Facilities

From: Jennifer Steenblock, Long Term Care Program Manager

Date: July 29, 2002

Re: Accountability Measures

Beginning with rates effective July 1, 2002, the case mix portion of your facility's Medicaid rate includes an additional payment component for accountability measures. 441 IAC 81.6(16)(g) describe the accountability measures and the nursing facility characteristics that indicate the quality of care, efficiency, or commitment to care for certain resident populations. These characteristics are objective, measurable, and when considered in combination with each other, deemed to have a correlation to a resident's quality of life and care. While any single measure does not ensure the delivery of quality care, a nursing facility's achievement of multiple measures suggests that quality is an essential element in the facility's delivery of resident care.

In order for a nursing facility to qualify for additional Medicaid reimbursement for accountability measures, it must achieve a minimum score of 3 points. Medicaid reimbursement is available in the following amounts:

0 – 2 points	No additional reimbursement	$0 per day
3 – 4 points	1% of the direct care and non-direct care medians	$.95 per day
5 – 6 points	2% of the direct care and non-direct care medians	$1.91 per day
7 or more points	3% of the direct care and non-direct care medians	$2.86 per day

A total of 10 accountability measure are obtainable. Achievement of each measure is based on your own facility's data compared to established criteria. Listed below are brief descriptions of each measure and the criteria required to achieve the measure. Please refer to 441 IAC 81(16)(g) for a complete description of the criteria, measurement period, point value, and data source of each measure.

Measure #1. Deficiency Free Survey – Based on the latest annual survey completed on or before December 31, 2001 and any subsequent surveys completed between the annual survey date and December 31, 2001. Point value equals 2.

Measure #2. Substantial Compliance with Survey - Based on the latest annual survey completed on or before December 31, 2001 and any subsequent surveys completed between the annual survey date and December 31, 2001. Point value equals 1.

2.14

Measure #3. Nursing Hours Provided – Based on a nursing facility's case mix adjusted nursing hours per patient day. For nursing facilities with nursing hours per patient day at or above 3.204 hours (50th percentile) and below 3.691 hours (75th percentile), the point value is equal to 1. For nursing facilities at or above 3.691 hours, the point value is equal to 2.

Measure #4. Resident Satisfaction – Measured using the Resident Opinion Survey – Form 470-3890. Nursing facilities with an average score of 4.066 (50th percentile) or greater receive 1 point.

Measure #5. Resident Advocate Committee Resolution Rate – Nursing facilities that have a resident advocate committee resolution rate of 60% or greater receive 1 point.

Measure #6. High Employee Retention Rate – Nursing facilities that have an employee retention rate of 72.7273 (50th percentile) or greater receive 1 point.

Measure #7. High Occupancy – Nursing facilities with occupancy at or above 95% receive 1 point.

Measure #8. Low Administrative Costs and Low Utilization of Contracted Nursing – Nursing facilities with per patient day administrative costs of $10.82 (50th percentile) or less and no contracted nursing (50th percentile) receive 1 point.

Measure #9. Special Licensure Classification – Nursing facilities with units licensed for the care of residents with chronic confusion or dementing illness (CCDI units) receive 1 point.

Measure #10. High Medicaid Utilization – Nursing facilities with Medicaid utilization at or above 50.41% receive 1 point.

The regulations covering accountability measures are comprehensive and should be helpful in answering most questions you may have about the criteria for each measure, the measurement period, point value, and the source of the information. The regulation on accountability measures, 441 IAC 81.6(16)(g), is accessible from the DHS web site www.dhs.state.ia.us. If you have questions after reviewing the regulations, please contact Jennifer Steenblock at (515) 281-8839.

Caring Hearts of Wichita
3500 N. Rock Road Bldg 200B
Wichita, Kansas 67226
(316) 634-6999

President's Task Force on Medicaid Reform

I appreciate the efforts of the President's Task Force on Medicaid Reform in dealing with the crisis of the Medicaid programs. As an owner of Caring Hearts of Wichita, a Home Health Agency, I'm always striving to learn ways to decrease the cost and increase the quality of care. I strongly encourage the committee to assess the numerous strategies that will decrease state funds while improving health care to those Kansans in need.

1. **Self-Direct Program**: Eliminate self-direct funding to those families who live under the same household of the disabled client. Families need to be encouraged to participate in the care of the client. Home Health Care could be utilized as a supplemental option.
2. **Independent Living Resource Centers** - ILRC has becomes the middle management for those clients who receive aide services. It would be more cost effective to eliminate the need for the caseworker at ILRC who prepares a duplicate care plan for the client. The client instead of ILRC can decide what agency he/she chooses and the nurse can determine the amount of care needed. Currently a nurse is required to make a plan of care upon admission to an agency for home care and completes the supervisory visits on the aides every 60 days. Eliminating the middle management at ILRC will eliminate the duplication of services provided.
3. **Waiver Waiting List**: Eliminate the waiting list for waived services

- Kansans in nursing homes have no incentives to regain independence and return to the home setting. Example: We have currently received a call from a client that went to a nursing home following a hospital stay. This client would like to go home. However, this client will continue to remain in the nursing home being placed on a waiver waiting list. He will continue to draw unnecessary monies that are required to stay in the nursing home. Money saved by discharging one client from a nursing home could possibly fund approximately three plus clients in their home setting.
- Clients who obtain levels that improve their functional status are hesitant to relinquish their waiver fearing that an exacerbation/set-back could leave them then unable to re-obtain waiver services due to the waiting list. Unnecessary dollars are spent on clients who are not in need of waivered services yet remain on the waiting list. This encourages clients to be dependant on the unnecessary waivered services.

President's Task Force
on Medicaid Reform
March 5, 2003 #1
Attachments 3-1

4. **Home Health Care**

- **EDS** – EDS was the company contracted by Medicaid to handle billing services. Currently providers are experiencing excessive administrative hours spent due to EDS errors resulting in an overpayment/underpayment to the provider. We would suggest more competent billing practices be required for Medicaid to manage Kansas dollars spent.
- **Prior Authorization Unit** – Utilizing the PA unit effect Sept. 1, 2002 has resulted in an increase in hospitalizations due to the lack of timely responses and/or lack of approval for necessary visits. Situations that could be resolved in the home and eliminate the need for excessive dollars resulted in an excess of tax monies needlessly spent. Eliminate the need for the approval of each and every visit and put the judgment upon the physician and nurses. Allow the qualified medical personnel to recognize the need to call if visits indicated exceed more than 1 visit per discipline per day. This will result in a decrease in PA unit staff needed decreasing office overhead expenditures resulting in more dollars available to those Kansans in need.
- Home Health Aides are currently asked to perform nursing tasks that fall outside of their educational scope. This is due to the fact that home health aide services are reimbursed at a lower rate than nurses. Because of the fewer RN visits authorized, client's conditions tend to worsen resulting in increased hospitalizations.
- Clients living at home who are at risk for nursing home placement could benefit from home health services. Services in the home may delay the need for nursing home placement or negate the need for placement altogether.

- **Home Care is the solutions**. A client in need of health care services whether it be skilled nursing services or therapies can receive these services more cost effectively in the home setting vs. outpatient or inpatient (hospital/nursing home). Our goal is to lower cost and improve independence in the clients. Home Care is the solution.

Any further information needed please contact Brenda Carver at 316-634-6999. I would be glad to provide any additional information on the above comments.

Thank you,

Brenda Carver

What's it gonna cost, Doc?

Tom Simpson, MD; Guest columnist

I'm not sure exactly where in my medical training I picked up an interest and a sensitivity to the cost of health care.

My senior year at KUMC (1972) we were asked to write a senior paper as a requirement for graduation. Active in student politics, I visited with the Dean, Dr. David Waxman, who thought that I should know the costs of the orders I was learning to write. "Patient Care Costs at KUMC" helped me complete my requirements for my MD, for which I remain grateful. Waxman must have thought it was pretty good, or at least amusing, and had it published and distributed to my classmates.

In 2003 we physicians find ourselves at the center of a major societal dilemma, i.e. how do we balance a seemingly insatiable desire for more and more healthcare with limited societal resources to pay for it.

Patients need to know what medical services cost and we as physicians have a responsibility to tell them. The cost of our services, their prescriptions, lab and imaging studies, hospital and ancillary services remain a mystery to most patients.

Defined benefit health insurance plans are the current trend from health care financing researchers, employers, and the insurance industry. Employees would be allowed to make their own choices with a fixed amount of money allocated for their health care costs, patients themselves, if they are made to feel they are spending their own money, can control spiraling cost increases. Indeed these plans always involve more out of pocket expense. How can we expect patients to make wise decisions about their health care expenditures if they don't have a clue what anything costs?

The number of uninsured Americans has leveled off at around 40 million. Some of this group are working folks who really are spending their own money.

Charges vary from pharmacy to pharmacy. Generics are usually cheaper than brand name. Hospitals differ in their prices for elective procedures. Physician fees are anything but uniform. Patients really do have choices if only they knew they had choice and the costs of their decisions.

Medicine will never become as consumer oriented or driven as food or transportation. We all make choices about the cost of the food we eat or the car we drive based on our income. Many times patients don't have those choices with health care. When they are faced with trauma or life-threatening medical or surgical disease, cost is usually not the issue. Patients want the best for themselves or their loved ones at any cost and we do our best to provide those services.

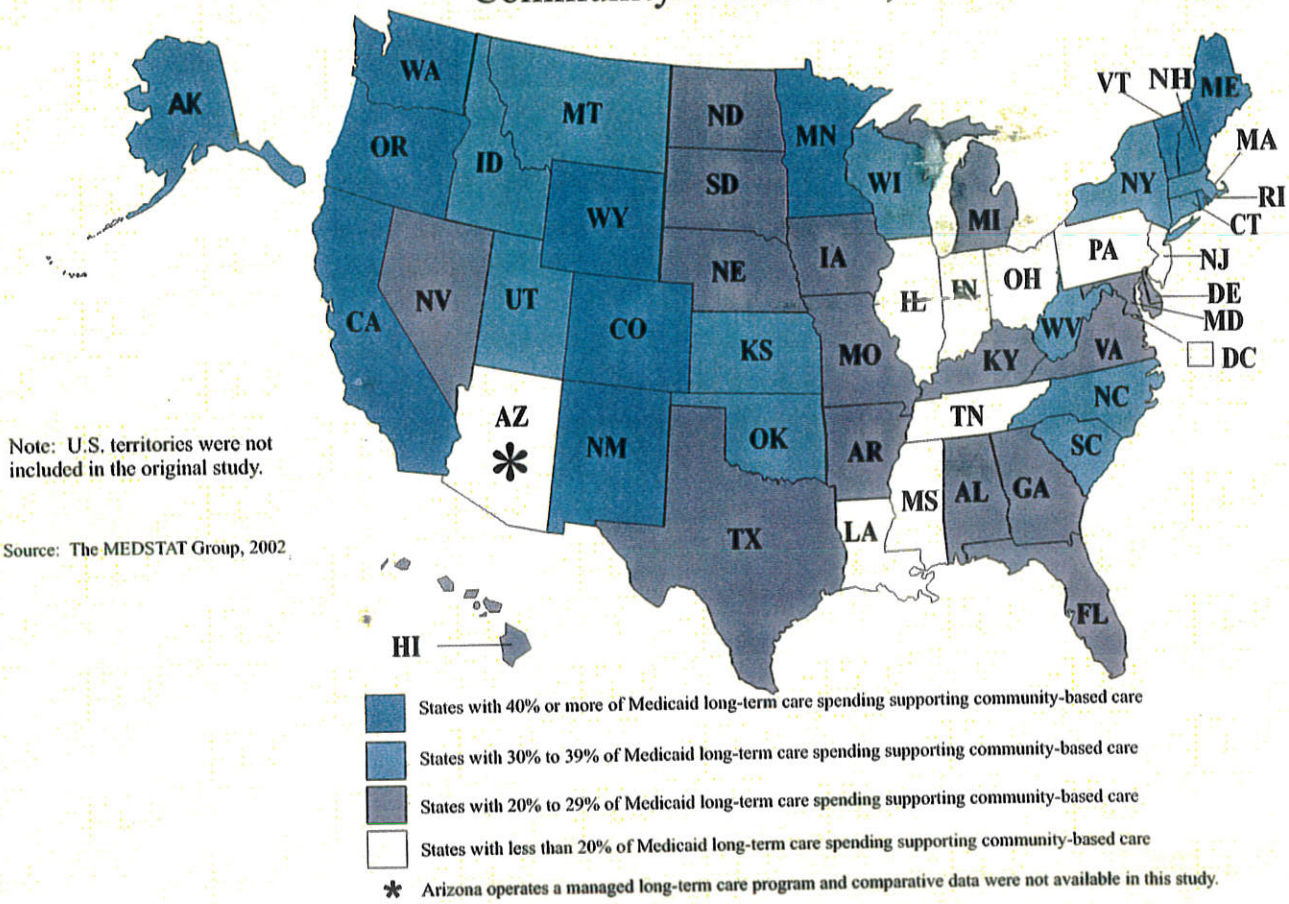
What am I suggesting? First, ask each patient if they have concerns about the cost of the services we are offering? Do they need to know the costs of their prescriptions? Do they want to know the charge for an office visit or for an elective procedure? How about a patient handout regarding the charges for our most commonly provided services?

Secondly, I believe we have a responsibility to become more aware of these costs ourselves. Our patients will always depend upon us to make health care decisions. Cost of care needs to become part of that decision-making process.

I humbly offer my colleagues my thoughts knowing full-well they are only a small piece of the puzzle we all need to be trying to solve. Were they to take me seriously, however, I suspect they would find how little they know about costs of care. Their patients, I suspect, will be pleased with the increased sensitivity they find when they ask "What's it gonna cost, Doc?" ▲

Dr. Simpson practices family medicine in Sterling, Kansas.

Medicaid Long-Term Care Spending for Community-Based Care, FY 2001



Note: U.S. territories were not included in the original study.

Source: The MEDSTAT Group, 2002

Medicaid Long-Term Care Spending

In 2001, Medicaid long-term care spending topped $75 billion, approximately 35 percent of total Medicaid expenditures. Of this amount, 71 percent, or $53 billion was allocated to fund long-term care institutions such as nursing homes and intermediate care facilities for the mentally retarded. The remaining $22 billion was spent on community-based care for people who would otherwise be in an institution.

The Supreme Court decision, *Olmstead vs. LC* (1999), encourages states to reevaluate how they deliver publicly funded long-term care services to people with disabilities. The court ruled that it is a violation of the Americans with Disabilities Act to discriminate against people with disabilities by providing services only in institutions when certain people could be served in a community-based setting. Forty-three states plus the District of Columbia have task forces, commissions or state agency work groups to assess current long-term care systems, address issues surrounding the *Olmstead* decision, and develop state *Olmstead* plans.

In some states, almost half of Medicaid long-term care spending supports community-based care for people who qualify for institutional services. As a result, many more people with disabilities receive services in their homes and communities, which generally are less expensive than institutions. States that rely heavily on institutional care may benefit from other states' experience as they plan to implement the *Olmstead* decision by developing community-based services.

President's Task Force on Medicaid Reform
March 5, 2003 #1
Attachments 5-1

K A N S A S

JANET SCHALANSKY, SECRETARY

KATHLEEN SEBELIUS, GOVERNOR

DEPARTMENT OF SOCIAL AND
REHABILITATION SERVICES

March 3, 2003

The Honorable Stan Clark
Chair
President's Task Force on Medicaid Reform
Statehouse, Room 449-N
Topeka, KS 66612

Dear Senator Clark:

On February 17th, the President's Task Force on Medicaid Reform heard from many conferees on the issue of long-term care. Attached please find followup information related to the following questions that were raised during that committee meeting:

(1) Provide the agency's position on the use of one waiver.

(2) Briefly describe the Working Health program, including outcomes tracked and a description of the Independence Plus Waivers and Cash and Counseling programs.

(3) Describe how the money could follow a person from a nursing facility to the community and what the cost ramifications might be.

(4) Provide information on the requirements of "sheltering" assets on the front-end and estate recovery on the back-end.

(5) Provide suggestions for statutory changes to deter the sheltering of assets.

If I can be of further assistance, please do not hesitate to call.

Sincerely,

Janet Schalansky
Secretary

cc: Emalene Correll, KLRD

President's Task Force
on Medicaid Reform
March 5, 2003 #1
Attachments 6-1

915 SW HARRISON, 6TH FLOOR, NORTH WING, TOPEKA, KS 66612
Phone 785-296-3271 Fax 785-296-4685 http://www.srskansas.org

1. What is the agency's position on "one waiver?"

SRS has conducted research over the years about how one waiver could be utilized in Kansas. We have also held conversations with the Centers for Medicare and Medicaid Services to gain a better understanding of how one waiver would work. Following is a summary of the research SRS has conducted and the conclusions that research has enabled us to draw:

HCBS waivers are designed for people to waive their right to receive Medicaid-funded services in an institutional setting and choose community-based services instead. The waivers Kansas administers use several different types of institutional alternatives as the service which people choose to waive. For example, the Frail Elderly and Physical Disability waivers both utilize the nursing facility as the institutional alternative; the Developmental Disabilities waiver uses the ICF/MR as the alternative; and the Head Injury Waiver utilizes the Head Injury Rehabilitation hospital as the alternative.

States that have attempted to move to one waiver have utilized the nursing facility as the alternative for all disability groups with the exception of developmental disabilities. Some states have carved out the developmental disabilities population and have a separate waiver for persons with developmental disabilities in order to address the institutional alternative issue.

There are three reasons SRS believes one waiver would not work in Kansas given the current array of services offered within the HCBS waivers:

- In Kansas, three of our six waivers (Developmental Disabilities, Serious Emotional Disturbance, and Technology Assisted Children) serve children under age sixteen. Because current regulations do not allow persons under age sixteen to be admitted to a nursing facility, we could not have one waiver in Kansas for all disability types.

- In a one waiver environment, case management services and needs assessments would continue to require trained persons in specialized areas of disability. For example, someone trained or specializing in developmental disabilities services would not be doing assessment and case management for children who require assistive technology to sustain life as is seen on the Technology Assisted Children's waiver.

- The state can only have one service package available in a waiver, and access to medically necessary waiver services cannot be limited once a person is on the waiver. Given that the menu of services available under one waiver would be much larger than is now the case, increased administrative time and case management time would be required under one waiver to help families understand they can only access the waiver services they need.

In a growing trend across the nation, states are moving to multiple waivers. Other states have found that having multiple waivers can provide the state with additional management tools and that multiple waivers allow for design of more specific service packages. Given the research we have conducted, the current array of services offered in Kansas, and the flexibility we are able to garner by having several waivers, SRS could not support moving to one waiver at this time.

2. Brief description of Working Healthy, including outcomes tracked, and including description of Independence Plus Waivers and cash and counseling programs.

***Working Healthy*: The Kansas Medicaid Buy-In Program**

Fear of losing health insurance has been identified as one of the major employment barriers for adults with disabilities. Established to eliminate this barrier and promote employment, *Working Healthy* is a work incentive program that allows employed adults with disabilities to pay monthly premiums in order to maintain their Medicaid coverage. *Working Healthy* began on July 1, 2002, with an enrollment of 150 people. Enrollment as of January 31, 2003, is 549 individuals.

To enroll a person must:

- be between 16 and 64 years of age;
- meet the Social Security definition of disability;
- verified earned income subject to FICA/SECA;
- have countable income less than 300% of the Federal Poverty Level;
- have assets less than $15,000;
- be a Kansas resident

In addition to having a higher income level, *Working Healthy* enrollees are able to have retirement accounts.

SRS, partnering with the University of Kansas, is in the process of tracking the following information for *Working Healthy*:

- monthly enrollment/disenrollment;
- number of premium payers; amount of premiums billed and paid;
- previous Medicaid eligibility category, if any;
- medical costs;
- number of enrollees who receive SSDI, Medicare, and/or other health insurance;
- annual pre-tax earnings;
- increase in earnings;
- program satisfaction (based on personal surveys);
- quality of life issues (based on personal surveys)

Independence Plus 1115 Waiver and Cash and Counseling

SRS is in the process of designing an *Independence Plus* 1115 Waiver to provide Personal Assistance Services (PAS) for individuals enrolled in *Working Healthy* who require such services to live and work in the community. The advantages of developing an *Independence Plus* Waiver for this population are:

- the ability to define the waiver population as *Working Healthy* enrollees who require PAS, and to design a waiver specific to the needs of a working population;
- the ability to include more than one disability population;
- increased consumer control over the planning of services and the resources chosen;
- the inclusion of a "cash and counseling" model, in which eligible consumers are permitted, within an established plan, to determine their services and providers, and are given the funds to purchase such services. (This model is presently being used in five states.)

3. Provide a description of how the dollar could follow the person from nursing facilities to the community and what the cost ramifications might be.

In consultation with stakeholders from the Independent Living community SRS and KDOA are currently studying ways in which funding could follow people out of nursing facilities to HCBS waivers for persons who are frail elderly or who have physical disabilities. This is a way for people who are living in nursing facilities and would like to live in the community to do so, without adding their names to long community services waiting lists.

The Texas Legislature included a rider in the state's 2001 appropriations bill to accomplish this goal. In Texas, every three to six months an estimate of the total dollars needed to serve people who have moved from a nursing facility to the community is calculated, and that amount is transferred to the community services budget. This does not reduce the number of beds available in nursing facilities in the state.

SRS and KDOA are exploring ways in which a similar budget transfer could work in order to ensure Kansas seniors and Kansans with disabilities are able to live in their own homes. In the first year, SRS and KDOA would plan to help up to 75 people move to the community by effecting budget transfers. A decision can be made then, based on the results of the first year, about how many people would be able to take advantage of this opportunity in the second year and future years.

There are a few issues SRS and KDOA need to consider to ensure the successful implementation of funding following people to the community: (1) transition plans to ensure people have the necessary resources in place when they move to the community, (2) protocols to assure health and safety after people transition, and (3) what the ramifications would be of some plans of care being more expensive in the community than in the nursing facility.

Kansas Department of Social and Rehabilitation Services

Medicaid Eligibility For Long Term Care, Treatment of Resources

Elderly or disabled persons applying for or receiving Medicaid coverage are subject to a resource test. This means that the value of the persons resources (or assets) are considered in the eligibility determination. In general, persons whose countable resources exceed the limit are not eligible for Medicaid.

For persons in long term care arrangements, the resource limit is dependent upon the individuals marital status. For single persons the limit is $2000.00; for a married person, the limit is established through application of the Spousal Impoverishment rules.

All resources in which the applicant/recipient has ownership interest are considered for the determination (see attached chart). For personal property jointly held with others, the full value of the resource is counted. For real property jointly held with others, a pro rata share of the value is countable.

Baseline Requirements

States are required to follow the same rules and processes of the federally administered Supplemental Security Income (SSI) program for Medicaid eligibility determinations. In other words, assets that are countable for SSI are countable at the same level for Medicaid and become the baseline standards. Less restrictive methodologies and rules may be adopted by states.

Spousal Impoverishment

Spousal impoverishment rules are special provisions for a married persons in long term care. Both resource and income rules as well as certain process issues are addressed. Resource rules apply when a married person requests long term care coverage:

- In the first month of long term care, an initial assessment is completed. Total countable resources owned by either or both spouses are summed.
- If total resources are less than the federal minimum standard of $18,132, the spouse in the long term care is resource eligible.
- If resources exceed this amount, one half of the resources are protected for the spouse in the community up to a maximum level of $90,660.
- Minimum and maximum levels are set by federal law and Kansas does not use higher standards. Federal rules prohibit using lower standards.

Spousal Impoverishment income rules:

- Income is used to determine the individual's patient liability. The patient liability is the amount the Medicaid recipient must contribute toward their cost of care. The monthly Medicaid payment to the facility is reduced by the patient liability.
- The gross income of the spouse in long term care is considered when establishing the patient liability.
- The patient liability can be reduced by allocating income to the community spouse and dependent family members.

Kansas Department of Social and Rehabilitation Services
Nursing Facility Case Examples : Mary and Maggie

ary and Maggie are both 86 year old Kansas residents entering a nursing facility in February, 2003. It is assumed both meet all other eligibility factors.

Event	Mary
	Resources: $50,000 **Home: $50,000** **Income: $900.00/month**
NF Entrance (2-03)	Total countable resources of $50,000 exceed $2000 limit. Mary is not eligible.
Resource Level Reached (05-03)	Mary reapplies as total resources now equal $1800. $48,200 had been spent on her monthly NF bill ($3000/mo.). Mary is now resource eligible as she is below $2000 standard.
Medicaid Coverage Begins (3-04)	Monthly patient liability is determined: Mary's income $900.00 Health Insurance -$ 70.00 Needs Allowance -$ 30.00 Patient Liability: $800.00
Ongoing Medicaid Payment	Medicaid monthly payment for Mary: NF daily rate = $100.00 x 30 day month (average) $3000.00 Less patient liability: -$800.00 Medicaid payment =$2200.00
Mary Passes Away (12-05)	Estate Recovery files probate claim on home and personal assets. Claim based on total Medicaid expenditures for Mary for period 10-03 to 12-05.

Event	Maggie and Jack	
	Total Combined Resources: $50,000 **Home in which Jack lives: $50,000** **Income: Mary- $900.00; Jack - 1193.00**	
NF Entrance (2-03)	Initial assessment completed & Community Spouse Resource Allowance determined Total combined countable resources: $50,000 / 2 = $25,000 is protected for community spouse (Jack) Remaining $25,000 considered for Maggie. Resources exceed $2000 level for Maggie and she is not eligible.	
Resource Level Reached (10-03)	Application filed for Maggie as her share now down to $1000. $24,000 had been spent on her monthly NF bill ($3000/mo.) Jack still has $25,000. Maggie is resource eligible.	
Medicaid Coverage Begins (10-03)	Monthly patient liability is determined: Maggie's Income: $900 Allocated to Jack: -$300 Health Insurance: -$ 70 Needs Allowance: -$ 30 Patient Liability: $500.00	Allocated income: Minimum Community Spouse Allowance: $1493 Jack's Income: - $1193 Amount that can be: $300 allocated from Maggie
Ongoing Medicaid Payment	Medicaid monthly payment for Maggie: NF daily rate = $100.00 x 30 day month (average) = $3000.00 Less patient liability: -$ 500.00 Medicaid payment: $2500.00	
Maggie passes Away (12-05)	Jack survives. Estate recovery claim is postponed.	
Jack Passes Away (12-06)	Estate recovery claim filed on Jack's estate. Claim based on total Medicaid expenditures for Maggie for period 10-03 to 12-05.	

Kansas Department of Social and Rehabilitation Services

CURRENT RESOURCE RULES

RESOURCE	STATE POLICY RULE	FEDERAL POLICY RULE
Bank Accounts (checking accts, savings, CD's, credit union, etc), and Cash	Countable in full.	Same
Stocks and Bonds	Countable in full; U.S. Savings bonds are not considered a resource for the first 6 months, as they cannot be cashed in	Same
Retirement Funds such as IRA, KEOUGH, 401(k), some annuities	Countable in full unless the individual is employed. For non-applicant/recipient spouses, the value of the fund is exempt	Same
Home and Surrounding Land	Exempt if spouse or dependent family member resides in the home or if individual intends to return home.	Same
Life Insurance	Policies with no cash value exempt in full. Exempt if total face value of other policies < $1500. Cash surrender value is countable for all other policies	Same
Income-Producing or Business- Related Property	Exempt in full if producing income consistent with fair market value. *Proposed State Regulation eff 07-03 would remove this exemption and adopt federal standard	Federal requirement requires exempting land up to a value of $6000 and producing a rate of return up to 6%.
Vehicles	One vehicle per household exempt (no equity limit); additional vehicles exempt if required for work, medical transportation or specially equipped for disability Vehicle may be non traditional (such as an RV or moped)	Federal requirement sets equity limit of $4500 for the vehicle OR if required for work, medical transportation or specially equipped for disability.
Personal Effects/Home Furnishings	All exempt	Federal requirement exempts one wedding ring, medical equipment and $2000 of other items.
Burial Funds/Funeral Agreements	Exempt prepaid burial space, casket, vault, urn, crypt, headstones, opening and closing of grave regardless of value. In addition, exempt up to $1500 earmarked for burial or up to $3500 irrevocable burial trust agreement.	Same; $3500 limit based on state law.

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Kansas Department of Social and Rehabilitation Services

RESOURCE	STATE POLICY RULE	FEDERAL POLICY RULE
Trust Funds/Annuities	Countable in full if available. Trusts allowed in OBRA 93 (disability pay back and pooled trusts) are exempt if established appropriately. Note that other assets otherwise exempt (e.g. the home) lose exempt status upon placement into a trust arrangement.	Same Kansas does not treat discretionary trusts funded by others as a resource.
Other Real Property such as land, buildings and life estates	Countable in full unless making a bona fide effort to sell.	Same
Other Personal Property such as boats, mineral rights	Countable in full unless making a bona fide effort to sell (non-liquid assets only).	Same
Potential Resources	Persons required to seek and cooperate in obtaining all potential resources available to them.	Same
Transfer of Property	Persons transferring certain properties without receiving fair market value in return are subject to periods of ineligibility for reimbursement of long term care expenses.	Same
Voidable Transfers of Property	Transfers of property which are not subject to penalty may be voided by Estate Recovery in an effort to protect a future claim.	No federal requirement

6-8

UPDATE - LPA RECOMMENDATIONS ON ASSET SHELTERING AND LONG TERM CARE	
2001 AUDIT RECOMMENDATIONS	**AGENCY ACTIVITY**
1. SRS should review and adjust its eligibility requirements accordingly to bring them more in-line with other states in terms of caps, criteria, limits, and the like. Specific issues highlighted where Kansas is more liberal: • No limit on value of automobile • Full exemption of income-producing property • No limit on personal effects and furnishings • Exemption of pre-paid funeral arrangements	• Eligibility policies continue to be reviewed on an ongoing basis. No changes made in regards to vehicle or personal effect provisions. KAR change submitted for July 2003 to reinstate $6000 limit on non-business related income producing property. Pre-paid funeral arrangements are exempt by state law. • Begun random review of long term care cases to identify resources being reported to better analyze the extent of potential estate planning and loopholes. Initial results should be available over next several months. • Have recently reviewed intent to return policies of other states in regards to treatment of out-of-state homes exempted under this policy. Explored possibility of raising residency issue but appears federal provisions would prohibit this. Have also explored possibility of setting time limits on intent to return and reviewing further evidence regarding ability of consumer to return to their home. Both issues are however prohibited based on both Medicaid and SSI guidelines. • Adopted restriction on transfer of exempt income producing property so that it is subject to $6000 limit and thus a transfer penalty. Also established transfer provisions to require that a spouse assert his or her rights to their lawful share of the estate of a deceased spouse. **OTHER OPTIONS EXPLORED:** • Setting a $4500 limit on vehicles primarily aimed at persons in institutions who cannot drive and whose transportation needs are met by the institution. This has potential to close an estate planning loophole but will require more work on the part of staff to establish values. Will be pursued further. • Establish $2000 limit on personal effects and home furnishings. Appears there are numerous caveats on this policy based on SSI rules and result is often that these assets aren't considered. Would require much work on the part of staff and consumers to get valuations of property. Do not plan to pursue. Most of these items are recovered through estate recovery processes.

UPDATE - LPA RECOMMENDATIONS ON ASSET SHELTERING AND LONG TERM CARE	
2001 AUDIT RECOMMENDATIONS	**AGENCY ACTIVITY**
2. To help ensure that applicants for Medicaid assistance for long term care provide complete information about the assets they own or have recently placed in trust, SRS should do the following: a. require applicants to provide additional documentation at the time they apply for Medicaid including recent residential address, copies of income tax returns, real estate deeds, and local property tax bills, bank statements, and life insurance policies. b. routinely and systematically conduct cross matches with the CAMA and motor vehicle registration data bases as well as any other relevant data bases maintained by other state agencies to determine whether applicants own additional assets that could be used to help pay for their long term care.	• Agency staff routinely require much of the documentation referred to in this recommendation including real estate deeds (and checks of local county records), bank statements, trusts, and life insurance policies. Agency also does annual cross matches of IRS data which serves the same purpose of requiring income tax records. • Ongoing training provided to staff regarding verification requirements and identifying assets. Staff instructed to forward many items to Central Office for review including trusts, annuities, life contracts, and other assets connected with potential estate planning activities. • State motor vehicle record access is already available online. It is not routinely used for long term care consumers as vehicles are currently exempt. The CAMA data base mentioned is through Dept. of Revenue but review of the system has revealed the information to be difficult to work with. County record information has been more accessible. • Additional documentation requirements at the point of application could be adopted but would increase processing times and workload issues as well as create a burden on the applicant/family.
3. To help ensure that SRS and the Legislature have relevant information to plan for needs of long term care, SRS should routinely compile commutative data about the number of persons applying for Medicaid assistance for long term care. At minimum that information should include the number of applicants and the number of applications denied and approved. The Department also should identify and compile information about the methods applicants are using to inappropriately shelter assets, and should provide that information to its staff.	• Quality Control staff have begun to randomly review long term care cases to inventory assets and ascertain potential estate planning activity. Review instrument currently being tested and initial data should be available within the next several months. This process was felt to be more productive than routine data on number of applicants and number of approvals/denials.
4. To ensure that applicants who've inappropriately transferred assets don't have to wait longer than federal regulations required to receive Medicaid benefits, SRS should promptly and regularly update the figure it uses to calculate the penalty period that should be imposed. That figure should reflect the current average monthly costs of nursing home care for a private-pay patient.	• The divisor was updated last July to $3000. No further update required at this time and it will continue to be reviewed on an annual basis.

UPDATE - LPA RECOMMENDATIONS ON ASSET SHELTERING AND LONG TERM CARE

OTHER AGENCY ACTIVITIES/PROPOSALS

- Legislature proposal submitted to establish lien authority to help prevent property transfer and protect estate recovery rights.
- Implemented 2002 legislation which provides that unspent monies in pre-paid funeral agreements be transferred to the Department for estate recovery purposes.
- Proposals were previously developed to limit joint property ownership for Medicaid recipients and to limit development of certain discretionary trusts but not pursued at this time.
- Reviewing proposal to expand the definition of an estate for purposes of estate recovery to include assets that would normally pass to survivors or other beneficiaries including joint tenancy property and life insurance proceeds. Current federal provisions allow for this and proposal would be incorporated as a KAR change (in the estate recovery regulation, 30-6-150) rather than a statutory change. If approved this would increase collections substantially. Would be controversial however to do as a regulation since the state law definition of estate is narrower.
- Currently tracking waiver request Connecticut submitted to CMS to permit extending the current 3 year look back period for transfers to 5 years. CMS has yet to issue a final decision even though waiver submitted last summer. If approved, Department intends to request similar waiver.
- Working with Department on Aging to develop promotional/educational campaign regarding private long term care insurance to help divert consumers who see Medicaid as the only source of long term care coverage.

Kansas Department of Social and Rehabilitation Services

Estate Recovery

All persons who receive long term care services are subject to estate recovery except:

- Recovery is delayed if a spouse survives. A claim is filed against the spouse's estate in the future.

- Recovery is prohibited if surviving children are under the age of 21 or disabled

Estate Recovery is a means to recover medical costs from the estate of a Medicaid recipient. The amount of the total claim is equal to medical expenses paid while on assistance. A claim can only be made if there is an estate in which to recover. Resources which do not enter the estate are not recoverable. For example, joint tenancy properties, property held in a living will and properties with a homestead assertion are generally not recoverable.

In most instances, assets exempt in the eligibility determination are recoverable by the estate recovery unit. These include:

- the home and surrounding property
- personal possessions (furniture, household goods, etc)
- vehicles
- business and other income producing property
- assets remaining in a disability payback trust
- excess funeral funds
- bank accounts, nursing facility accounts, stocks, bonds, etc.

Recommendations for Future Statutory Changes to Deter Sheltering of Assets as part of Medicaid Estate Planning in Kansas.

1. Lien authority for estate recovery. Adopt legislation similar to SB497 presented in the 2002 session which permitted the agency to establish a lien on the real property of a Medicaid recipient who has been in a long term care facility for a year or more. The lien would be enforced at the time of sale or upon the death of the individual for repayment of their Medicaid expenditures.

2. Legislation changing the definition of an estate, for estate recovery purposes, to include jointly owned property. Such property currently passes to a survivor upon the death of the other joint owner and is not available for estate recovery purposes.

3. Legislation outlawing property owners to specify a certain percentage of ownership of jointly owned property. A recent Kansas Court of Appeals decision allowed a Medicaid recipient to add an additional owner to exempt property without penalty and avoid estate recovery. The new owner received only 1% ownership while the recipient retained 99%. This did not result in a penalizable transfer but did remove the property from the recipient's estate and prohibits the agency establishing a claim at the time of death.

4. Legislation that requires discretionary trusts funded by people other than the consumer (or spouse) to be considered a resource for public assistance purposes. Refusal to pay for necessary medical care from the trust would be considered a breach of fiduciary duty and contrary to public policy. This would overrule a longstanding District Court case that allowed such trusts to be exempted for Medicaid purposes.

5. Legislation to limit the scope of contracts established between a Medicaid recipient and his or her family members to provide basic services to the recipient over their lifetime in exchange for a large prepayment. Those contracts established solely for socialization services such as visitation and transportation for appointments and errands would be considered as a transfer of assets solely to obtain Medicaid coverage and result in a penalty. The agency has seen an increase in such contracts whereby, for example, the recipient gives his or her family $50,000 or more to perform such duties instead of using the money for medical needs.

S Stan Clark

From: Emalene Correll [EmaleneC@klrd.state.ks.us]
Sent: Wednesday, February 05, 2003 10:10 AM
To: Stan Clark
Subject: Medicaid Uodate

National Conference of State Legislatures 444 North Capitol Street, N.W., Suite 515
Washington, D.C. 20001
202-624-5400 202-737-1069 (fax)

Fact Sheet
State Health Care Partnership Allotment

Overview

The Administration proposes to establish a new state option under Medicaid and the State Children's Health Insurance Program (SCHIP). Federal Medicaid, SCHIP, Disproportionate Share Hospital (DSH) payments, and related administrative costs, would be transformed into two lump-sum allotments, one for acute care and one for long term care. States would be permitted to transfer up to 10 percent between allotments. Administrative costs would be limited to 15 percent of the state's allotment and DSH payments would be considered administrative funds. States would receive higher payments from the federal government for the first seven years of the program. These payments would be reduced in years 8-10 to make the overall effort budget neutral to the federal government over the 10-year period. Under the proposal, states would be given significant flexibility in determining eligibility and benefits for optional population groups.

State Allotments

The size of each participating state's allotment will be determined using the state's FY 2002 expenditure levels as a base. This amount will be increased annually using a trend rate based on medical inflation, utilization and population (the details of this formula are not currently available). The proposal includes a maintenance of effort (MOE) provision that will be initially determined based on the state's FY 2002 expenditures. A state's MOE will be inflated annually by a trend rate that will be based primarily on medical inflation1.

According to Administration sources, the federal payment to participating states would exceed the amount the state would have received under the existing program in the first seven years. Growth in federal payments in years 8-10 will be reduced so that at the end of the ten-year period, the expenditures would be budget neutral to the federal government. The Administration estimates that $3.25 billion will be available in FY 2004 and that $12.7 billion will be available between FY 2004- FY 2014.

State Requirements

In addition to the MOE on state expenditures, states will be required to continue to provide mandatory Medicaid benefits to individuals who are entitled to Medicaid coverage (see attachment).

Treatment of State Children's Health Insurance Program (SCHIP) Funds

States have three years to spend each fiscal year's SCHIP allotment. At the end of three years, any unspent funds are pooled and redistributed among states that spent all of their allotments for that fiscal year. These redistributed funds are available to states for one more year. After the fourth year, all unexpended funds expire and are returned to the federal treasury. As you know, many states have not been able to spend their SCHIP funds within the three-year timeframe and have contributed to a pool that redistributes the unspent funds to states that have expended their funds.

A rst glance, it would appear that states that have been unable to expend their S funds, could protect their SCHIP funds from redistribution due to the pooling of Medicaid and SCHIP funds. Alternatively, if a large number of states were to opt into the program with protection of their SCHIP funds, states dependent on the redistribution pool would face a greatly diminished pool. The Administration has no position on the treatment of SCHIP funds regarding redistribution at this time, but are interested in feedback.

Treatment of Non-Participating States

There will be no change for states that do not choose to participate.

Medicaid Mandatory Beneficiary Groups/Services

Mandatory Populations

Children below federal minimum income levels
Adults in families with children (Section 1931 and TMA) Pregnant women with incomes at or below 133% FPL Disabled SSI beneficiaries Certain working disabled Elderly SSI beneficiaries Medicare Buy-in Groups (QMB, SLMB, QI-1, QI-2)

Mandatory Services (Acute Care)

Physician
Laboratory and X-ray
Inpatient hospital
Outpatient hospital
Early and periodic screening, diagnostic, and treatment (EPSDT) for individuals under age 21 Family planning services and supplies Federally-qualified health center (FQHC) Rural health clinic Nurse midwife Certified nurse practitioner

Mandatory Services (Long Term Care)

Nursing facility (NF) for individuals aged 21 and older
Home health care (for individuals entitled to NF care)

Medicaid Optional Beneficiary Groups/Services

Optional Populations

Children above federal minimum income levels
Adults in families with children (above Section 1931 minimum) Pregnant women with incomes above 133% of FPL Disabled Individuals (above SSI income level) Disabled (under home and community-based care waivers) Certain working disabled individuals (above SSI income level) Elderly (above SSI; SSP-only recipients) Elderly nursing home residents (above SSI income level) Medically needy

Optional Services (Acute Care)

Prescription Drugs
Medial care or remedial care furnished by licensed practitioners under state law
Diagnostic, screening, preventive, and rehabilitative services Clinic services Dental (including dentures) Physical therapy and related services Prosthetic devices, eyeglasses Tuberculosis treatment and related services Primary care case management
Other specified medical and remedial care
Optional Services (Long Term Care)

Intermediate care facility for individuals with mental retardation (ICF/MR) Inpatient and nursing facility services for individuals ages 65 or older in and institution for mental diseases (IMD) Inpatient psychiatric hospital services for individuals under age 21 Home

h services Case management Respiratory care services for ventilator-dependent individuals Personal care
Private duty nursing
Hospice
Services furnished under a PACE program
Home and community-based (HCBS) services (under budget neutrality waiver)

Source: Kaiser Commission on Medicaid and the Uninsured

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