MINUTES

JOINT COMMITTEE ON HOME AND COMMUNITY BASED SERVICES OVERSIGHT

November 19-20, 2009
Room 143-N—Statehouse

Members Present

Senator Carolyn McGinn, Chairperson
Representative Bob Bethell, Vice-chairperson
Senator Laura Kelly
Senator Kelly Kultala
Senator Dwayne Umbarger
Representative Jerry Henry
Representative Peggy Mast (November 20)

Members Absent

Representative Brenda Landwehr
Representative Melody McCray-Miller

Staff Present

Terri Weber, Kansas Legislative Research Department
Reed Holwegner, Kansas Legislative Research Department
Amy Deckard, Kansas Legislative Research Department
Kathie Sparks, Kansas Legislative Research Department
Doug Taylor, Office of the Revisor of Statutes
Nobuko Folmsbee, Office of the Revisor of Statutes
Jan Lunn, Committee Secretary

Conferees

Carole Jordan, Director, Rural Development Division, Kansas Department of Commerce
Don Jordan, Secretary, Kansas Department of Social and Rehabilitation Services
Craig Kaberline, Executive Director, Kansas Area Agencies on Aging Association
Martin Kennedy, Acting Secretary, Kansas Department on Aging
Tina Langley, Director of Information and Community Resources, Kansas Department on Aging
Corey Mohn, Coordinator, Office of Rural Opportunity, Kansas Department of Commerce

Heather Pierce, 2-1-1 Coordinator, 2-1-1 Information and Referral Search Service, United Way of the Plains
Dr. Jane Rhys, Executive Director, Kansas Council on Developmental Disabilities
Mark Shiff, Section Director, Children and Youth with Special Needs Section, Kansas Department of Health and Environment
Tom Akins, Vice President for Development and Planning and CEO, Brewster at Home, Brewster Place
Monte Coffman, Executive Director, Windsor Place
Dr. Helen Connors, Chairperson, e-Health Advisory Council
Aaron Dunkel, Deputy Secretary, Kansas Department of Health and Environment
Doug Farmer, Deputy Director, Kansas Health Policy Authority
Bill McDaniel, Commissioner, Senior Services, Kansas Department on Aging
Larry Pittman, CEO, Kansas Foundation for Medical Care
Dr. Ryan Spaulding, Director, Center for TeleMedicine and TeleHealth, University of Kansas Medical Center

Others Attending

See attached list.

Thursday, November 19
Morning Session

Chairperson McGinn called the meeting to order at 10:05 a.m. and welcomed those attending.

Amy Deckard, Kansas Legislative Research Department (KLRD), reported that representatives from the Division of the Budget, Department of Social and Rehabilitation Services (SRS), Kansas Health Policy Authority (KHPA), Kansas Department on Aging (KDOA), Juvenile Justice Authority (JJA), and KLRD recently met to revise human services caseload estimates for FY 2010 and to make initial estimates for FY 2011 (Attachment 1). She noted that optional services and waivers are excluded from the estimate. The estimate for FY 2010 was increased by $24.3 million from the State General Fund (SGF) and $40.2 million from all funding sources. The estimate for FY 2011 increased by $118.4 million from the SGF and $51.6 million from all funding sources above the revised FY 2010 estimate. Ms. Deckard indicated that American Recovery and Reinvestment Act of 2009 (ARRA) funding ends December 31, 2010 (halfway through FY 2011) resulting in substantially increased FY 2011 estimates for State General Fund expenditures.

At the last meeting, Ms. Deckard was requested to submit information related to total funding for community developmental disabilities (DD) programs from all funding sources (not just waiver funding sources). Ms. Deckard distributed a spreadsheet containing the requested information (Attachment 2). Committee members discussed the information and requested an enhanced report containing case load estimates for FY 2010 by item and FY 2011 agency requests including enhancements and without enhancements. Ms. Deckard indicated that information would be presented later in the day or during the November 20, 2009 meeting.

Secretary Don Jordan, SRS, was recognized to report on requests for clarification on questions raised at the October 14, 2009 meeting. Secretary Jordan provided information on the following (Attachment 3):

- Home and Community Based Service (HCBS) programs and requested enhancements, state grants, and budget cuts contained in HCBS programs;
- The number of individuals waiting for physically disabled (PD) waiver services at the conclusion of FY 2010, and the definition of "crisis" exceptions;
- The cost and number of individuals served through crisis services by specific waiver;
- The number of children served by the autism waiver;
- Information on the Parent Fee Program (by waiver) and revenue generated by this program, how the fee schedule is determined, and consequences (if any) for non-paying families;
- The status of the review by the Centers for Medicare and Medicaid Services (CMS) related to fee schedules;
- Admissions to Kansas Neurological Institute (KNI) and Parsons State Hospital (PSH) programs and whether these admitted individuals were receiving waiver services prior to admission;
- The number of individuals on DD waivers prior to and after the Winfield closure;
- The number of individuals at the Winfield facility and their disposition following closure;
- The impact or experience of other states who have closed DD institutions;
- Costs for DD waiver programs in Kansas and other states;
- Costs for tiers of service and number of individuals within each tier at KNI and PSH, including current reimbursement rates;
- Detailed information concerning waiver enhancement requests;
- Clarification on recent PD waiver audits; and
- An overview of the Sexual Predator Treatment Program (SPTP), including the number of individuals in the program, their current location, and the average cost per individual in the Program.

Committee members expressed concern that the FY 2011 waiver enhancements indicate expenditure estimates are above budgeted projections. Secretary Jordan stated these enhancements are to maintain the current level of services. Following questions from Representative Henry, Secretary Jordan indicated that without these enhancements, program changes could occur. Considerable discussion ensued regarding the agency's expenditure projections; reasons for the higher number of individuals being served without explanation or documentation as to reasons for the increase; negotiated reimbursement rates; and whether expenditure projections have been underestimated in the recent past. Committee members also focused on the possible implementation of sliding fee scales; whether fees currently in place have undergone review to ensure the appropriateness of fees in today's economy; whether a review has

occurred to ensure those eligible to pay a sliding fee for services are actually paying; and whether the actual revenue collected is reasonable for the number of individuals who are required to contribute under a fee schedule program.

Committee members discussed the high costs associated with the SPTP, its treatment phases and standards, transitions within the program, and how the Kansas SPTP compares to other states.

Senator Kultula requested information related to a chart submitted by Secretary Jordan outlining percentages, by tier, of all persons allocated funding for HCBS MR/DD services for Residential Supports, Day Supports, and In-Home Supports (for adults and children) from FY 2004 through FY 2010 (see page 4 of Secretary Jordan's written testimony Attachment 3). Senator Kultala commented that, for In-Home Child services, the trend appears to be inverted in relationship to the trend for other service types. Secretary Jordan indicated he would research the question further and provide the information to Senator Kultula and other Committee members.

Representative Bethell asked whether historical information was available as to the reasons individuals in "crisis" were approved for waiver services. Secretary Jordan indicated that information was available and would be categorized and provided to Representative Bethell and other Committee members.

Chairperson McGinn requested clarification from Ms. Deckard regarding whether any cost savings could be realized with the reduction or elimination of any optional waiver services included in Medicaid spending. Ms. Deckard indicated that the spreadsheet for optional services by type, actual costs from the SGF, and all funds, as well as projected costs, are being updated by the KHPA. It is anticipated the information will be available in early December. She also indicated that she could provide the FY 2008 information (including projections for FY 2009 and FY 2010). In response to a question, Ms. Deckard stated it is her understanding that until federal ARRA stimulus dollars end (December 31, 2010) optional population eligibility cannot be changed or eliminated and, therefore, changes are prohibited. However, optional services could be changed or eliminated after December 31, 2010.

Ms. Deckard presented an overview of the Facilities Closure and Realignment Commission recommendations (Attachment 4). Representative Bethell, who is a member of the Commission, provided additional information about the Commission's deliberation and recommendations.

Chairperson McGinn recessed the meeting at 12:00 p.m. and announced the meeting would reconvene at 1:30 p.m.

Afternoon Session

Chairperson McGinn reconvened the meeting at 1:38 p.m. and recognized Dr. Jane Rhys, Executive Director, Kansas Council on Developmental Disabilities.

Dr. Rhys indicated that as a result of questions at the October meeting, she surveyed other states (Attachment 5) to determine how persons with a developmental disability who have been accused of committing a felony, but are incompetent to stand trial, are handled. Responding states included Alaska, Hawaii, Maine, Massachusetts, New Mexico, Oklahoma, Vermont, and Washington. The majority of the respondents indicated some level of dissatisfaction with their current programs. Dr. Rhys elaborated that issues exist in all states, including the difficulty in identifying a person with

a developmental disability and whether to place the individual in a separate facility or a community environment. Dr. Rhys reported that, in her opinion, the most promising systems appear to be in Vermont and Oklahoma, who provided clear direction and funding for their programs.

Heather Pierce, 2-1-1 Coordinator, 2-1-1 Information and Referral Search Service, United Way of the Plains, provided information on how this service can strengthen access to available services (Attachment 6). Ms. Pierce explained the 2-1-1 service in Kansas and its purpose to empower people to access services. The program also provides opportunity to assist people desiring volunteer opportunities. At the current time, 80 percent of the program is covered by land line telephones with mobile access being developed. The program also provides disaster response assistance. Ms. Pierce provided historical and current information on the number of calls received by the program. She outlined the top ten call categories for Kansas and detailed the aging and disability-related calls received.

Craig Kaberline, Executive Director, Kansas Area Agencies on Aging Association (K4A), was recognized. Mr. Kaberline provided an overview of the organization (Attachment 7) indicating that in Kansas, area agencies on aging are the single points of entry that coordinate the delivery of publicly funded community based services needed by Kansas seniors and their caregivers. Mr. Kaberline distributed a booklet entitled *Explore Your Options* to each Committee member that included information specific to his or her district. The booklet is a comprehensive publication that is used by individuals for information relative to available services for Kansas seniors. The booklet is available on the KDOA website, as well as other distribution points, including hospitals, nursing facilities, assisted living facilities, meal sites, doctors' offices, SRS facilities, home health agencies, libraries, senior centers, health fairs, various support groups, and some post offices.

Chairperson McGinn recognized Martin Kennedy, Acting Secretary, KDOA, who introduced Tina Langley, Director of Information and Community Resources at KDOA. Ms. Langley reported on the Kansas Aging and Disability Resource Connection (ADRC) program which resulted from federal grants from CMS and the Administration on Aging (Attachment 8). The ADRC program is designed to serve individuals who need long-term support, families and caregivers, people planning for future long-term support needs, and agencies and organizations that serve older adults and persons with disabilities. Key partners for the Kansas ADRC project were discussed. The referral and call log system, consisting of methods to share information among agencies, was discussed. The implementation timeline for this project also was reviewed.

Mark Shiff, Section Director, Children and Youth with Special Needs Section, Kansas Department of Health and Environment (KDHE), informed Committee members on the Make A Difference Information Network (MADIN) which is a collaborative effort among KDHE, the Kansas State Board of Education, SRS, and Oral Health Kansas (Attachment 9). MADIN's purpose is to connect Kansans and service providers with resources and services for individuals with disabilities. Mr. Shiff elaborated that 2-1-1 and the MADIN web site are channels in which to access information and that MADIN is a requirement of the Title V Block Grant.

Carole Jordan, Director, Rural Developmental Division, Kansas Department of Commerce, distributed her written testimony (Attachment 10) outlining the creation and purpose of the Division. Ms. Jordan discussed the importance of "value added" programs for rural Kansas and rural communities. Rural Development Division staff members work to push state and federal dollars into rural areas to help these areas and communities meet their goals. Ms. Jordan also discussed the Office of Rural Opportunity, and its satellite offices, and their work to assist towns in leveraging dollars for health projects and healthy communities. Ms. Jordan introduced Corey Mohn, Coordinator, Office of Rural Opportunity, who briefly reported on the importance of collaboration and developing partnerships to improve the total health of Kansas' rural communities.

Chairperson McGinn adjourned the meeting at 3:45 p.m.

Friday, November 20
Morning Session

Chairperson McGinn called the meeting to order at 9:08 a.m. and welcomed those attending. Chairperson McGinn indicated the minutes of the meeting held on October 14, 2009, were previously distributed and *upon a motion by Senator Kelly and a second by Representative Bethell to approve the minutes as written, the motion passed.*

Chairperson McGinn placed a call to the 2-1-1 access service. As noted during the November 19, 2009, meeting, to demonstrate the type of information available to the public, 2-1-1 provides toll-free access for Kansans to talk with trained specialists. Calls are answered 24 hours a day, seven days a week, and all calls are confidential. Chairperson McGinn spoke with a specialist who provided information on the services and agencies available to assist her with a scenario she described. Committee members expressed appreciation for the service and the simplicity it provides for accessing information.

Chairperson McGinn recognized Aaron Dunkel, Deputy Secretary, KDHE, who reported that KDHE is the state designee for the health information technology (HIT) initiative (Attachment 11). In this role, KDHE is to facilitate the creation of strategic and operational plans for a Health Institute Exchange (HIE) infrastructure. Discussion followed related to funding from federal grants and federal stimulus dollars (ARRA) for state HIE development. Mr. Dunkel reported that although there will be an initial infusion of stimulus dollars for implementation, on-going expenses will occur and must be addressed to ensure the implemented model is sustainable. Information on the e-Health Advisory Council (eHAC), its structure and membership, its five domain workgroups, and other partners and stakeholders involved in this project was presented and discussed.

Doug Farmer, Deputy Director, KHPA, spoke about the involvement of KHPA in the project (Attachment 12). He indicated Health Information Technology for Economic and Clinical Health Act (HITECH) provides incentive funding for health care providers that achieve "meaningful use" of health information contained in the exchange. KHPA is responsible for administering incentive payments for meaningful use of HIT by Medicaid providers. Currently, the national administration has begun working on an administrative definition of "meaningful use." Once a definition is published, KHPA will work with stakeholders and policy makers to operationalize the standard in Kansas. Senator Umbarger encouraged Mr. Farmer to work with the state's Joint Committee on Administrative Rules and Regulations so that, as a definition is finalized at the federal level, appropriate state action will occur.

Dr. Helen Connors, Chairperson, eHAC, presented testimony related to the Committee's five domain work groups, the structure and purpose of the domain work groups, and an organizational chart outlining the state's HIT governance structure (Attachment 13). Dr. Connors also described the work of the eHAC since August 2009. Proposals submitted for possible funding through ARRA include expanding the Chronic Disease Electronic Management System with a grant request of $2.8 million; a funding request for $4.3 million to provide essential workforce training through seven community colleges, as well as Kansas State University and the University of Kansas; a funding request for $9 million for the creation of a Regional Health Information Technology Center (RC) for the state; and a funding request for $10 million to develop the infrastructure to achieve widespread and sustainable health information exchange within and among states through the meaningful use of certified electronic health records (EHR). All funding request notifications will

occur in the next several months. Dr. Connors discussed the challenges involved in the project, such as implementation of broadband in rural areas, long-term sustainability, and statutory or policy revisions within federal and state law. Questions from Committee members included how the education partners were selected, how the private sector integrates and partners with the eHAC, and how the eHAC is funded. Dr. Connors responded that education partners were selected based on which facilities had healthcare informatics curricula in place and where the greatest need existed. In partnering with the private sector, Dr. Connors assured Committee members conversation had occurred with the Cerner Corporation and will occur with other similar business and industry leaders to develop skill set needs for education. Dr. Connors stated all members of the eHAC are volunteers and no funding is received.

Larry Pittman, President and CEO of the Kansas Foundation for Medical Care (KFMC), discussed his involvement in the project. Since KFMC's purpose is to facilitate the improvement of healthcare in Kansas, that entity was invited to submit a proposal to the Office of the National Coordinator (ONC) for Health Information Technology to serve as the Regional Extension Center for Kansas. If awarded, KFMC will provide expert technical support (subsidized by federal funds) to over 1,200 primary care providers who are interested in adopting EHRs or using existing systems to achieve "meaningful use" incentives (Attachment 14). Mr. Pittman reported incentives up to $44,000 per Medicare provider over five years and up to $63,750 per Medicaid provider over six years are possible. To qualify for incentives, the provider must meet the "meaningful use" definition, exchange health information that improves the quality of care, and report on quality measures. Family practice, OB/GYN, internal medicine, and pediatrics practitioners are eligible for incentives, as well as community and rural health centers serving under- and uninsured Kansans. Mr. Pittman also reported on the project's scope, and its short- and long-term program goals. Committee members discussed the EHR and how to ensure a standard e-health system purchased by providers is capable of information exchange. Mr. Pittman reported that any system that is approved by the Certification Commission for Healthcare Information Technology (CCHIT), the United States certification authority for EHR and their networks, guarantees the system's capability for health information exchange. Senator Kelly inquired whether medical care cost savings could be realized with implementation of an HIE and whether cost savings will be incorporated into the evaluation or as a success measure of the HIE. Mr. Pittman indicated there had been cost-savings studies conducted and that, in his opinion, cost savings would be realized. Senator Kelly encouraged evaluation of current costs to serve as a baseline that could be used as a performance measure (after exchange implementation) to document declining medical costs in future years.

Bill McDaniel, Commissioner, Program and Policy Commission, KDOA, provided an update (Attachment 15) on the evaluation of the Windsor Place At-Home Care telehealth pilot project. He reported the pilot project began in 2007 and will cover three years. The pilot will be completed October 31, 2010. The University of Kansas Research Institute serves as the contracted entity responsible for evaluation of the pilot project. A final evaluation report will be available in 2010.

Mr. McDaniel introduced Dr. Ryan Spaulding, Director, Center for Telemedicine and Telehealth, Health Policy and Management, University of Kansas Medical Center, to discuss the statistical evaluation of the pilot project. Dr. Spaulding submitted written testimony (Attachment 16) indicating that this pilot project was intended to provide an indication of feasibility and effectiveness and although there were many lessons learned, the data is not statistically conclusive even though most participants clearly believed his or her condition improved as a result of telehealth. Dr. Spaulding stated that, in his opinion, a larger group and better control would provide improved data. Select participants were followed for two years and some were followed for only one year. Healthcare utilization and the costs associated with visits and services were collected. All CMS claims information for these participants were gathered to track variables before and after the project began. One variable, emergency room visits, decreased significantly. From a research perspective, data skewing could have occurred due to the multiple services received at end of life. Dr. Spaulding

indicated a more complete report will be made after further results are compiled. He indicated that additional research will attempt to determine when telehealth is most helpful based on patient condition and what age group will realize the greatest benefit from telehealth.

Monte Coffman, Windsor Place Executive Director, distributed his testimony (Attachments 17 and 18) which included a detailed summary of telemedicine or telehealth. He defined telemedicine services as those encompassing a specialist involved in referral services, patient consultations via direct transmission links or internet communication, remote patient monitoring, medical education, and consumer medical or health information. Benefits of telehealth include access, quality improvement, and efficiency or lower cost of care. Mr. Coffman described various tools used in telehealth and provided a graphic algorithm of the monitoring process. Mr. Coffman reported that the savings for telehealth services as compared to nursing facilities (NF) were approximately $2,000 per month per individual. If 500 Kansas seniors could be deferred from NF placement, an annual savings of $12 million could be realized with the use of telehealth in the home under HCBS waiver services. Cost savings also could be realized for consumers on the PD waiver by utilizing telehealth in the home to avoid hospitalizations or NF placement. Mr. Coffman indicated the initial cost of monitoring equipment is $250 and the monthly cost is $180, or $6 per day. Committee members discussed the presentation, specifically focusing on the potential for cost reductions while improving patient outcomes. Questions were raised as to whether telehealth monitoring could interface to an EHR via a regional HIE. Mr. Coffman reported this possibility is included in the future of telehealth. Mr. Coffman indicated an enhancement request through KDOA was made for an additional 410 and 500 telehealth units. Committee members also discussed how this could be achieved in the KDOA budget by inclusion in HCBS FE waivers and, therefore, reducing the number of seniors presenting for costly services in LTC facilities. Committee members expressed concern over the lack of provisions in the budget process that could accommodate the shifting of funding from one program to another, especially where cost savings could be realized or the budget remains unchanged.

Tom Akins, Vice President of Development and Planning, Brewster Place Retirement Community, discussed the Brewster at Home model (Attachment 19), which is a membership-based organization providing the services people need, when they need them, in the home. The model includes socialization opportunities such as community activities; a network of providers who offer services such as housekeeping, meals, massage therapy, and handyman services; and telemonitoring such as medication dispensers, monitoring equipment, and detection sensors that notify a caregiver if a person is potentially unsafe. Mr. Atkins spoke about the need for facilities such as Brewster Place to undertake demonstration projects that will provide information for legislators to implement sound decision making and data-driven public policy.

Chairperson McGinn recognized Amy Deckard who provided follow-up information to earlier Committee requests in the "Community Funding for Individuals with Developmental Disabilities (Revised)" (Attachment 20) and "Detailed Estimates of Optional Spending in Medicaid" (Attachment 21) handouts. Dustin Moyer, KHPA, substantiated Ms. Deckard's earlier comments regarding the elimination or reduction of optional services. Ms. Deckard reminded Committee members that the optional services spending chart is in the process of revision. Chairperson McGinn requested that the finalized chart be forwarded to Committee members.

Chairperson McGinn reviewed the charge of the Joint Committee on Home and Community Based Services Oversight, which was followed by Committee discussion. Based on testimony heard and Committee deliberations, the Joint Committee on Home and Community Based Services Oversight made the following recommendations:

- **2-1-1 Service.** Agencies under the oversight of the Joint Committee on Home and Community Based Services Oversight are encouraged to provide all relevant

information to the 2-1-1 Information and Referral Search Service on the services their agencies offer.

- **Sliding Fee Scales.** The Department of Social and Rehabilitation Services is directed to provide to the Oversight Committee an analysis of the Department's policies concerning sliding fee scales for all HCBS Waiver programs to include:
  - Whether applying a sliding fee scale is appropriate for the particular waiver program;
  - Where a sliding fee scale is appropriate, the assumptions and formula that will be used to develop the fee scale;
  - For sliding fee scales already in use, a review of the appropriateness and adequacy of the current structure to include the number of individuals required to pay for some portion of the services received, the number of individuals making the required payment, and the total dollars received by the state; and
  - For current and proposed sliding fee scales, how the Department will develop baseline data to determine the efficiency, effectiveness, and equity of the fee scales.

- **Crisis Services.** The Department of Social and Rehabilitation Services and the Department on Aging are requested to continue to monitor and analyze the provision of waiver services in crisis situations to include:
  - A categorization of the crisis that precipitated the request for emergency waiver services;
  - The number of individuals who received crisis services; and
  - The number of individuals who requested but did not receive crisis services, and the reason they did not receive services.

- **Statewide Health Information Exchange Initiative.** The eHealth Advisory Committee is requested to provide periodic updates to the appropriate legislative committees concerning the Advisory Committee's work, including the:
  - Application for and receipt of federal health information technology/health information exchange (HIT/HIE) grants; and
  - Development of criteria and data elements to be used to measure healthcare cost savings resulting from the implementation of the Statewide Health Information Exchange Initiative.

- **Telehealth Pilot Project.** The Department on Aging is directed to continue to support and fund the telehealth pilot project currently being conducted to include:

- Forwarding to the Governor for his consideration, the Committee's recommendation that the Department's telehealth budget enhancement request be fully funded. In addition, the Oversight Committee notes the potential cost avoidance or cost savings in other program areas following the enactment of this enhancement request; and

- Investigating the possibility of using an accounting model similar to that for the Money Follows the Person program, where funding is transferred periodically between agencies or accounts, or both.

- **Budget and Policy Changes.** The appropriate legislative committees and members of the executive branch are requested to analyze the fiduciary, program service, statutory, and regulatory impact of:

  - Amending the current budget process to create an additional budget adjustment type to classify where programmatic changes, including the addition of new initiatives, would result in immediate or future cost savings, or cost neutrality. The amended process should specifically address instances where the cost savings or cost neutrality would cross programs or agencies, or both; and

  - Reducing or eliminating certain optional services or optional populations, or both, currently funded in the state's Medicaid Program following the conclusion, in December 2010, of the enhanced federal Medicaid match rate authorized in the federal American Recovery and Reinvestment Act of 2009.

- **Build Community Capacity.** The Department of Commerce, through its Office of Rural Opportunity is requested to investigate the entrepreneurial opportunities available to build community services capacity as state institutions are identified for closure.

Chairperson McGinn thanked all conferees and Committee members for their input and attention. The meeting was adjourned at 12:25 p.m.

Prepared by Jan Lunn
Edited by Terri Weber

Approved by Committee on:

February 15, 2010
(Date)

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JOINT COMMITTEE ON HOME AND COMMUNITY BASED SERVICES OVERSIGHT

November 19 - 20, 2009

Room 143-N—Statehouse

Please sign in.

Name	Organization
Connie Hubbell	
Martin Kennedy	KDOA
Michelle Bullis	Cap. Strategies
Barb Conant	KDOA
Dustin Moyer	KHPA
Tom Laing	InterHab
[illegible]	SRS
[illegible]	KCDD
Mary Ellen Conlee	United Way
Larry Pitman	KFMC
Carol [illegible]	EDS
Kevin Rucker	EDS
Sean Miller	Capitol Strategies
Chad Austin	KHA
David Rowe	KU Med Center
Ryan Spaulding	KU Med Center
Monte [illegible]	Windsor Place At-Home Care

KANSAS LEGISLATIVE RESEARCH DEPARTMENT

010-West–Statehouse, 300 SW 10th Ave.
Topeka, Kansas 66612-1504
(785) 296-3181 ◆ FAX (785) 296-3824

kslegres@klrd.state.ks.us http://www.kslegislature.org/klrd

November 2, 2009

To: Legislative Budget Committee and Governor Mark Parkinson

From: Kansas Legislative Research Department and Kansas Division of the Budget

Re: Human Services Consensus Caseload Estimates for FY 2010 and FY 2011

The Division of the Budget, Department of Social and Rehabilitation Services, Kansas Health Policy Authority, Department on Aging, Juvenile Justice Authority, and the Legislative Research Department, met on October 29, 2009, to revise the estimates on human services caseload expenditures for FY 2010 and to make initial estimates for FY 2011. The caseload estimates include expenditures for Nursing Facilities, Regular Medical Assistance, Temporary Assistance to Families, General Assistance, the Reintegration/Foster Care Contracts, psychiatric residential treatment facilities, and out of home placements. A chart summarizing the estimates for FY 2010 and FY 2011 is included at the end of this memorandum. The estimate for FY 2010 is increased by $24.3 million from the State General Fund and $40.2 million from all funding sources. The new estimate for FY 2011 then increases by $118.4 million from the State General Fund, and $51.6 million from all funding sources. **The combined increase for FY 2010 and FY 2011 is an all funds increase of $91.8 million and a State General Fund increase of $142.7million.**

The estimates include Medical Assistance expenditures by both the Kansas Health Policy Authority (KHPA) and the Department of Social and Rehabilitation Services (SRS). Most health care services for persons who qualify for Medicaid, MediKan, and other state health insurance programs were transferred to the KHPA on July 1, 2006, as directed in 2005 Senate Bill 272. Certain mental health services, addiction treatment services, and services for persons with disabilities that are a part of the Regular Medical Assistance Program remain in the budget of SRS.

FY 2010

For FY 2010, the estimate is an all funds increase of $40.2 million and a State General Fund increase of $24.3 million as compared to the budget approved by the 2009 Legislature, further modified by the Governor through the allotment process. The associated allotment reduction captured the additional increase in anticipated federal contribution and a corresponding decrease in the State General Fund requirements for FY 2010. This State General Fund reduction in FY 2010 totaled $140.9 million, mainly due to the American Recovery and Reinvestment Act (ARRA) funding.

The all funds increase is due largely to increased estimates for Mental Health services, regular medical expenditures and Temporary Assistance to Families expenditures, partially offset by a decrease in Reintegration/Foster Care. Certain benefits which have a correlation to changes in the economic conditions in the state have been made, but may require additional adjustment in the April estimate.

The SRS Mental Health increase of $26.5 million in all funds and $7.8 million State General Fund increase in FY 2010 reflects an increase in beneficiaries and an increase in the payment rates for both the Prepaid Ambulatory Health Plan (PAHP) and the Psychiatric Residential Treatment Facilities. The Temporary Assistance to Families increase of $2.2 million from all funding sources mainly is attributable to increased caseloads. In addition, expenditures for the regular medical program have increased by $11.4 million from all funding sources, including $18.3 million from the State General Fund. This estimate includes a decrease in fee fund expenditures for the state match and a corresponding increase of State General Fund expenditures attributable to decreased fee fund revenue projections for the Kansas Health Policy Authority for FY 2010. Out of Home Placement estimates for the Juvenile Justice Authority increased by $1.0 million, including $1.1 million from the State General Fund, due to increasing population among the youth. Estimates of Nursing Facilities expenditures increased by $2.0 million, including $607,700 from the State General Fund, mainly attributable to increased estimated cost per person.

FY 2011

The FY 2011 initial estimate is $2.3 billion, including $841.9 million from the State General Fund. The estimate is an all funds increase of $51.6 million and a State General Fund increase of $118.4 million as compared to the revised FY 2010 estimate. The portion of expenditures anticipated to be funded by the federal government for the Medicaid program have decreased due to the end of the American Recovery and Reinvestment Act (ARRA) funding at the end of December 2010, or half way through FY 2011. The increased amount of State General Fund required for matching in FY 2011 is estimated at $93.5 million. The base Medicaid matching rate for federal contribution, excluding ARRA funding, was reduced by 1.33 percent between FY 2010 and FY 2011. The estimated impact of this reduction in FY 2011 is $20.5 million. In addition, FY 2010 includes 53 weeks of payments, while FY 2011 returns to the standard 52 week payment year.

Regular Medical expenses for KHPA were increased by $80.0 million from the State General Fund and $39.4 million from all funds due to estimated increases in caseloads and higher per person expenditures. Nursing Facility expenditures were increased by $3.7 million all funds, including $20.7 million from the State General Fund, due to increased cost per person. Caseloads for Temporary Assistance for Families have increased by $8.8 million, from all funding sources, due to increased estimates regarding the numbers of persons accessing services. The SRS Mental Health increase of $1.9 million in all funds and the $13.0 million State General Fund increase in FY 2011 generally is tied to estimated increases in beneficiaries for the Prepaid Ambulatory Health Plan (PAHP). These increases are partially offset by small decreases in expenditures for Psychiatric Residential Treatment Facilities by the Juvenile Justice Authority, General Assistance payments, and Addiction and Prevention Services (AAPS)/Prepaid Inpatient Health Plan (PIHP) by SRS.

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Human Services
October 2009
Consensus Caseload Estimates

Program		FY 2010 Approved	October Revised FY 2010	Difference from Approved	October Estimate FY 2011	Diff. from FY 2010 Estimate
Nursing Facilities	SGF	$ 111,816,800	$ 112,424,500	$ 607,700	$ 133,149,324	$ 20,724,824
	AF	368,000,000	370,000,000	2,000,000	373,700,000	3,700,000
Targeted Case Management (Aging)	SGF	$ 1,580,020	$ 1,580,020	$ 0	$ 1,852,760	$ 272,740
	AF	5,200,000	5,200,000	0	5,200,000	0
Psychiatric Residential Treatment Facilities (PRTFs) (JJA)	SGF	$ 2,157,335	$ 2,157,335	$ 0	$ 2,315,950	$ 158,615
	AF	7,100,000	7,100,000	0	6,500,000	(600,000)
Out of Home Placements (JJA)	SGF	$ 18,500,000	$ 19,600,000	$ 1,100,000	$ 21,037,226	$ 1,437,226
	AF	21,968,941	22,900,000	931,059	23,383,470	483,470
Nursing Facilities for Mental Health (NFMH)	SGF	$ 13,360,427	$ 13,900,000	$ 539,573	$ 14,000,000	$ 100,000
	AF	15,743,520	16,251,608	508,088	16,258,274	6,666
Temporary Assistance to Families	SGF	$ 29,821,028	$ 29,821,028	$ 0	$ 29,821,028	$ 0
	AF	50,812,736	53,000,000	2,187,264	61,800,000	8,800,000
General Assistance	SGF	$ 4,022,160	$ 4,500,000	$ 477,840	$ 4,300,000	$ (200,000)
	AF	4,022,160	4,500,000	477,840	4,300,000	(200,000)
Reintegration/Foster Care	SGF	$ 90,196,703	$ 85,000,000	$ (5,196,703)	$ 86,000,000	$ 1,000,000
	AF	137,000,000	131,115,351	(5,884,649)	131,789,617	674,266
Regular Medical (KHPA)	SGF	$ 346,676,000	$ 365,000,000	$ 18,324,000	$ 445,000,000	$ 80,000,000
	AF	1,310,206,747	1,321,580,000	11,373,253	1,361,000,000	39,420,000
Mental Health (SRS)	SGF	$ 65,162,609	$ 73,000,000	$ 7,837,391	$ 86,000,000	$ 13,000,000
	AF	212,565,574	239,085,578	26,520,004	240,993,850	1,908,272
Community Supports and Services (SRS)	SGF	$ 9,211,482	$ 9,700,000	$ 488,518	$ 11,700,000	$ 2,000,000
	AF	30,315,888	31,928,901	1,613,013	32,837,496	908,595
AAPS/PIHP* (SRS)	SGF	$ 6,663,674	$ 6,800,000	$ 136,326	$ 6,734,070	$ (65,930)
	AF	21,930,800	22,383,147	452,347	18,900,000	(3,483,147)
TOTAL	**SGF**	**$ 699,168,238**	**$ 723,482,883**	**$ 24,314,645**	**$ 841,910,358**	**$ 118,427,475**
	AF	**$ 2,184,866,366**	**$ 2,225,044,585**	**$ 40,178,219**	**$ 2,276,662,707**	**$ 51,618,122**

SGF - State General Fund
AF - All Funds
* Addiction and Prevention Services (AAPS)/Prepaid Inpatient Health Plan (PIHP)

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Joint Home and Community Based Services Oversight
Attachment: 2
Date: 11/19/09

Community Funding for Individuals with Developmental Disabilities

All Funding Sources

Item	FY 2007 Actual	FY 2008 Actual	FY 2009 Acutal	FY 2010 Revised Estimate	FY 2011 Agency Request
State Aid	$ 5,163,174	$ 5,163,174	$ 5,163,174	$ 5,163,174	$ 5,163,174
Grants for direct services	13,039,989	13,840,283	14,038,597	4,896,190	11,684,364
Targeted Case Management*	28,293,720	17,332,367	16,825,254	15,997,554	15,997,544
Postitive Behavior Supports*	208,657	278,401	7,439	189,660	189,660
ICF/MRs	17,002,709	16,529,934	14,133,796	14,510,625	14,510,625
HCBS/DD Waiver	248,145,859	274,809,894	293,283,426	304,780,365	306,773,224
TOTAL	**$ 311,854,108**	**$ 327,954,053**	**$ 343,451,686**	**$ 345,537,568**	**$ 354,318,591**

State General Fund

Item		FY 2008 Actual	FY 2009 Acutal	FY 2010 Revised Estimate	FY 2011 Agency Request
State Aid	$ 5,163,174	$ 5,163,174	$ 5,163,174	$ 5,163,174	$ 5,163,174
Grants for direct services	13,039,989	13,840,283	14,038,597	4,896,190	11,684,364
Targeted Case Management*	1,340,621	6,989,229	5,872,276	5,860,854	5,594,021
Postitive Behavior Supports*	83,091	111,583	2,370	57,628	66,320
ICF/MRs	6,751,358	6,671,098	4,950,539	4,409,053	5,074,075
HCBS/DD Waiver	98,535,966	110,934,150	102,684,931	92,607,514	107,272,461
TOTAL	**$ 124,914,199**	**$ 143,709,517**	**$ 132,711,887**	**$ 112,994,413**	**$ 134,854,415**

* Included in Human Services Consensus Caseload process

DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

Don Jordan, Secretary

Joint Committee on Home & Community Based Services Oversight

November 19, 2009

Responses to Questions From October 14, 2009 Joint Committee Meeting

Don Jordan, Secretary

For Additional Information Contact:
Katy Belot, Director of Public Policy
Patrick Woods, Director of Governmental Affairs
Docking State Office Building, 6th Floor East
(785) 296-3271

Joint Home and Community Based Services Oversight
Attachment: 3
Date: 11/19/09

Joint Committee on Home and Community Based Services Oversight

November 19, 2009

Responses to Questions From October 14, 2009 Joint Committee Meeting

Question #1: *Please provide the budgets for the Home and Community Based Service (HCBS) programs, with respect to state grants and what budget cuts have been made, excluding program waiver dollars.*

Response: A reduction of $6,788,174 (from a total of $11,684,364 – a 58% reduction) was made to the Day and Residential grant program for FY 2010 in order to meet the budget allocation. In addition, $2,500,000 in state general funds were transferred to the Developmental Disabilities (DD) waiver program to leverage federal dollars to provide supports for approximately 300 clients who might otherwise have been adversely impacted. These adjustments leave a total of $10,059,364 in state funds, including $5,163,174 State Aid funding, to provide Day and Residential Services, other direct care funding on behalf of clients not eligible for waiver programs, and necessary contractual obligations.

Question #2: *What is the projected number of individuals that will be on the waiting list for the Physically Disabled (PD) waiver at the end of FY 2010?*

Response: It is currently projected that 2,700 individuals will be on the PD waiting list at the end of FY 2010.

Question #3: *Please provide the following information pertaining to crisis exceptions.*

a.) Please provide the crisis exceptions, by waiver.

Response:

For Mental Retardation/Developmental Disability (MR/DD) services, the crisis determination language from the FY2010 contract with the CDDOs is as follows:

Persons who are in crisis or imminent risk of crisis and whose needs can only be met through services available through the HCBS/MRDD waiver are those persons who:

1. Require protection from confirmed abuse, neglect, or exploitation or written documentation of pending action for same; or
2. Are at significant, imminent risk of serious harm to self or others in their current situation.

Effective December 1, 2008, crisis exceptions for PD waiver services are approved by SRS and are limited to:
1. SRS APS confirmed abuse, neglect, or exploitation case; or
2. Risk of family unit dissolution (break-up) involving minor dependent child or dependent spouse; or
3. End stages of a terminal illness, and life expectancy is documented by a physician to be less than six (6) months; or
4. Individual is the victim of domestic violence.

A February 27, 2009, amendment added a fifth category of potential crisis exceptions for PD waiver services: Significant, imminent risk of serious harm because the primary caregiver(s) is/are no longer able to provide the level of support necessary to meet the consumer's basic needs due to the primary caregiver(s):
a. own disabilities;
b. return to full time employment;
c. hospitalization or placement in an institution;
d. moving out of the area in which the consumer lives; or
e. death.

b.) Historically, what has the impact been (increase) to waivers due to crisis exceptions?

Response: **Crisis history for MR/DD services**

Point in Time	Total added for Crisis	New Persons in Crisis	Savings from those leaving - costs of those in crisis	Waiting list Funds (AF)
Mar-05	220	no data	$611,928.00	$7,500,000.00
Mar-06	295	no data	$402,973.00	$6,250,000.00
Mar-07	256	no data	$1,021,041.00	$9,000,000.00
Mar-08	288	140	$956,958.00	$9,500,000.00
Mar-09	408	171	($853,347.00)	$600,000.00
Sep-09	139	46	($912,321.00)	$0.00

Crisis history for HCBS/PD waiver services

FY END	FY05	FY06	FY07	FY08	FY09	FY10 YTD
# of CE	303	12	0	0	171	129

Question #4: *Please provide a historical perspective of changes in the tier level of individuals coming into service. Has there been any significant movement between tiers - upward or downward?*

Response: The following chart gives the percentages, by tier, of all persons allocated funding for HCBS MR/DD services for Residential Supports, Day Supports and In-Home Supports (for adults and children) from FY2004 through FY2010.

Service Type	Percent of Persons by Tier, Per State Fiscal Year 2004-2010						
	FY04	FY05	FY06	FY07	FY08	FY09	FY10
Residential	n = 3834	n = 3940	n = 4080	n = 4314	n = 4474	n = 4566	n = 4467
Tier 1	26.29	26.90	27.06	28.00	27.63	26.95	26.8
Tier 2	18.00	18.05	18.48	18.75	18.92	19.29	19.3
Tier 3	21.00	21.45	22.06	22.04	23.02	24.44	26.15
Tier 4	14.45	14.57	14.34	14.39	15.14	14.45	13.9
Tier 5	20.16	19.04	17.82	16.81	15.28	14.87	13.86
Day	n = 4407	n = 4504	n = 4705	n = 4795	n = 5027	n = 5267	n = 5328
Tier 1	23.17	23.87	24.12	24.36	23.99	24.16	25.11
Tier 2	17.31	17.14	17.94	17.96	18.00	18.09	18.24
Tier 3	20.35	20.91	21.54	21.90	22.90	23.54	24.57
Tier 4	15.50	15.39	15.32	15.26	16.33	15.95	15.41
Tier 5	23.67	22.70	21.36	20.54	18.78	18.26	16.67
In-Home Adult	n = 978	n = 1089	n = 1181	n = 1245	n = 1370	n = 1467	n = 1517
Tier 1	27.91	29.84	29.55	29.80	28.10	29.37	29.53
Tier 2	18.00	15.89	16.43	14.86	15.11	15.21	16.02
Tier 3	18.30	18.37	17.02	19.68	18.18	17.72	18.59
Tier 4	16.46	15.70	17.61	15.10	18.03	17.93	17.53
Tier 5	19.33	20.20	19.39	20.56	20.58	19.77	18.26
In-Home Child	n = 972	n = 847	n = 950	n = 986	n = 1072	n = 1189	n = 1074
Tier 1	46.91	45.81	42.32	42.80	42.63	44.07	42.46
Tier 2	16.87	17.95	20.00	17.95	19.40	16.82	17.5
Tier 3	18.31	17.24	16.95	16.53	14.93	15.56	15.64
Tier 4	10.00	10.51	10.11	12.68	13.90	13.04	14.8
Tier 5	7.90	8.50	10.63	10.04	9.14	10.18	9.5

Question #5: *Please provide the number of children that have been placed on the Autism waiver and been removed from the waiver.*

Response:

- First Program Year – 25 children placed in program
- Second Program Year – 20 children placed in program
- Note: Since program implementation, 3 children have left the waiver program. The 3 openings were filled by 3 children from the waiting list.
- Current number of children on the waiting list – 279 children, as of November 9, 2009.

Question #6: *Please provide the following information on the Parent Fee Program.*

a.) What programs are included in the parent fee program?

- Developmental Disabilities (DD) Waiver program
- Technologically-Assisted (TA) Waiver program
- Serious Emotional Disturbance (SED) Waiver program

b.) How much revenue is generated, by program?

Waiver Program	SFY 2009	SFY 2010 - YTD
DD Waiver program	$138,990	$47,937
TA Waiver program	$7,605	$6,870
SED Waiver program	$101,249	$39,873

c.) What is the fee scale?

- The current fee scale has been provided as a handout.

d.) What is the Parent Fee collections policy, including policy with respect to non-paying families?

- During the time a child is receiving HCBS services and parent(s) fail to pay, SRS will not deny services to the child.

- For collection process description, please see the handout with the sliding fee schedule.

e.) *What would the process and timing be to add the Autism Waiver to the parent fee program?*

- To include the Autism Waiver in the Parent Fee program would require notification of the parents of the children currently on the waiver or on the waiting list, by way of letter, of the intended change and of the process by which they could formally comment following the publication of official notice in the Kansas Register. The notification would also be posted on the SRS Parent Fee Website. Manuals, policies and procedures would need to be updated, along with the sliding fee scale.

  SRS is in the process of adding the Autism Waiver, the TBI Waiver, and the PD Waiver to the Parent Fee program. Prior to those changes, affected parents will receiving written notification and opportunity to comment, which will occur before the end of this calendar year. It is the intent of SRS to include the additional waivers in the Parent Fee program, effective February 1, 2010.

f.) *Provide status of the Centers for Medicare and Medicaid Services (CMS) review.*

- CMS initiated a review of the SRS Parent Fee program in April 2005. During the active part of the review, multiple questions and potential concerns were identified by CMS and responded to by SRS. In August 2008, SRS had an extensive conference call with CMS, discussing their questions and concerns in detail. At the conclusion of the call, CMS staff indicated that a draft report of their findings would be forthcoming. To date, SRS has received nothing further concerning the review.

Question #7: *Please provide the distribution of the 21 admissions to KNI and Parsons, and whether any of the individuals were receiving waiver services prior to admission.*

Response:

- KNI – 4 admissions. All 4 adults were receiving waiver services before admission.
- Parsons – 17 admissions. Of the 17 admissions, 9 were children and 8 were adults. 5 of the children were receiving waiver services before admission and 7 of the adults were receiving waiver services before admission.

Question #8: *Please provide information as to how other states, particularly Oklahoma, serve individuals with Developmental Disabilities (DD) who also have inappropriate sexual behaviors.*

Response: There are multiple approaches across the states as how to support people with developmental disabilities with sex offending behavior. In most states, if a person has a conviction of a sexual offense the Department of Corrections manages the case.

If a person is known to have sex offending behavior but has not been convicted, then most states utilize their current HCBS systems, with additional offender specific supports/funding and collaboration, to individualize services for the person with offending behavior. Florida and New Mexico are examples of this approach.

SRS is aware of only one state that has a HCBS Waiver specific to sex offenders with developmental disabilities. In Washington State the program eligibility criteria focuses on those; convicted of, or charged with a crime of sexual violence; or those with a known history of behavior that demonstrates the likelihood of a sexually violent or predatory act.

Currently, there is no program in Oklahoma (model or statewide) that addresses and/or funds individuals with sexual offender issues, other than confinement in correctional type settings or halfway houses.

Question #9: *Please provide the number of individuals on the DD waiver waiting list both before and after the closure of Winfield.*

Response:

	SFY 95 ACTUAL	*SFY 96 ACTUAL*	*SFY 97 ACTUAL*	*SFY 98 ACTUAL*	*SFY 99 ACTUAL*
EXPENDITURES IN MILLIONS					
DD WAIVER	***$45.46***	***$71.76***	***$91.40***	***$120.07***	***$156.89***
PERSONS SERVED					
DD Waiver	***1,864***	***3,147***	***3,872***	***4,891***	***5,120***
HOSPITAL TOTAL	***732***	***676***	***543***	***407***	***395***
Persons Waiting	***798***	***70***	***65***	***77***	***333***

The above chart captures total costs for the HCBS/MR/DD waiver, number of persons served on the MR/DD waiver and number of persons served in MR State Hospitals for the period of SFY95 through SFY99.

As you can see for the periods SFY96, SFY97 and SFY98, the numbers of persons on waiting lists was very small. During this time, funds were diverted from WSH to the HCBS program to eliminate the waiting list and there was language in the contracts between SRS and the CDDOs that all eligible persons had to be served. During this time, the HCBS/MR/DD waiver grew from 3,147 persons to 4,891 and expenditures grew from $71.76 million to $120.07 million. The number of persons waiting in SFY95 was 798. From SFY96-SFY98 the numbers were almost zero. Understanding that not every person could be served immediately it would be expected that the number would have never gone to zero. We see the waiting list start to grown again in SFY99 to 333 persons.

Question #10: *Following the closure of Winfield, how many individuals remained in the Winfield area and how many went to other institutions?*

Response:

- 241 - Total population at time of closure
- 112 - Individuals remained in Cowley County (Winfield area)
- 93 - Individuals moved to receive community services in other Kansas counties
- 36 - Individuals transferred to other state hospitals
  - 26 - KNI
  - 10 - Parsons

Question #11: *Please provide the following information concerning the experience of other state closures of DD institutions.*

a.) List of 12 states that have closed all DD institutions.

b.) Were all the funds redirected to community services?

c.) What was the impact on their waiting lists?

d.) Were there any costs savings, and, if so, were the savings directed to HCBS programs?

Response: Below is comparative data for States that have closed all of their state DD institutions. The funding following an institutional closure has typically flowed into the HCBS funding for the individual's transition. Additional research could identify the mechanism if requested.

Also, listed are states that have no state operated ICF/MR facilities or no privately run ICF/MR facilities with some information about their funding levels.

Sources utilized were University of Minnesota data on Residential Services for persons with developmental disabilities: status and trends through 2007, The State of the States in Developmental Disabilities 2008, and NASDDS survey and consultation.

STATES	State ICF/MR	Private ICF/MR	Increase in HCBS funding? (at least doubled 1996-2007)	Current 2007 ICF/MR funding? (in thousands)
Alaska	No	No	Yes	0
District of Columbia	No	Yes	Yes	$85,050
Hawaii	No	Yes	Yes	$8,683
Maryland	Yes	No	Yes	$60,133
Maine	No	Yes	Yes	$75,512
Massachusetts	Yes	No	Yes	$206,594
Michigan	Yes	No	Yes	$44,729
Montana	Yes	No	Yes	$10,521
New Hampshire	No	Yes	Yes	$2,512
Oregon	Yes	No	Yes	$12,271
South Dakota	Yes	No	Yes	$20,148
Vermont	No	Yes	Yes	$978
West Virginia	No	Yes	Yes	$57,575
Wyoming	Yes	No	Yes	$20,006

Question #12: *Please provide an overview of DD waiver program costs for Kansas and surrounding states.*

Response: In addition to the information below, a handout is provided which details comparative information compiled last year for the committee.

Below are lists of services provided through the comprehensive HCBS MR/DD waivers for Oklahoma and Missouri. As you can see, they both offer many services in their waivers (i.e. OT, PT, speech therapy, audiology, foster care, and prescription drugs) that Kansas does not offer in its waiver. That is due to the fact that many of these services are available through the Kansas State Medicaid Plan and the services are not limited to those who are just on an HCBS waiver. To accurately compare the services available to persons on HCBS waiver programs, it is important to look at the array of services available to the persons not just through the HCBS program but also through each state's Medicaid plan. Only then could a person make an accurate representation of the costs to provide services to these individuals across states.

Oklahoma

Homemaker Services, Respite Care, Habilitation (prevocational, supported employment), Intensive personal Supports, Habilitation training specialists, Environmental Accessibility adaptations, Transportation, Family training, Specialized Foster Care, Physician Services, Home Health Services, Prescribed Drugs, Assistive Technology, Specialized Medical Equipment and Supplies, Dental, Nutritional Services, Psychological Services, Audiology Services, Occupational Therapy, Physical Therapy, Speech Therapy

It should also be noted that access to the Oklahoma comprehensive waiver is limited to those persons whom the State has determined cannot have their needs met through either their adult or children's in-home support waiver programs.

Missouri

Personal Assistance, Day Habilitation, Respite Care, Transportation, Community Specialist, Environmental Accessibility Adaptations, Specialized Medical Equipment and Supplies, Crisis Intervention, Behavior Therapy, Communication Skills Instruction, Counseling, Physical Therapy, Speech Therapy, Occupational Therapy, Supported Employment

Question #13: *Please provide a list of the tiers and the range of reimbursement for each tier for individuals living at KNI and Parsons.*

Response: As of July, 2009, the tier breakdown of persons served at PSH and KNI, together with current reimbursement rates for the various MRDD waiver services by tier, are as follows:

PSH	Number		KNI	Number
Tier 1	47		Tier 1	74
Tier 2	43		Tier 2	35
Tier 3	50		Tier 3	32
Tier 4	32		Tier 4	15
Tier 5	15		Tier 5	2
Total	187		Total	158

FY09 HCBSMR/DD New Rates Revised July 2009		
Service	**Procedure Code**	**FY10 Rates**
Residential Habilitation		
Regular Tier 1	T2016	$160.21
Regular Tier 2	T2016	$131.22
Regular Tier 3	T2016	$94.86
Regular Tier 4	T2016	$61.26
Regular Tier 5	T2016	$44.27
Residential Habilitation		
Special Tier 1	T2016	$192.05
Special Tier 2	T2016	$171.36
Special Tier 3	T2016	$152.56
Special Tier 4	T2016	$133.74
Special Tier 5	T2016	$114.55
Day Habilitation		
Regular Tier 1	T2020	$99.53
Regular Tier 2	T2020	$73.60
Regular Tier 3	T2020	$59.19
Regular Tier 4	T2020	$43.55
Regular Tier 5	T2020	$37.37
Day Habilitation		
Special Tier 1	T2020	$120.87
Special Tier 2	T2020	$111.12
Special Tier 3	T2020	$102.36
Special Tier 4	T2020	$93.31
Special Tier 5	T2020	$85.31
Supportive Home Care	S5125	$3.06
Respite - Temporary	S5150	$3.06
Respite - Emergency	T1005	N/A
Respite - Overnight	H0045	$58.34
Personal Assistant Services	T1019	$3.06
Supported Employment	H2023	$3.06
Night Support	T2025	$30.65
Specialized Medical Care - RN	T1000 - TD	$7.50
Specialized Medical Care - LPN	T1000	$7.00

Question #14: *Please provide detailed information concerning the waiver enhancements requests.*

Response: Details are provided in the following chart. The funding amounts requested are the difference between what has been budgeted and our projections for expenditures.

FY 2011 Enhancement Requests

Priority	Division	Description	SGF	All Funds
1	DBHS/CSS	**Maintain Home and Community Based Services Physical Disabilities (PD) Waiver Services** This enhancement provides funding to maintain the current level of service in FY 2011. This level of funding will support current waiver recipients and allow continuation of a rolling waiting list policy, with two people coming off the waiver for one person going on the waiver.	$3,621,250	$10,355,897
2	DBHS/CSS	**Maintain Home and Community Based Services Developmental Disabilities (DD) Waiver Caseload** This enhancement provides funding to maintain the current level of service in FY 2011. This level of funding will support current consumers, and allow only new consumers in crisis to access services.	3,283,435	9,389,828
3	DBHS/CSS	**Maintain Home and Community Based Services Traumatic Brain Injured (TBI) Waiver Caseload** This enhancement provides funding to maintain the current level of service in FY 2011. This level of funding will allow the program to continue to operate without a waiting list.	1,045,782	2,990,683
4	DBHS/CSS	**Maintain Home and Community Based Services Technology Assistance (TA) Waiver Caseload** This enhancement provides funding to maintain the current level of service in FY 2011. This level of funding will allow the program to continue to operate without a waiting list.	954,050	2,728,352

Question #15: *Please provide a synopsis of the PD waiver audits.*

Response: SRS requested these audits to provide us with information to determine how well the payment system was being managed by SRS. The results indicate there are no problems of fraud or mismanagement in the service billing system. This indicates we will need to undertake additional programmatic/system

management actions to further control costs. One of the significant challenges will be how to effectively identify and address consumer "needs" vs. consumer "wants."

PD Waiver Sample Audit – This audit looked at claims paid for PD Waiver Services in April 2009. The purpose was to determine whether services were paid for only PD eligible individuals. We found all services were for eligible individuals and were either on the Plan of Care or were preapproved.

PD Claims/Services Verification Audit – This audit also used claims paid in April 2009. The purpose of this audit was to verify documentation existed which supported the service which was claimed and paid. In nearly every case, we were able to find documentation which supported the date and type of service.
PD Waiver Assessments and Services Audit – A sample for this audit was chosen using the April 2009 paid claims data. The purpose of this audit was to determine whether the services claimed and paid aligned with the client's assessed needs as documented on the initial assessment or the Plan of Care. Most of the services claimed were identified as needs. Exceptions were noted most frequently for Sleep Cycle Support and Emergency Response System claims. The reason the auditors did not find these service needs documented on the initial assessment or Plan of Care is that these services would be documented on the worksheet used by case managers to demonstrate how a person's needs are met for a 24 hour period. These two services are used as more cost effective substitutes for personal care attendants, and are used when sufficient to meet the consumer's needs.

PD Waiver Audit – The purpose of this audit was to identify and determine possible causes related to the increase in PD eligible individuals and costs of the services received. Field work for this audit has been completed and it is in the process of being reviewed.

Question #16: *Please provide the number of individuals currently on conditional release and where they are located, and the number of individuals that have completed the program and where they are located.*

Response:

- SRS currently operates a transitional release program located on the grounds of the Osawatomie State Hospital.
- Legislation passed last year limits the program to 8 beds in any one county.
- Currently, there are 5 residents assigned to the transitional services program.
- Two SPTP residents have completed Transitional Release and Conditional Release (both granted by the Court) and achieved Final Release.
    - There are no supervision requirements or reporting requirements back to the program about residents who have achieved conditional or final release.

- It is our understanding one of the residents who achieved final release lives on his family farm near Springfield, Missouri and the other lives in Sedgwick County.

- Four residents have completed Transitional Release and are on conditional release under the supervision of the courts; we believe one individual resides in Miami County, one in Butler County, one in Johnson County, and one in Labette County.

Question #17: *Please provide the costs per individual to serve SPTP phase 1-5 at Larned State Hospital and SPTP phase 6 at Osawatomie State Hospital.*

Response:

Program	FY 2009 Expenditures	Average Daily Census	Average Annual Cost Per Person
SPTP at LSH	$11,326,333	171	$66,236
THS at OSH	$601,081	9	$66,787

Question # 18: *Please provide an overview of the Sexual Predator Treatment Program (SPTP).*

Response: Overview of Sexual Predator Treatment Program
The Sexual Predator Treatment Program (SPTP) was established in 1994 by the Sexual Predator Act (K.S.A. 59-29A01) to provide treatment for convicted sex offenders who have finished their prison sentences, and who have been civilly committed by the courts to the SPTP inpatient treatment program at Larned State Hospital (LSH). The SPTP was given a dual mission. First, SPTP's goal is to protect the public from any further victimization by sexual offenders committed to the program. Second, SPTP is required to provide a program of treatment which would assist motivated offenders to reduce their risk for re-offense to the point that they could safely live in open society and become contributing citizens.

The SPTP is comprised of 7 phases of treatment: 1) orientation and preliminary identification of issues; 2) academic learning of principles; 3) application of principles; 4) completion of inpatient issues and development of a relapse prevention plan; 5) reintroduction to open society and preparation of transition; 6) demonstration of ability to perform transition tasks (getting a job, paying bills, outpatient therapy, etc.) and 7) formal transition (ordered by the Court). Phases 1 through 5 are located at LSH; phases 6 and 7 are located at Osawatomie State Hospital.

Treatment Standards
States have an obligation to provide a minimally acceptable and appropriate level of professional treatment to those who are forcibly detained. It is a requirement of due process to provide available health treatment to a convicted individual with a mental condition. The Supreme Court has recited ten specific standards, known as the **Turay Standards,** by which an institutional based sexually violent predator program must be judged in order to meet due process constitutional muster (Turay v. Seling, 1999 Wash. LEXIS 74 (2000)). The standards consist of:

- Adequate, competent staff that is supervised by a mental health professional.
- Appropriate training of staff in order to ensure a consistency of treatment between all staff.
- Individualized treatment plans for patients. This includes providing the resident with a "roadmap" in a manner understandable to the resident as to what it takes to complete the treatment and show the progress of the resident.
- Appropriate behavioral management policies and procedures.
- Inclusion of the resident's family in the rehabilitation effort, including visitation, telephone, and mail.
- A treatment oriented "flavor" to the facility that is lacking a Department of Corrections "flavor".
- Separation of participating residents from non-participating residents, in order to avoid harassment of the participating residents.
- Educational, vocational, religious, and recreational opportunities.
- Availability of a grievance procedure.
- External oversight, either in the form of licensing, certification, or a consultation agreement.

Overarching Principle

The overarching principle of the program is "no more victims," which we believe is consistent with the legislative intent to protect the citizens of Kansas. Philosophically, we believe this goal allows for the possibility of positive, therapeutic change by the SPTP residents while also maintaining increased responsibility to protect the citizens of Kansas, especially its children. In that sense, the program views itself as part of the child protection network within SRS. The program is also structured to meet the Constitutional requirements set out by the United States Supreme Court.

Growth of the Program

The program has been steadily growing from its inception in 1994. We currently have 188 residents in the program at Larned and 5 residents in the transition program at Osawatomie State Hospital. It is difficult to predict the actual number of offenders who will enter the program from year to year. To illustrate this challenge, let me describe what the process is for a person to be committed to the program.

Within 90 days of release from prison or a state mental health hospital, an individual who has been convicted of a violent sex offense and has a mental abnormality, or has been found not guilty by reason of insanity for a violent sex offense, will be reviewed by the Multidisciplinary Team (MDT) to assess the level of risk to sexually reoffend upon release. The MDT is a group of five representatives from state agencies, mental health professionals, and sex offender treatment professionals, who are appointed by the Secretary of Corrections. Once assessed by the MDT, the case is reviewed by the Prosecutor's Review Committee within the Attorney General's (AG) office to determine if there is enough probable cause to detain the individual.

If so, there is a hearing in the county of the original conviction. If the probable cause of the AG's office is upheld, the individual is ordered to Larned State Security Program (LSSP) for an inpatient sexually violent predator evaluation. If the person is found by LSSP to meet the definition of sexually violent predator (SVP), he is returned to the county jail and awaits trial. He may stipulate to being a SVP and be immediately committed to the SPTP on the grounds of Larned State Hospital, or he may wait for a jury trial, which will determine if he is a sexually violent predator. At any time after the assessment by the MDT, if there is a determination made that the individual does not meet the criteria for SVP, he may be released.

Every person ultimately committed to the SVP program has been screened several times and determined to present an extremely high level of risk of repeating their prior sex offending behaviors. Currently, approximately 3.9% of those persons who are being released from DOC custody with a history of sexual offending behavior are committed under the law.

I have provided a handout which shows the number of possible SVPs assessed by the MDT and the final number who are committed to the SPTP. As you can see the number of inmates assessed fluctuates through the years as well as the number committed to the SPTP.

2006 House Bill 2576 (*Jessica's Law*) which was enacted on July 1, 2006, is another complicating factor in determining the growth of the program. With the passing of this law it was estimated that each year 77 sex offenders would be sentenced to 25 + years or more. Logically, this would suggest that commitments to the SPTP will decline at some future time due to these longer prison sentences. However, the exact impact on the number of new commitments into the SPTP is uncertain and will not be known for several years.

The Kansas Sentencing Commission's August 2009, Fiscal Year 2010 Adult Inmate Prison Population Projections, reported in FY 2009, there were 56 sex offenders admitted to prison under Jessica's Law. This accounted for an increase from 48 in FY 2008. Of the 56 admissions, 20 were sentenced to the "Hard 25 or more"; 3 to 300 months, 586 months, and 600 months; 33 were sentenced to below 300 months. The average length of sentence was 130.7 months.

Because of the large percentage of those sentenced with a downward departure under Jessica's Law the impact on admissions to the SPTP may be small. However, because this data is from only three years it is too early to identify any real effect.

The best estimates of growth at this time are the historical averages which are approximately 16 persons per year to the SPTP at LSH and approximately two persons per year moving from the inpatient program at Larned to the Transitional Housing Services at OSH.

Release Rates

An August 2007 comparison study of state laws authorizing involuntary commitment, by the Washington State Institute for Public Policy, compares 2006 discharge and release rates from the states with civil commitment laws. The numbers of persons released from similar programs around the country appear in general to be higher than in Kansas. This is due, in part, to the mechanism of release in some states, in which release is determined by an independent panel of persons and the courts with no direct input from the program. It is also due, in part, to the structure of the laws in some states which either require a periodic re-commitment of the individual or which have no provision for transition and take an "all or nothing" approach to offender release. In its 14-year history, Kansas has had 2 persons who have been granted final release by the courts. There are four residents currently on conditional release, and 5 persons in the transitional facility of the program at Osawatomie State Hospital.

Because of public concerns about locating sexual predators in the community, SRS has experienced difficulty in finding suitable placements for residents who have been determined to no longer be a threat due to their age and health condition. In addition, SB 506 which passed during the 2006 legislative session, included residency restrictions for sex predator transitional release and conditional release facilities. These restrictions, (facilities can't be within 2,000 feet of

churches, schools, homes with children residing in them etc.) will make it more difficult to place these individuals in the community. In addition, as I mentioned earlier, there is now a provision that limits the number of SVPs on conditional or transitional release to no more than 8 in any one county.

One aspect of the Kansas program which is widely admired around the country is the systematic structure of our transition programming. Few states, with the exception of Arizona, have been able to approach our 3-phase system with its separate facility for transitioning. This is a strong advantage of the Kansas approach but also adds to time required for a resident to complete the program. Given the focus of "no more victims" for the Kansas program, this additional time has the value of giving program staff the opportunity to observe the real-world behavior of the resident before any recommendation for conditional release is made.

Comparison to Other Programs

The Kansas SPTP compares well with other programs across the country. I have already mentioned the study by the Washington State Institute for Public Policy when I talked about the release rates, this same study compared the cost of the programs in different states as well. Kansas' program costs are about in the middle of all of the states reviewed.

In addition to this study, the SPTP was reviewed in July of 2008, by Robert J. McGrath, a nationally known consultant on Sexually Violent Treatment Programs. His review of the Kansas SPTP found that overall the program was sound, followed best practices, and administrators and staff were knowledgeable and committed. He also observed that the amount of treatment was average or slightly above average compared to other programs and that the rate of placement in the transitional release phase of the program (about 6% of the committed population) is similar to or slightly higher than other programs.

Summary

In closing I would like to reemphasize this program has been built on the overarching principle that there will be "no more victims," as well as a treatment program focused on reducing the risk of reoffending and meeting constitutionality requirements of the program.

Parent Fee Collection Process

Part VI. Collection Process

1. Parents unable to pay their fees by the due date are encouraged to contact the Division's Collection Unit staff at (785) 296-3536 to discuss entering into a Payment Agreement and to see if their fees may be paid in whole or part by the State Debt Set Off process described in #2 below. Parents who either do not pay their fees or otherwise do not cooperate with the rules of the Parent Fee Program are subject to the Division's collection process.
(**NOTE:** During the time a child is receiving HCBS services, if parents fail to pay the fees, SRS will not deny HCBS services to the child, but SRS is authorized to pursue collection of the delinquent balance due, including pursuing payment through legal action, if necessary. SRS is also authorized to pursue any balance due after a child is no longer receiving services.)

2. When a parent has received at least three monthly billing statements and is $25 or more overdue, SRS may submit a notice to the State Debt Set-off (SDSO) Section. This Section is not a part of the Department of SRS. SDSO will intercept any State payment due the parent and may include the following types of payments: tax refunds; lottery winnings; contract payments; salary; wages; KPERS lump-sum withdrawals; and travel reimbursements. Money secured from the SDSO will be applied to the parent's debt. SRS may negotiate a Payment Agreement in addition to the SDSO process.

3. Parents with overdue balances not brought current by SDSO are to be mailed a Collection Letter stating the amount due and the need for them to contact the Collection Unit within 10 days to set up a Payment Agreement that will pay the debt in a reasonable amount of time, usually within 12 - 24 months, depending on the size of the debt.

4. If the parent contacts the Collection Unit within the 10 days, a mutually agreeable method for the debt to be paid will be negotiated.

   A) The Collection Unit will send the parent a written Payment Agreement to sign and return and the case will be monitored until the debt is paid in full.

   B) If the Payment Agreement is not complied with through full payment of the remaining balance, the Collection Unit will refer the matter to the SRS Legal Section (see #5 below).

5. If the parent does not contact the Collection Unit within 10 days, then the Unit will refer the matter to the SRS Legal Section for Judgment, Wage Garnishment, and Notification to Credit Bureaus. The SRS Legal Section will notify the parent of the referral as appropriate during the legal process. The Collection Unit will be the contact if the parent wants to discuss payments prior to the SRS Legal Section obtaining Judgment.

The Collection Unit will monitor all cases involved in the above Collection Process until the balance is paid and the matter is resolved to the satisfaction of SRS.

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PARENT FEE SCHEDULE
(Also Referred to as the "Sliding Fee Scale")

Federal Poverty Level (FPL)	Monthly Parent Fee	Family of Two AGI		Family of Three AGI		Family of Four AGI		Family of Five or more AGI	
		Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly
100%	$0	$13,200	$1,100	$16,600	$1,383	$20,000	$1,667	$23,400	$1,950
151%	$0	$19,932	$1,661	$25,066	$2,089	$30,200	$2,517	$35,334	$2,945
176%	$0	$23,232	$1,936	$29,216	$2,435	$35,200	$2,933	$41,184	$3,432
201%	$10	$26,532	$2,211	$33,366	$2,781	$40,200	$3,350	$47,034	$3,920
226%	$15	$29,832	$2,486	$37,516	$3,126	$45,200	$3,767	$52,884	$4,407
251%	$20	$33,132	$2,761	$41,666	$3,472	$50,200	$4,183	$58,734	$4,895
276%	$26	$36,432	$3,036	$45,816	$3,818	$55,200	$4,600	$64,584	$5,382
301%	$33	$39,732	$3,311	$49,966	$4,164	$60,200	$5,017	$70,434	$5,870
326%	$41	$43,032	$3,586	$54,116	$4,510	$65,200	$5,433	$76,284	$6,357
351%	$49	$46,332	$3,861	$58,266	$4,856	$70,200	$5,850	$82,134	$6,845
376%	$58	$49,632	$4,136	$62,416	$5,201	$75,200	$6,267	$87,984	$7,332
401%	$68	$52,932	$4,411	$66,566	$5,547	$80,200	$6,683	$93,834	$7,820
426%	$79	$56,232	$4,686	$70,716	$5,893	$85,200	$7,100	$99,684	$8,307
451%	$90	$59,532	$4,961	$74,866	$6,239	$90,200	$7,517	$105,534	$8,795
476%	$102	$62,832	$5,236	$79,016	$6,585	$95,200	$7,933	$111,384	$9,282
501%	$115	$66,132	$5,511	$83,166	$6,931	$100,200	$8,350	$117,234	$9,770
526%	$129	$69,432	$5,786	$87,316	$7,276	$105,200	$8,767	$123,084	$10,257
551%	$143	$72,732	$6,061	$91,466	$7,622	$110,200	$9,183	$128,934	$10,745
576%	$159	$76,032	$6,336	$95,616	$7,968	$115,200	$9,600	$134,784	$11,232
601%	$174	$79,332	$6,611	$99,766	$8,314	$120,200	$10,017	$140,634	$11,720

You will need the "number of exemptions" you claimed and your "Adjusted Gross Income" (AGI) from your most recent federal income tax return. Then follow the steps under A or B below, depending upon the size of your AGI.

A. For Incomes Below 601% of the FPL:

1. Find the column for your family size (# of exemptions on your federal tax return)
2. Read down the column until you find the 2 AGI figures your own AGI falls between,
3. From the smaller of those 2 AGIs, read horizontally back to the left column titled "Monthly Parent Fee" and that figure is your estimated Monthly Fee.

EXAMPLES

(a) For family of two, with an AGI of $36,000: this AGI falls between $33,132 and $36,432. From the smaller AGI of $33,132 read horizontally back to the left to the column "Monthly Parent Fee" and the fee is $20/mo.

(b) For family of five, with an AGI of $70,000: this AGI falls between $64,584 and $70,434. From the smaller AGI of $64,584 read horizontally back to the left to the column "Monthly Parent Fee" and the fee is $26/mo.

B. For Incomes Above 601% of the FPL:

1. The fee is set at 3% of the income of a family size of 2 at the corresponding FPL.

EXAMPLE

For a family of 4 with an adjusted gross income of $225,000 -

Steps:

1. $225,000 is 1125% above the FPL of $20,000 (225,000 divided by 20,000 = 1125%)
2. 1125% above FPL for family of 2 is (13,200 * 11.25% = 148,500)
3. $148,500 multiplied by 3% is 4455 divided by 12 months is $371.25.

updated April 2006

Fiscal Year	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Assessed by MDT for possible SVP commitment	681	611	428	403	329	330	348	455	327	338	300
Assessed "High" by MDT	164	182	164	160	139	113	111	109	99	93	76
Filed on by Prosecuting Review Committee	51	54	47	40	51	36	22	26	38	46	38
Probable Cause Hearing held and probable cause found to proceed	39	52	46	37	47	28	22	22	27	36	32
LSSP Evaluation "yes" found to be a predator	21	19	22	30	37	15	15	12	9	18	19
LSSP Evaluation "no" not found to be a predator	18	33	24	7	10	4	2	7	8	28	20
Court hearing/SVP Trial/Stipulate	15	19	26	23	33	23	21	18	12	20	15
Committed to SPTP	14	17	18	21	28	23	21	18	15	20	16

Source of data: KDOC Activity Summary: SVP Act (Yearly report of activities); Monthly LSH/SPE Report

An Overview of MR/DD Supports and Services
Models for Kansas and Surrounding States

State Population	Waivers	Services Provided	Funding Capped (Y/N)	# Served	Average Cost	Annual HCBS-MR/DD Expenditures	Number of Persons in ICFs-MR	Annual ICFs-MR Expenditures per person	Number of Persons on Waiting Lists
Oklahoma 3,617,000	Community Waiver *The State must determine that an adult's needs cannot be met by the Adult In-Home Supports waiver to be granted access to the Community Waiver	Homemaker Services, Respite Care, Habilitation (prevocational, supported employment), Intensive personal Supports, Habilitation training specialists, Environmental Accessibility adatpations, Transportation, Family training, Specialized Foster Care, Physician Services, Home Health Services, Precribed Drugs, Assistive Technology, Specialized Medical Equipment and Supplies, Dental, Nutritional Services, Psychological Services, Audiology Services, Occupational Therapy, Physical Therapy, Speech Therapy	No	5043	$45,397.00	$228,940,900.00	1588	$78,754.00	2860 for all waivers combined
	Adult In-Home Supports Waiver	Habilitation and Attendant Care, Homemaker Services, Prevocational Services, Supported Employment, Respite Care, Assistive Technology, Nursing Services, Psychological Services, Family Counseling Training, Occupational Therapy	Yes, $19,225/yr						
	Children In-Home Supports Waiver	Respite Care, habilitation (habilitation training specialist, self-directed support), Environmental Accessibility adaptations, Family Training, Assistive Technology Services, Specialized Medical Supplies	Yes, $12,225/yr						
Nebraska 1,774,000	Comprehensive Waiver	Day Habilitation and Residential Habilitation (either of which can be provided in supported or assisted settings), Respite and Team Behavioral Consultation	No	3238 for all adult waivers	$39,198.00	$126,925,800.00	602	$100,280.00	1445 for all MR/DD services not just HCBS
	Residential Supports Waiver	Same as Comprehensive waiver without the Day Habilitation							
	Day Supports Waiver	Same as Comprehensive waiver without the Residential Habilitation							
	Community Supports Waiver for Adults	Community Living and Day Supports, Assistive Services such as home modifications and respite services for if the family members are not paid to provide other supports. Services are primarily delivered with a Self-Directed model and the person cannot receive any type of specialized day or residential habilitation services	Yes, $20,000/yr.						
	Children's Waiver	Provider/Agency directed 1-1 care, Respite, Home Modifications, Homemaker services to the family, Child care limited to when the family is working		300					

mbers used for Kansas are as of July 1, 2008.

nation for other States was taken from two sources;

1. The College Of Education and Human Development, University of Minnesota. Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2006, August, 2007.
2. Braddock, D., Hamp, R., Rizzolo, M.. The State of States in Developmental Disabilities 2008. University of Colorado, 2008.

An Overview of MR/DD Supports and Services Models for Kansas and Surrounding States

State Population	Waivers	Services Provided	Funding Capped (Y/N)	# Served	Average Cost	Annual HCBS-MR/DD Expenditures	Number of Persons in ICFs-MR	Annual ICFs-MR Expenditures per person	Number of Persons on Waiting Lists
Kansas 2,776,000	Comprehensive	Assistive Services, Day Supports, Medical Alert Rental, Oral Health Services, Sleep Cycle Support, Personal Assistant Services, Residential Supports, Supported Employment, Supportive Home Care, Temporary Respite, Overnight Respite, Wellness Monitoring	No	7477	$42,108.00	$283,000,000.00	624	$104,190.00	1458
Colorado 4,861,000	Individual Residential Services and Supports Waiver (No more than 3 adults)	Residential Habilitation and Supports, Day Habilitation and Supports, Transportation, Supported Living Services	No	6850 combined	$37,953.00	$253,092,700.00	135	$341,211.00	1176 for all waivers combined
	Group Residential Services and Supports Waiver (4-8 Adults)	Residential Habilitation and Supports, Day Habilitation and Supports, Transportation, Supported Living Services	No						
	Children's Extensive Support Waiver	Personal Assistance Services, Community Connection Services, Behavioral Services, Professional Services, Specialized Medical Equipment and Supplies, Environmental Engineering	Yes - $35,000 per year	400					
Missouri 5,878,000	Comprehensive	Personal Assistance, Day Habilitation, Respite Care, Transporation, Community Specialist, Environmental Accessibility Adaptations, Specialized Medical Equipment and Supplies, Crisis Intervention, Behavior Therapy, Communication Skills Instruction, Counseling, Physical Therapy, Speech Therapy, Occupational Therapy, Supported Employment	No	8183	$37,952.00	$310,567,100.00	1054	$225,343.00	465
	Community Support Waiver	Same as above but does not provide Individualized Supported Living, Residential habilitation or Transition Services	Yes, $22,000/yr						3971
	Children with Developmental Disabilities Waiver	Personal Assistance, Day Habilitation, Respite Care, Transporation, Community Specialist, Environmental Accessibility Adaptations, Specialized Medical Equipment and Supplies, Crisis Intervention, Behavior Therapy							for both waivers combined

The numbers used for Kansas are as of July 1, 2008.

Information for other States was taken from two sources;

The College Of Education and Human Development, University of Minnesota. Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2006, August, 2007.
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KANSAS LEGISLATIVE RESEARCH DEPARTMENT
68-West–Statehouse, 300 SW 10th Ave.
Topeka, Kansas 66612-1504
(785) 296-3181 ◆ FAX (785) 296-3824
kslegres@klrd.state.ks.us http://www.kslegislature.org/klrd

November 19, 2009

JOINT COMMITTEE ON HOME AND COMMUNITY BASED SERVICES OVERSIGHT: OVERVIEW OF THE FACILITIES CLOSURE AND REALIGNMENT COMMISSION

Background

- The Facilities Closure and Realignment Commission was created by the Governor in Executive Order 09-01.
- The Commission's charge is to "study and evaluate the closure and/or realignment of state facilities, and alternative uses of such facilities."
- The Commission is to make its final recommendations to Governor Mark Parkinson by December 2009.
- The facilities for review include but are not limited to:
  - Kansas School for the Deaf;
  - Kansas School for the Blind;
  - Kansas Neurological Institute;
  - Parsons State Hospital and Training Center; and
  - Rainbow Mental Health Facility.

Facilities Closure and Realignment Commission Action and Discussion to Date

In general:

- The Commission has toured each facility mentioned as well as heard overviews from facility staff and public hearings.
- The Commission rejected the idea of closing either the School for the Blind or the School for the Deaf, but wants to pursue putting the separate schools on the same campus. "Co-locating" the two schools could reduce operating costs, although they maintained that the two school populations would remain separated to provide the special instruction tailored to each group.
- The Commission recommended closure of the Rehabilitation Center for the Blind and Visually Impaired and provide services to individuals using current organizations within the state, the expansion of current community services, and accessing services in states near Kansas.
- The Commission recommended the creation of an Advisory Committee to the Kansas Services for the Blind and Visually Impaired.

Specific items of note concerning State Hospitals:

Rainbow Mental Health Facility

- The Commission recommended that Rainbow Mental Health Facility be kept open and functioning.

- The Commission recommended the pursuit of public/private partnership with community hospitals, with an integrated health model, inclusive of community mental health centers and moving toward the closure of state hospitals. Further, a status report of the progress be made to the 2011 Legislature.

Developmental Disabilities Hospitals

- The Commission recommended consolidation of developmental disability facilities with Kansas Neurological Institute downsized and moving the residents to appropriate community services resulting in the eventual closure of Kansas Neurological Institute. In addition, the Commission recommended downsizing Parsons State Hospital and Training Center and transferring residents to community services that were determined by the Department of Social and Rehabilitation Services to have a high probability for success given appropriate community supports and services.

- The Commission recommended maximizing and continuing the specialized capacities at both institutions (for example the seating services at Kansas Neurological Institute and the behavior intervention services at Parsons State Hospital and Training Center). These specialized capacities can be continued as programs offered through state government, affiliations in the community or in partnership with other organizations.

- The recommendation for closure is contingent upon all funding being moved to the HCBS/DD Waiver and the enactment of the Executive Reorganization Order (ERO). Specifically, the Commission recommends:

  - Requiring the ERO to transfer all funding from Kansas Neurological Institute to the HCBS/DD Waiver prior to closure of the state hospital.

  - Immediately transferring, through ERO or other means, all State General Fund appropriations for Kansas Neurological Institute into the same budget line item as HCBS/DD Waiver Services, to ensure that funding saved in closure will stay in the HCBS/DD Waiver budget.

  - Writing into the ERO that all programmatic savings due to closure as well as all proceeds from the sale of real estate, surplus property, and all other savings must flow to a special trust fund which can only be used for new services on the HCBS/DD Waiver.

  - Having the Governor require by ERO or Executive Order (EO) that his agencies separately track all expenditures from this trust account and from any accounts with Kansas Neurological Institute or HCBS/DD Waiver services, in order to ensure that the savings are going to new HCBS/DD Waiver services.

  - Having the Governor take any and all other steps to ensure that the full recommendation of the Commission is carried out, whether it is through EO, ERO, policy directive, or via the proposed *FY 2011 Governor's Budget Report.*

The recommendations identified above were noted during the course of committee action and have not been finalized or published in the official Facilities Closure and Realignment Commission Recommendation Report expected in December 2009.

Survey of Selected States Developmental Disabilities Systems Regarding Services For Those Alleged To Have Committee Felonies

By Jane Rhys, Kansas Council on Developmental Disabilities

I was asked to discover what other states have done regarding persons who have a developmental disability, have been accused of committing a felony, and who are incompetent to stand trail. Most of the states contacted had closed some or all of their state facilities.

The responding states include Alaska, Hawaii, Maine, Massachusetts, New Mexico, Oklahoma, Vermont, and Washington.

Most of the respondents indicated that it was a difficult situation and some were not completely satisfied with their solution. I tried to discover where people were placed, what state agency had authority and fiscal responsibility, and any other information they could quickly send me.

Table 1

State	Placement	Responsible Agency	Methodology
Alaska	Depends on provider may include AK Psychiatric Institute. There are 3-4 community service provider who can provide services.	DD Program unless found guilty then Corrections	AK has been trying to improve services in state – university is doing training, lots of networking among agencies, and an annual conference for fields of DD, behavioral health, corrections, parole and vocational education *Note:* Some may be sent to an Idaho ICF-MR
Hawaii	At state hospital under court order, some may be in prison - not known to DD Program	DD Program if known, otherwise Corrections	Do not have set methods – very few alleged to have committed felonies

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State	Placement	Responsible Agency	Methodology
Maine	State mental health facility	DD Program	Policymakers are working on system - Trying to develop a small (8-12 bed) facility just for this population
Massachusetts	Community DD services if they have been identified, if not in prison	DD Program if identified, if not, Corrections	The major problem is with those who have not been identified. People with DD who have not been identified are often placed in prison. Philosophy is that DD system is the best service provider/placement.
New Mexico	Persons who are dangerous are served in private ICFMR. It is voluntary but most do not leave, some higher funct-ioning do go to prison. Dually diagnosed go to MH institution	DD Program works with Judicial to determine placement	People coming out of DD system may be court ordered on to DD Waiver to get into services, off the street, to prevent repeat offenses
Oklahoma	Alternative 4 bed group homes that are secure but not lock down.	DD Program has special rate for group homes	Oklahoma passed a specific law giving authority over this population to DD Program and a specific waiver. Persons in this system have a Public Guardian who travels the state and is appointed when these persons are identified. The Guardian sees to their placement in the group home.
Vermont	Most stay in the DD system	DD Program, Special Programs are funded by Public Safety Fund	There is a special crisis and respite program for sex Offenders with DD
Washington	If found incompetent to stand trial the person is sentenced to a state hospital there are 2 with a total of 42 DD beds in Habilitation Units	DD Program	However, there is further Legislation that requires services to be provided according to an individual habilitation plan where appropriate and subject to available funds.

Attached to this report is a blue page from the Vermont Developmental Disabilities Services Annual Report, 2009. This page contains the unique DD Offender system currently used in Vermont. Services are funded through the Vermont Public Safety Fund and persons are served in the community.

In summary, there are several issues. The first is whether the person has been identified as having a Developmental Disability. If not, they may become lost in the correctional system. The second issue is whether or not to place them in a separate facility or to provide services in the community. Both instances were found, depending upon different state's legislation. The third issue is, of course, how to pay for services. In my quick review the most promising systems appeared to be in Vermont and Oklahoma. Both states studied the issues and passed legislation that provided clear direction and funding for their programs. Washington did have Legislative explanation but it left me confused as to what exactly was provided by the state and in what capacity.

If desired, I can obtain the statutes from Oklahoma and Vermont as well as additional information regarding their systems. I apologize for not having it today but yesterday was my first day back in the office after surgery.

Jane Rhys, Ph. D., Executive Director
Kansas Council on Developmental Disabilities
785-296-2608
jrhys@windstream.net

Offenders with Developmental Disabilities

The Division of Disability and Aging Services is proud of its public safety record of supporting and treating offenders in non-institutional settings. When individuals with developmental disabilities commit crimes, the courts and correctional system may not be able to respond to their special needs for supervision and treatment, and the public looks to the developmental disabilities service system to meet the need. In FY 2008, the developmental disabilities services system supported approximately 195 individuals who committed serious offenses which were against the law in Vermont. Approximately 130 of these offenders committed a sexual offense and the remainder committed other offenses, such as arson and assault.

Developmental services agencies experience stresses and dilemmas when expected to serve a public safety function in the context of a system designed to promote self-determination and community participation. The Division sponsors a monthly training and support program and provides specialized consultation for staff who are supervising offenders with developmental disabilities in community settings. Through a contract with Northeast Kingdom Human Services, DDAS funds a specialized crisis and respite program for sex offenders with developmental disabilities.

Funds designated for offenders are managed through the Public Safety Fund. The fund is supervised by the Public Safety Funding committee, which meets monthly to review proposals. Criteria for access to the fund are included in the *Vermont System of Care Plan*. Twenty-one (21) people received Public Safety funding in FY 2008. Eight of these individuals were new to the developmental disability services system and 13 were people already getting services with increased costs related to public safety concerns.

The Division of Disability and Aging Services continues to collect data regarding all sex offenders served through the developmental disabilities services system in order to track the efficacy and cost of treatment, training needs and support of offenders. Information on demographics, offense characteristics and Treatment Progress Scale scores collected and analyzed on an annual basis contributes to our understanding about best practices in serving this group. We are currently in the midst of conducting the survey for 2008 but do not yet have the data.

A Public Safety Specialist was hired whose primary duties include, but are not limited to: oversight and coordination of supports and services, and victim and community notifications for offenders with developmental disabilities who pose a risk to public safety with the goal of improving victim and community safety.

The Policy on Community Notification Procedures for Sex Offenders with Developmental Disabilities went into effect and the Community Notification Review Committee began reviewing referrals.

Joint Home and Community Based Services Oversight
Attachment: 6
Date: 11/19/09

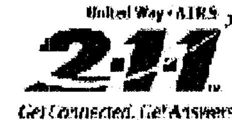
United Way 2-1-1 of Kansas

2-1-1 builds America's capacity to strengthen the way people access help and engage in civic life.

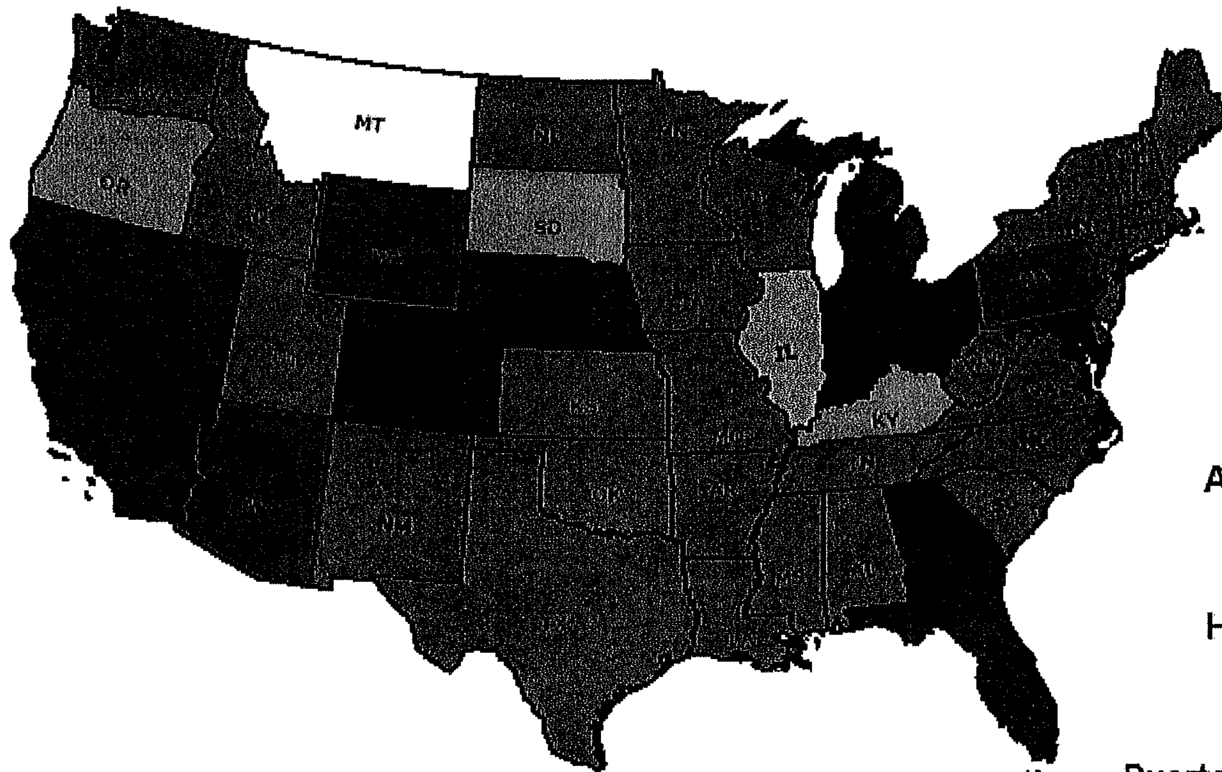
What is 2-1-1?

- 24/7 access to a trained, certified call specialist that will help match you with non-profit and governmental services that might meet your needs
- Online access available at www.211kansas.org
- To get help and give help

% of Population Covered* by 2-1-1 in each State



80% Landline Coverage



% 2-1-1 Coverage By State

Group

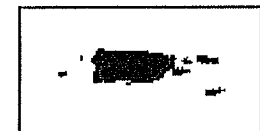
1) 100% Coverage
2) More than 80% Coverage
3) More than 60% Coverage
4) More than 40% Coverage
5) More than 20% Coverage
6) Less than 20% Coverage
7) 2-1-1 in Development

* Includes DC & Puerto Rico

Alaska

Hawaii

Puerto Rico



Produced by United Way of America: April 2009

* Coverage is defined as population with landline telephone access to 2-1-1 dialing code. Population based on 2005 US Census estimates.

United Way 2-1-1 of Kansas Calls

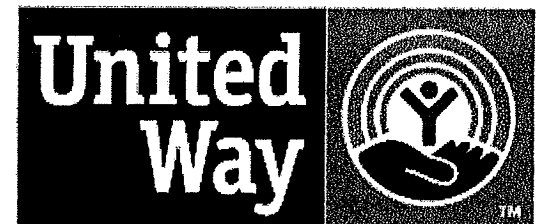
Year
2008
2007
2006
2005
2004

0 10,000 20,000 30,000 40,000 50,000

United Way of the Plains

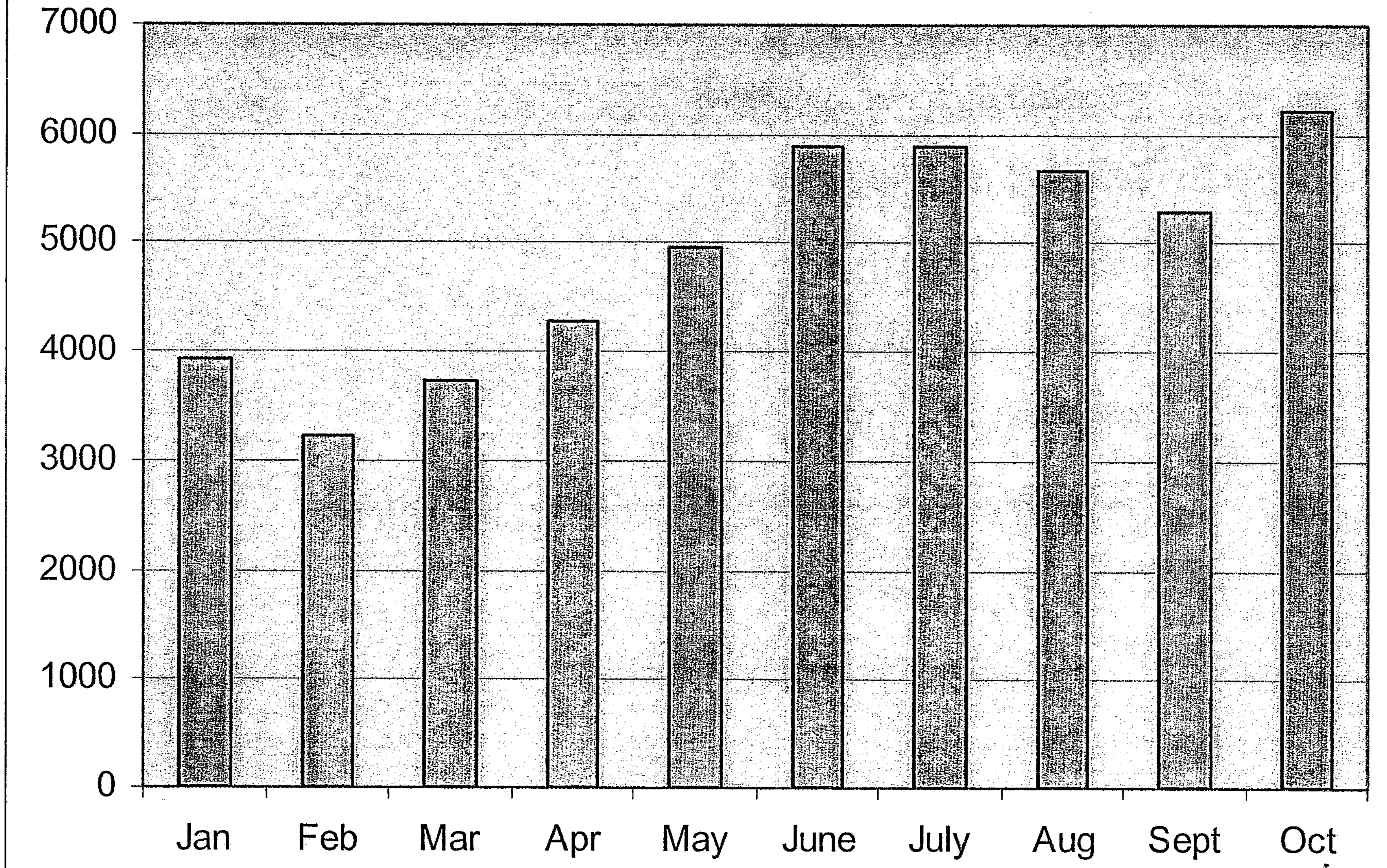
Top 10 Needs in 2008

1. Utility Assistance
2. General Information
3. Rent Assistance
4. Food Assistance
5. Tax Prep. Assistance
6. Affordable Housing
7. Homeless Issues/Homeless Shelters
8. Holiday Assistance
9. Volunteer Opportunities
10. Health Care



United Way of the Plains

6-9

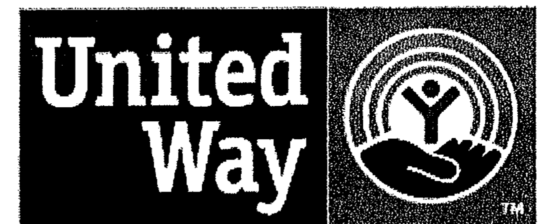


# of Calls per Month for 2009
7000
6000
5000
4000
3000
2000
1000
0
Jan
Feb
Mar
Apr
May
June
July
Aug
Sept
Oct

Disaster Response

2-1-1 in Action

- **Greensburg Tornado**
  » Recorded 1725 Disaster related calls
    * 170 from those needing assistance
    * 1555 from people wanting to help
- **Valley Center Chemical Fires**
  » Call Center activated by SG County Emergency Mgmt
  » Over the next few days the call center took 512 calls from residents seeking information
- **Reno County Ice Storm Debris Removal**
  » 322 calls from people requesting assistance and offering to volunteer
- **H1N1 Response**
  » Nearly 1000 calls from people seeking information on H1N1 and/or the vaccine



United Way of the Plains

Aging and Disability

- 2720 Aging and Disability related calls in 2008
- MOUs with all Area Agencies on Aging and Centers for Independent Living
- Successful “Links 4 Living” campaign highlights the benefits of our partnerships

United Way of the Plains

11.05.2009 - EXECUTIVE ORDER 09-09

EXECUTIVE ORDER 09-09

WHEREAS, the Federal Communications Commission of the United States of America has designated 2-1-1 as the national telephone number for information and referral on human services, declaring that 2-1-1 best satisfies the public interest in allotting the limited resource of this abbreviated number; and

WHEREAS, the 2-1-1 number is an easy-to-remember telephone number that facilitates critical connections between individuals and families seeking services, volunteer opportunities, or both and the appropriate human services agencies, including community-based and faith-based organizations and government agencies; and

WHEREAS, with approximately 1,500,000 nonprofit organizations in the United States, including 18,540 in Kansas, individuals and families often find it difficult to navigate through a complex and ever-growing maze of human service agencies and programs, spending inordinate amounts of time trying to identify an agency or program that provides a service that may be immediately or urgently required and often abandoning the search from frustration or lack of quality information; and

WHEREAS, at the Federal, State and local levels, government funding supports well-intentioned systems that are not fully utilized because of lack of access to and information on such programs by the public; and

WHEREAS, program administrators have indicated that there is a need for a simple way to connect those eligible for programs with available program resources; and

WHEREAS, 2-1-1 telephone service can reduce the number of inappropriate calls to government offices by directing consumers to the appropriate human services agent, resulting in a more effective use of government services; and

WHEREAS, Americans desire to volunteer and become involved in their communities and a simple call to 2-1-1 will help Kansans find the volunteer opportunity they seek; and

WHEREAS, 2-1-1 telephone service has been recognized by the 107th Congress for the important role 2-1-1 plays in disaster prevention, community preparedness and response information, and public and community health information, thus making our State's communities safer, stronger and better prepared to respond to threats of domestic and international terrorism and domestic emergency situations of all natures; and

WHEREAS, 2-1-1 telephone service facilitates the availability of a single repository where comprehensive data on all community services is collected, maintained and updated regularly, reducing costs and duplication of efforts; and

WHEREAS, 2-1-1's reliable data allows for better assessment of the needs of our communities and immediate mobilization of resources toward those needs; and

WHEREAS, United Way of the Plains has established a statewide 2-1-1 call center that ensures prompt and efficient dissemination of information by highly trained call center representatives and has established standards for its call center operations; and

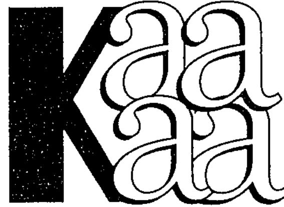
WHEREAS, a single information network has been created by United Way of the Plains through leveraged resources so that every resident of the State with phone service can dial the 2-1-1 telephone at no charge to the caller; and

WHEREAS, the 2-1-1 statewide database is available to all residents of the State as well as all human services programs, through the Internet, allowing for individuals to search for programs or services available according to the data gathered from human services programs in the State.

NOW, THEREFORE, pursuant to the authority vested in me as Governor of the State of Kansas, I hereby designate United Way of the Plains as the lead entity for 2-1-1 Kansas as identified in the Calling for 2-1-1 Act of 2009.

This document shall be filed with the Secretary of State as Executive Order 09-09, and shall become effective immediately.

Source: http://governor.ks.gov/issues-a-initiatives/executive-orders/458-11052009-executive-order-09-09



KANSAS
AREA AGENCIES
ON AGING
ASSOCIATION

Meeting the Needs of Older Kansans

2910 SW TOPEKA BOULEVARD • TOPEKA, KS 66611 • 785-267-1336 • FAX - 785-267-1337

Joint Committee on Home and Community Based Services

November 19, 2009

The Kansas Area Agencies on Aging Association (K4A) represents the 11 Area Agencies on Aging (AAA) in Kansas, who collectively serve all 105 counties of Kansas. In Kansas, Area Agencies on Aging are the "single points of entry," that coordinate the delivery of publicly funded community-based services that seniors and their caregivers need. The Area Agency on Aging (AAA) system is funded by federal, state and local resources, and administered locally. Service delivery decisions are made at the community level—often in the homes of the seniors who need those services. The Area Agencies on Aging carry out their federal mandate as "the Leader" on aging issues at the local level. The Kansas Area Agencies on Aging Association works to improve services and supports for all older Kansans and their caregivers.

Thank you for this opportunity to appear before you today. The Kansas Area Agencies on Aging Association has a few comments about the Single Portal for Services Information for Kansas seniors.

Explore Your Options

Explore Your Options is a publication of the Kansas Department on Aging that we work cooperatively with the department on developing each year. The local Area Agency on Aging reviews and revises the resource section of the guide each. The job of the local AAA information and referral staff is to add and delete information about local resources available to seniors.

The *Explore Your Options* publication is available online at the Kansas Department on Aging website. The printed version of *Explore Your Options* is available through KDOA, AAA offices, as well as the various distribution points mentioned below.

East Central KS AAA (Ottawa)

East Central KS AAA sends them to all hospitals, nursing facilities, assisted living facilities, nutrition sites, senior centers, places where potlucks are held, county councils on aging, inter-agencies, pharmacies, doctors offices, extension offices, health departments, and anywhere else we can put a stack. But more importantly, I think it needs to understood that the best way to get information out is "word of mouth" and having a presence in the communities. Even when we distribute *Explore Your Options* books, we take them ourselves for the most part so we can talk to the business and give them a "face" to make referrals. There is also a level of trust when you have a face to put with the agency that coordinates the service.

Southeast KS AAA (Chanute)

We distribute to all hospitals, nursing facilities and assisted living facilities in our nine county area. They are also distributed to three hospitals in Joplin, MO and Jane Phillips Hospital in Bartlesville, OK because our Kansas seniors go to these hospitals. We distribute at five health fairs in our region, monthly elder abuse coalition meetings, meal sites, doctors' offices, SRS facilities, Home Health Agencies, dentists' offices, pharmacies, optometrists' offices, senior centers, CARE Update and CARE trainings, Caregiver Breakfast Clubs, and walk-ins in our offices in Chanute and Pittsburg. When I make my yearly visits to County Commissions I distribute to them, and at our older worker workshops in the nine county region.

Jayhawk AAA (Topeka)

Jayhawks AAA distributes EYOs to: Libraries, nursing facilities, hospitals, independent senior housing complexes, assisted living facilities, wellness/medical centers, senior centers, churches, meal sites, health fairs, at presentations to groups such as civic organizations, AARP tax sites, emergency aid agencies such as Salvation Army, aging social service agencies, caregiver support groups/workshops, mortuaries, etc. JAAA begins each year with an EYO fair as an avenue to release the new edition. At the fair various social service agencies are invited to exhibit and educational workshops are offered.

South Central KS AAA (Arkansas City)

South Central Kansas AAA distributes our EYO's to hospitals, assisted living facilities, nursing facilities, churches, doctor's offices, senior centers, County Council on Aging, health fairs, mental health centers, health dept., Etc.

Central Plains AAA (Wichita)

Central Plains provide to the same ones as other AAA's and businesses, retirement groups, hospitals, senior centers, professional organizations, discharge planners, ALF's, ILRS's and at all of our community events and outreach events . All of our providers get cases and neighborhood associations, small towns, Extension offices, CMHC's and the CDDO. We also get the word out through word of mouth which as East Central KS AAA pointed out is so important.

Southwest KS AAA (Dodge City)

In PSA 06 the EYOs have been distributed to 73 senior centers, hospitals, assisted living centers, courthouses, some post offices and banks in some of our smaller communities, county extension offices, medical centers in our larger cities, our four regional offices in Great Bend, Liberal, Garden City, and Pratt, all SRS offices in our service area including APS, selected churches in the larger cities, and our list of minority organizations in Liberal and Garden City.

We also deliver full cases of EYOs to all the hospitals in Wichita and the Hays Regional Medical Center.

Wyandotte-Leavenworth AAA (Kansas City)

The Wyandotte-Leavenworth AAA provides EYO's to all of the aforementioned agencies and groups provided in the preceding responses, but I can add Human Resource departments, and Employee Assistance Programs, at some of the large Corporations/Employers in the area, i.e. General Motors, Unified Government, etc.

Johnson County AAA (Olathe)

The Johnson County AAA distributes Explore Your Options to hospitals, assisted living / nursing facilities, nutrition sites, senior centers, independent senior housing, libraries, and information fairs. Other social service agencies also utilize the EYO's to assist the aging population of the county such as SRS programs: Adult Protective Services and Economic & Employment Services division for Medical and Frail Elderly.

Northeast KS AAA (Hiawatha)

We place EYOs in senior centers, meal sites, doctors offices, thrift stores, and hand them out at our annual senior Expo. We also give them to other social service agencies, so they have a desk reference if someone asks them about our services. They also sometimes hand them out as well. We also take them to the VA in Leavenworth & Topeka, as their social workers hand them out. We also try to place them wherever SRS has access points.

Northwest KS AAA (Hays)

EYO's are distributed to hospitals, nursing facilities, senior centers, meal sites, libraries, senior housing, etc. We distribute them to many of the same places mentions by others.

K4A Toll-Free Information Line - 1-866-457-2364

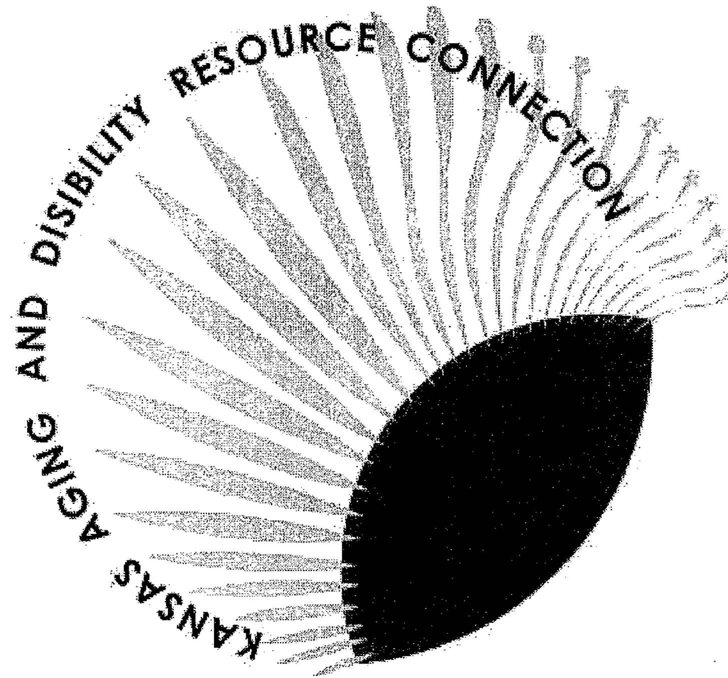
- **New Number**
- **Established Under Grant, K4A will be continuing**
- **Routing System**
- **Developing materials and press releases**

Thank you for the opportunity to appear before you today!

Craig Kaberline, Executive Director
Kansas Area Agencies on Aging Association (K4A)
2910 SW Topeka Blvd.
Topeka, KS 66611
(785) 267-1336

Joint Home and Community Based Services Oversight
Attachment: 8
Date: 11/19/09

Kansas Aging & Disability Resource Connection



A joint program of the Administration on Aging and the Centers for Medicare and Medicaid Services

Aging & Disability Resource Centers (ADRCs) Serve

- Individuals who need long-term support
- Families and caregivers
- People planning for future long-term support needs
- Agencies and organizations that serve older adults and/or persons with disabilities

National Vision for ADRC Program

- To create synergies between the Aging Network and CMS to implement consumer-directed care
- To truly embrace the vision of the Americans with Disabilities Act (ADA) – serve all ages & income levels
- To develop programs that provide person-centered, “one-stop” entry into the long-term support system.
- To increase knowledge of and access to long term supports and services

What is Different about ADRC?

- Connects the aging and disability communities
- Involves multiple partnerships on all levels
- Offers more than information and referral (e.g. options counseling, benefits counseling)
- Makes effective use of technology to streamline access
- Has strong consumer orientation
- Focuses on appropriate setting for services & supports

The Kansas ADRC Project

- Kansas Department on Aging was awarded federal ADRC grants in 2005, 2008 and 2009
- Current key partners are AAAs, CILs, SRS and KHPA
- The *Kansas Aging & Disability Resource Connection* is using technology to streamlines access to services
  - Public access website offers a searchable database of service providers
  - Limited-access referral/call log system offers tools for ADRC participating agencies

Public Access Website

8-6

Kansas Aging & Disability Resource Connection

KANSAS
DEPARTMENT ON AGING

Quick Search | Zip | Go | Advance Search

Change text size:
Medium | Larger | Largest

- What's New
- Assess Your Need
- Care Options
- Search for Services
- Key Resources
- Application Forms
- Calendar
- Report a Problem
- User Survey
- I Need Help

Welcome to Kansas ADRC, the online directory and care coordination tool connecting the people of Kansas to long-term care services and resources. Kansas ADRC offers a state-wide service directory to help consumers and their families quickly and easily access services.

Hot Topics
- Latest News
- Important Facts
- Things You need to Know

Helpful Links
- KDOA
- SRS
- SHICK
- SMP
- Medicare.gov
- Social Security

Site powered by RTZ Associates

Disclaimer: Please note that because providers voluntarily list their services on this site, all providers in the territory may not be listed. While we strive to ensure the accuracy of the information on this site, the inclusion of a provider listing on Kansas ADRC does not constitute a recommendation or endorsement of that service. Always use appropriate caution by consulting trusted advisors and checking references and licensure before hiring a care provider.

8-7

"Assess Your Needs"

Quick Search [ ] County [ ] Go Advanced Search

Change text size: Medium | Larger | Largest

- Home
- What's New
- Assess Your Needs
- Care Options
- Search for Services
- Key Resources
- Application Forms
- Calendar
- Report a Problem
- User Survey
- I Need Help

Needs Assessment

This assessment was designed to quickly evaluate your care needs. There are 12 questions; please answer as many as you can. You don't need to answer all the questions, but it is required that you answer question #2. It will take about 5-10 minutes to complete.

When you finish, click the 'Submit' button, and we'll recommend care options to meet your needs.

Then you can learn about each option, select those that seem most appropriate and find care providers anywhere in Arkansas.

1. **I am seeking care for:**
   - ○ Myself
   - ○ My Parent
   - ○ My Spouse
   - ○ Another Relative
   - ○ My Friend
   - ○ Other
2. **I prefer to receive services:(check all that apply)**
   - ☐ In my home
   - ☐ In the community
   - ☐ At a residential facility
   - ☐ In an institutional setting
   - ☐ I'm not sure
3. **I require assistance with the following tasks:**
   - ☐ Eating
   - ☐ Dressing/Grooming
   - ☐ Transferring (from bed into a wheelchair)
   - ☐ Toileting
   - ☐ Bathing
   - ☐ Medication reminders or supervision
   - ☐ None of the above
4. **I require assistance with the following household chores:**

Hot Topics

- Latest News
- Important Facts
- Things You need to Know

Helpful Links

- KDOA
- SRS
- SHICK
- SMP
- Medicare.gov
- Social Security

"Care Options"

Quick Search [ ] County [ ] Go Advanced Search

Change text size:
Medium | Larger | Largest

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Learn about Care Options

This section of Kansas GetCare is designed to help you learn about common care options. We have organized long term care services into seven main categories. Each category includes a range of care options. Simply click on a category for a list of services that are available in most communities. Get the information you need in order to make important decisions and to find providers, resources, and support.

In-Home Care
Products and services available to seniors and people with disabilities who wish to live independently in their homes and communities. Services include assistance with personal care and household tasks, home health care, and home modifications.

Community Health and Social Services
Community-based services such as meal and transportation programs offer support for individuals who live independently. People often use a combination of community-based services and in-home care to maintain independence.

Nursing Homes
24-hour medical attention for extended post-operative care or complex health monitoring.

Residential Facilities
Options range from assisted living communities, where residents enjoy private apartments, to continuing care retirement communities which meets residents' health needs as they change over time.

Medical Services
Hospitals, rehabilitation and dialysis centers, and outpatient centers offer services for individuals with a wide range of medical needs.

Caregiver Resources
Caring for a family member or friend can be both challenging and rewarding. Finding the right resources can help. Learn about caregiver respite and support, grief recovery services, and caregiver education.

Care Coordination and Other Services
Learn about a variety of services, including elder law, and abuse prevention. Find your local Area Agency on Aging, which can be a good source of additional information.

Hot Topics

Latest News
Important Facts
Things You need to Know

Helpful Links

KDOA
SRS
SHICK
SMP
Medicare.gov
Social Security

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Helpful Tools

Checklist Provided by GetCare.com

Nursing Home Checklist

Carry this checklist with you when you visit nursing homes (simply print out one checklist per nursing home you plan to review). The checklist is designed to help you know what to look for and to remember what you saw. Use the back of the checklist to write down any additional comments. After visiting the facilities use the checklists to compare one provider with another.

Name of Nursing Home: ______________________________

Owner/Administrator: ______________________________

Address: ______________________________

Phone: ______________ **Website or E-Mail :** ______________

Who is Served?

Yes	No	
❑	❑	Can the nursing home provide the level of assistance you require, given your medical condition?
❑	❑	Are there medical conditions the facility will not accept? If yes, what are these conditions? ______________________

Services

Yes	No	
❑	❑	Does the physician and nursing staff meet with residents and their families to assess residents' needs and develop individualized care plans?
❑	❑	Is there a physician available on site for emergencies?
❑	❑	Does the facility have an arrangement with a nearby hospital?
❑	❑	Are physical, speech and/or occupational therapy available?
❑	❑	Is confidentiality of medical records assured?
❑	❑	Are private rooms available?
❑	❑	Can the facility consider personal food likes and dislikes when planning meals?
❑	❑	Can meals be delivered to residents' rooms?
❑	❑	Are snacks available around the clock?

Information Updates

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Should My Relative Come Live With Me?

If we can offer one piece of advice on the topic of moving a parent into your home, it is to think the decision through carefully and discuss the pros and the cons of a new living situation with everyone concerned. That includes your spouse, children living at home, other caregivers and the elder him or herself.

Here are some of the important factors to consider in making the decision:

Studies show that most older adults prefer not to reside with their children, particularly if it takes them away from their community of friends and familiar places. Do not underestimate the comfort and security a senior finds in being located in his own neighborhood, near his church, the bank and even a long-time barber.
Will your home accommodate another adult? Consider space and privacy, as well as safety. For example, can your parent walk up and down stairs? Are the hallways well-lit? Do you need to install grab bars in the bathroom?
Know your parent's preference. Don't assume that your parent would like to move into your home. After years of living independently, residing under someone else's roof may not be of your parent's choosing.
Think through the potential challenges of creating a multigenerational household. Discuss roles and responsibilities with everyone who will be living together, including your spouse, children and parent.
Do you have an easy relationship with your parent? If you have held resentments or been prone to arguing in the past, chances are that living under the same roof will exacerbate any tensions between you.
Your lifestyle may change considerably, especially if your parent requires regular supervision. Are you prepared to share your personal time and space? Do you have plans for respite?
Consider how you will pay for the extra expense of boarding and caring for your parent. If appropriate, talk to your siblings about sharing the cost.
Examine all of the options. If your parent can no longer live independently, what are the other alternatives for providing the necessary care, such as hiring in-home services? Present all of the options for the elder and other caregivers to consider.
Source: **Seniorlink**, which provides eldercare management services to aging adults, family caregivers and employers through its nationwide network of credentialed care managers.

Other Resources

Quick Search [ ] County [ ] Go Advanced Search

Change text size:
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Official U.S. Government Sites

Centers for Medicare and Medicaid Services(CMS)
CMS is the U.S. agency that manages Medicare, Medicaid and the Children's Health Insurance Program (CHIP). On this site, you can find information about coverage and benefits for these programs.

U.S. Administration on Aging(AoA)
AoA is the U.S. government agency that advocates for older persons and their concerns. AoA works to inform people about the valuable contributions that older Americans make to the nation, as well as the needs of older people. This site contains educational material on aging-related issues.AoA is the U.S. government agency that advocates for older persons and their concerns. AoA works to inform people about the valuable contributions that older Americans make to the nation, as well as the needs of older people. This site contains educational material on aging-related issues.

Administration on Developmental Disabilities(ADD)
The Administration on Developmental Disabilities works to help people with developmental disabilities live as independently as possible and to make the general public aware of this population's needs and potential.

U.S. Food and Drug Administration(FDA)
The U.S. Food and Drug Administration evaluates the safety of drugs that are available to American consumers. It identifies drug safety concerns and recommends actions to improve the safety of prescription and non-prescription drugs and to protect the public health.

National Council on Disability(NCD)
CMS is the U.S. agency that manages Medicare, Medicaid and the Children's Health Insurance Program (CHIP). On this site, you can find information about coverage and benefits for these programs.

US Department of Veterans Affairs
The U.S. Department of Veterans Affairs serves former members of the American military. This site contains information about veteran health care benefits, pensions, and educational opportunities for veterans.

Social Security Administration
The Social Security Administration manages Social Security retirement and disability payments. This site has benefits information and answers to frequently asked questions.

Hot Topics

Latest News
Important Facts
Things You need to Know

Helpful Links

KDOA
SRS
SHICK
SMP
Medicare.gov
Social Security

Referral/Call Log System

- Each agency retains its own autonomy
- Key functions are coordinated and streamlined between organizations
- Client information is shared between agencies to reduce duplicate intake and assessments
- Only available to certain providers (e.g. case managers) to control access to client information
- Project begins with AAAs and CILs, will expand to include CMHCs and CDDOs

Timeline

- Rollout of public access website in early 2010
- Phased implementation of referral/call log system beginning in early 2010
- Plan to expand listings to include CDDO and CMHC providers by 2011.

KANSAS
DEPARTMENT OF HEALTH
AND ENVIRONMENT
Division of Health

Mark Parkinson, Governor
Roderick L. Bremby, Secretary

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Testimony on
MAKE A DIFFERENCE INFORMATION NETWORK
to
Joint Committee on Home and Community Based Services Oversight
Presented by
Marc Shiff, Director, Children & Youth with Special Health Care Needs
November 19, 2009

Chairwoman McGinn and members of the Committee, I am pleased to appear before you today to provide information on the KDHE Make A Difference Information Network (MADIN). My name is Marc Shiff, Director of Children and Youth with Special Health Care Needs.

The MADIN is a collaborative effort among the KDHE, the Kansas State Board of Education, the Kansas Department of Social and Rehabilitation Services, and Oral Health Kansas to connect Kansans and service providers with resources and services for individuals with disabilities.

The MADIN is available online at www.makeadifferenceks.org and resources are available in Spanish. The MADIN toll free number (800-332-6262) serves Kansans with disabilities Monday through Friday from 8 to 5 in one telephone call. The MADIN promotes individual responsibility by providing links to topics of interest, including:

- Screening, diagnosis, evaluation
- Early intervention for infants and preschool children
- Parent support groups
- Resource materials for families and service providers
- Information regarding education, public health and social service agencies
- Clinical information for people with disabilities

MADIN receives approximately 300 calls per month: of those calls about 50 (17%) are in Spanish. The MADIN web site receives more than 1,700 web requests for information each month or an average of 57 web requests each day. Each month, madin@kdheks.gov receives about 20 requests for information, plus questions and concerns regarding individuals with disabilities.

The MADIN Specialist regularly receives referrals from persons who have contacted the United Way 211 number requesting information about services and resources for Kansans with disabilities.

Thank you for the opportunity to appear before this Committee. I will be happy to respond to any questions you may have.

CURTIS STATE OFFICE BUILDING, 1000 SW JACKSON ST
Voice 785-296-1316 Fax 785-2

Joint Committee on Home- and Community-Based Services Oversight
Carole Jordan
Director, Rural Development Division
Kansas Department of Commerce
Nov. 19, 2009

Good afternoon Chairperson McGinn, Vice-Chair Bethel and members of the joint committee. Thank you for inviting us here today to tell you about the Rural Development Division and, in particular, the Office of Rural Opportunity. Our four Office of Rural Opportunity field staff are our troops on the ground in rural Kansas.

First, a little bit about the Rural Development Division. Kansas doesn't have a separate rural economy and a separate urban economy. We have one Kansas economy in a world economy. As such, we cannot afford not to work hard to ensure the health of our Kansas communities and the agriculture and rural economy.

The Rural Development Division was created through reorganization in the fall of 2008. This change gave agriculture and rural Kansas a direct pipeline to the secretary of commerce, and vice versa. It signifies the importance our state's premier economic development entity places on the successes of rural Kansas. It also focuses and creates a direct route to rural development activities in state government and among the rural development partners. It came about after a recommendation in the Kansas, Inc., strategic plan of 2007, "Enhancing the Structure of Rural Development in Kansas."

Kansas, Inc. hoped that a state rural development division would provide a central point of access, an understanding and inventory of assets and resources available to rural Kansas, help convene and coordinate efforts, measure needs and efforts, and ensure follow-up and follow-through on rural issues.

The division is an umbrella under which there are some 30 Commerce programs that deal with some aspect of rural development. Those subdivisions include agriculture marketing, community development and the offices of rural opportunity. What they have in common is they all add value to rural Kansas and rural communities....thus they add value to the state of Kansas. Or to be more basic, we work to push state and federal dollars out into the rural areas of our state and to use them wisely to help rural areas and communities meet their goals. A few of our value-adding programs include:

- Agriculture value-added loans
- CDBG grants to build city parks, infrastructure, fire stations
- Rural business development tax credits

Joint Home and Community Based Services Oversight
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- Community service tax credits
- Community Capacity Building Grants
- Individual Development Accounts
- Main Street Program
- Incentives Without Walls
- Small Business Development Centers
- NetWork Kansas
- Agritourism and agritourism business assistance
- CDBG urgent need grants—Greensburg and SE Kansas floods in 2007, Chapman Jewell, and most recently Anthony and Wilson.

Besides managing funds and administering programs, the division has created an informal Partners Group, bringing together a plethora of agencies and groups with resources and interests in rural development to meet and talk together on a regular basis. This communication helps find synchronicities and avoid wasted effort. Among our partners are KSBDC, the SBA, USDA Rural Development, KU and KSU, the state's associations for community foundations and regional foundations, KEDA, the Kansas Department of Health and Environment's Office of Local and Rural Health, the Commission on Rural Policy and others.

The existence of a rural development division helped the Department of Commerce create the Connect Kansas initiative to increase high-speed Internet access in the state's underserved – and largely rural – areas. The initiative is funded primarily by the federal American Recovery and Reinvestment Act and has two components: 1) mapping Kansas' current broadband capacity; and 2) providing federal grants and loans to qualified organizations involved in expanding broadband to rural areas. We believe high-speed internet is another component of success for rural communities.

Offices of Rural Opportunity

You asked specifically about the offices of rural opportunity. Funded by the legislature in 2007, we've just recently celebrated their second year.

Through the cooperation and generosity of the schools, they are based in community colleges in Colby, Garden City and Chanute, and the private college in Sterling.

The mission of the Office of Rural Opportunity is to support the efforts of rural Kansas communities to achieve their goals by increasing awareness and access to available resources. Their focus is on towns of 5,000 and under.

Often we had heard that our smaller communities just did not know what resources were available to them. The Office of Rural Opportunity was created specifically to deal with this problem. We tell the rural communities that we are not there to dictate to them from Topeka; instead, we are here to help them reach their goals after they have agreed upon them and created a roadmap to success.

We developed a Kansas Rural Development Resource Guide, describing our partnerships with business development, community capacity building, community development and various assistance agencies. It also gives regions and names and contact information for the rural opportunity staff.

The offices of rural opportunity not only gather data about available resources, and connect towns with the resources, but they also can tell us where there are conditions and situations for which there are not

sufficient resources. Identification of needs unmet can help guide policy decisions. Housing, health care and infrastructure are areas of concern all across the state, they tell us.

In the two years of work, the offices of rural opportunities have helped towns leverage dollars for health projects as follows:

Eastern Kansas

- Cherokee County (Riverton) - $400,000 CDBG award for a Health Education and Wellness Center

Central Kansas

- Attica Nursing Home - Alzheimer's Wing, Portable X-Ray Equipment, etc., - $105,000 CSP tax credit award
- Rice County Community Healthcare Foundation - Health Needs Assessment - $22,250 from Kansas Rural Health Works Program

Northwest Kansas

- Rawlins County Hospital Expansion - $250,000 CSP tax credit award
- Rawlins County Dental Clinic - $300,000 from multiple grant sources (including Sunflower Foundation, United Methodist, etc.)

Southwest Kansas

- Greeley/Wallace County Health Foundation - Health Capacity Grant - $185,000 from the Sunflower Foundation

Excluding Commerce programs, these rural Kansas field staff have leveraged resources from outside sources amounting to $11,888,551 in the last two years, according to the data base we have developed.

Healthy Communities

Health professionals talk about healthy communities and so do we. We believe healthy rural communities have a convergence of positive forces—among them are housing, leadership, infrastructure, communications, jobs and health care services. High-speed Internet is another component, providing the infrastructure for telemedicine, future home health care services, eGovernment, equal education and economic development.

Beyond the comforting fact of having home health care available for loved ones in rural communities, or good assisted living or nursing home services or a nearby hospital, rural health care is a factor in the economic health of rural communities. I'm sure you've heard of the Kansas Rural Health Options Project—a team effort of KDHE, KHA, Kansas EMS Board and KMS. It has created a series of county studies of the economics of rural health care. They note that Medicare, Medicaid and private insurance payments make a strong difference in health care services and economy, and that telemedicine holds promise for increasing primary, consultative and specialty health care services in rural Kansas.

I am a Russell County native and I graduated from high school in Jefferson County, so I looked at the report for Russell. Health services in Russell County employ 380 people, 6.8 percent of the county's jobs. Health services are number five in the county in terms of employment, number four for wages and number seven in income. This is important to the economy of Russell, Kansas and other rural areas.

The availability of health care plays into the decisions of business and industry to stay, expand or move into an area. It's important to young people who are deciding whether to stay home and raise a family. It's important to people in their thirties or early retirement ages deciding whether or not to come home to Kansas now that many jobs are not place specific. The Federal Reserve Bank of Kansas City tells us there has been a quiet trend toward more of these age groups returning home to rural areas here in the Midwest. They can help ease population declines that had been going unchecked for years.

Renee Lippincott, the central Kansas ORO, says:

"I have had many communities express a need to build nice senior housing, maybe beside the nursing home, for people who don't want the responsibility of a home but aren't interested in or needing to move to a nursing home. If this housing isn't available, they usually end up moving to a town where it is available and the community loses important community members. I have had assistance requests by very small nursing homes and rural health clinics for funding to upgrade equipment. Our Community Service Tax Program can be used, but I haven't found many options for smaller projects that are less appropriate for CSP. An example: One needed a portable x-ray unit to replace a unit that takes poor quality images. The portable unit would open up the room for more uses – additional space for other services as needed. I had another community say they want to have a health nurse available to children in their child care program to improve child and family health. Many communities find it very challenging to start child care programs. I think that the availability of good, safe child care is an important component of the health and well-being of children."

The Kansas Community Service Program (CSP) gives non-profit organizations a way to improve their ability to undertake major capital fund-raising drives for various projects. This year, $4.1 million of tax credits have been allocated and will be awarded to selected non-profit organizations to offer Kansas tax credits for contributions made to approved projects. Projects eligible for tax credit awards include community service, crime prevention and health care. Tax credit awards are distributed through a competitive application process. Based on the scope and cost of the proposed project, applicants can request up to $250,000 in tax credits. Applicant organizations in rural areas (less than 15,000 population) are eligible for a 70 percent credit. Applicant organizations in non-rural areas are eligible for a 50 percent credit.

On the federally funded side, the CDBG Economic Development program might, in some cases, assist with certain kinds of health care facilities. These grants to cities or counties are then loaned to provide gap financing for private businesses that create or retain permanent jobs. Eligible activities include infrastructure, land acquisition, fixed assets, and working capital. At least 51 percent of the jobs created or retained by the for-profit entity must meet HUD's low- and moderate-income standard. Some repayment is required for all Economic Development categories. It is possible that a for-profit nursing home, for example, might be able to use these dollars.

We've also met with the Kansas Association of Medically Underserved, Kansas Medical Society, Kansas Health Institute, Kansas Hospital Association, Association of Community Mental Health Centers of Kansas Inc., Kansas Public Health Association and the Kansas Dental Association, and have joined with KDHE and USDA Rural Development to form a subcommittee of the Rural Partners group to discuss rural health care issues.

In conclusion, we in the Rural Development Division are always interested in ways to partner with other agencies and private entities to improve the total health of our rural communities. Thank you for your interest, and I would be glad to answer questions if time allows.

Mark Parkinson, Governor
Roderick L. Bremby, Secretary

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Testimony to
The Joint Committee on Home and Community Based Services Oversight
Presented By
Aaron Dunkel, Deputy Secretary
Kansas Department of Health and Environment
November 20, 2009

Madame Chair and members of the committee I am Aaron Dunkel, Deputy Secretary of the Kansas Department of Health and Environment (KDHE). Thank you for inviting me this morning to discuss the State Health Information Exchange (HIE) initiative with you. I will be providing a high level overview of activities related to the State HIE for you, with much of the detail to be provided in the testimonies of Dr. Helen Connors, Mr. Larry Pitman, and Mr. Doug Farmer, which you will hear immediately following my presentation.

In the spring of this year KDHE was assigned to be the state designee for health information technology, in this role KDHE is facilitating the creation of both strategic and operational plans for a statewide infrastructure for HIE. The discussion around the necessity of electronic health records (EHR) and HIEs has been taking place in Kansas for many years. This discussion has been reinvigorated by the inclusion of the Health Information for Economic and Clinical Health Act (HITECH) in the American Recovery and Reinvestment Act (ARRA) signed by President Obama in February 2009.

As part of HITECH there have been three funding streams identified to help in removing barriers to the implementation of EHRs and HIEs. HITECH provides for $643

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Voice 785-296-0461 Fax 785

million over the next four years for the establishment and operation of Regional Centers (RC). Our state has identified the Kansas Foundation for Medical care as the sole entity in the state to apply for funding as an RC in the first round of grants. HITECH also provides for $564 million in State HIE development. On October 16th KDHE applied to the Office of the National Coordinator for $9,066,010 of federal funds over the next four years to manage the planning and implementation of an HIE in the State of Kansas. Finally, HITECH provides for incentive payments to providers that can achieve meaningful use related to EHRs and HIEs prior to 2016. This funding is available through the Medicaid and Medicare programs directly to providers.

To enable the statewide interoperability of healthcare data, it is necessary to align a number of concurrent projects including the activities of KDHE, the Kansas Health Policy Authority (KHPA), KFMC, regional HIEs, and other interested parties through a coordinated approach. In response to this need and the need for expedited discussions concerning HIE in the state, KDHE re-convened the eHealth Advisory Council (eHAC). The eHAC is made up of representatives from 33 health care related organizations around the state representing providers, hospitals, third-party payers, consumers, local health departments, small practices, academia, and public health. To date this group has met four times. It has helped in the production of the State HIE grant application and has begun to discuss the development of both a strategic plan and an operational plan as required by the grant. These plans will act as a blue print for the governance and structure of the HIE into the future

As a part of the eHAC there has been a Steering Committee created as well as five Domain Workgroups. The steering committee includes the domain chairs from each of

the eHAC workgroups, as well as representatives from the KHPA, KFMC, and a Quality Improvement Consortium.

As the state designated entity on HIE, KDHE plans to continue to be heavily involved in planning and implementation discussions with the KHPA and the KFMC as the future of HIE in Kansas continues to develop. For additional information on the HIE Initiative please visit our project website at www.KanHIT.org. Thank you for your time this morning and I would be happy to stand for questions.

HCBS Oversight Committee:
Update on HIT/HIE

November 20, 2009

Doug Farmer
Deputy Director, KHPA

In February 2008, Governor Sebelius asked the Kansas Health Policy Authority (KHPA) to work jointly with her office, and serve as the convening agency in guiding the development and administration of statewide health information technology and exchange. In response, KHPA established a Kansas E-Health Information Advisory Council to provide guidance on policy issues related to health information technology and exchange.

In the spring of 2009 the Department of Health and Environment (KDHE) was designated by the Governor as the state designee for health information technology. Since that time, KDHE has assumed oversight and coordination of the E-Health Advisory Council efforts, and KHPA serves as a member of the E-Health Steering Committee.

Part of the American Recovery and Reinvestment Act (ARRA) known as the Health Information for Economic and Clinical Health Act (HITECH) provides incentive funding for health care providers that achieve "meaningful use" of health information contained in the exchange. KHPA will be responsible for administering incentive payments for meaningful use of HIT by Medicaid providers. At this point, HHS has begun working on an administrative definition of "meaningful use", but no final determinations have been made. In general, "meaningful use" will be measured by how well each provider is able to improve or maintain the health status of patients in their care. The definition will

Rm. 900-N, Landon Building, 900 SW Jackson Street, Topeka, KS 66612-1220
www.khpa.ks.gov

Medicaid and HealthWave:
Phone: 785-296-3981
Fax: 785-296-4813

State Employee Health Benefits Plan:
Phone: 785-368-6361
Fax: 785-368-7180

State Self Insurance Fund:
Phone: 785-296-2364

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most likely include different measures for different types of providers (physicians, hospitals, etc.).

The KHPA will be responsible for developing the infrastructure to make incentive payments to those Medicaid providers that demonstrate meaningful use of HIT. Once HHS defines "meaningful use" standards, the KHPA will work with state policy makers and stakeholders to operationalize the standard in Kansas. The HHS definition will serve as a minimum threshold, and the state will need to determine whether those standards need to be more tailored to Kansas' needs.

The KHPA will continue to track developments at the federal level and will continue to plan for implementation at the state level. As soon as the US Department of Health and Human Services publishes a "meaningful use" guideline, the KHPA will present an overview of those guidelines to the HCBS Oversight Committee.

Joint Committee on Home and Community Based Services Oversight

Update on Statewide Health Information Exchange

November 20, 2009

Helen Connors, PhD, RN

Chairman McGinn and members of the committee, thank you for inviting me to provide testimony on behalf of the Kansas e Health Advisory Council. My name is Helen Connors. I am a professor at the University of Kansas, School of Nursing and Executive Director for the University of Kansas Center for Health Informatics. Currently, I chair the Kansas e Health Advisory Council (eHAC).

The eHAC was originally established by Governor Sebelius's office through KHPA in 2008. It was established to guide the continued development of Kansas E-Health initiatives based on the final recommendations of the Health Information Technology/Health Information Exchange Policy Initiative, the Kansas Health Information Exchange Commission, and the Health Information Security and Privacy Collaborative (HISPC). However, the 2009 Legislature did not fund any of the agency's enhancement requests as recommended by the Governor. With multiple new funding opportunities through the American Recovery and Reinvestment Act, in July 2009, Governor Parkinson appointed Kansas Department of Health and Environment as the state designated entity for Health Information Technology (HIT) and named Secretary Bremby as the HIT Coordinator for Kansas. The re-envisioned e-Health Advisory Council includes representatives from thirty-three different healthcare-related organizations across Kansas; including KDHE – the State's designated HIT/HIE agency, and Kansas Health Policy Authority (KHPA) – the State's designated Medicaid entity (see attachment for a list of the Council members).

The purpose of the eHAC is to:

1. Advise the Secretary of KDHE on the development of strategic and operational plans for a state-level implementation of HIE;

2. Advise and identify points of coordination regarding related HIT activities, including but not limited to workforce development, broadband planning, coordination with Medicaid planning, development of the Regional Center, Chronic Care initiatives, etc.; and

3. Listen to and represent the interests of a broad group of HIE stakeholders as Kansas moves toward a State-Level HIE effort.

Since August 2009, the eHAC has met monthly and will continue to meet monthly as long as necessary to develop and implement the Kansas HIT Strategic and Operational Plans. The eHAC is supported by five domain work groups essential to the project. State-level HIE's are required by the ONC to plan, implement and evaluate activities across all five of these domains. A brief description of the five work groups and their chairpersons are listed below:

1. **Governance** – Helen Connors, PhD, RN

This domain addresses the functions of convening health care stakeholders to create trust and consensus on an approach for statewide HIE and to provide oversight and accountability of HIE to protect the public interest. One of the primary purposes of a governance entity is to develop and maintain a multi-stakeholder process to ensure HIT/HIE among providers is in compliance with applicable policies and laws.

2. **Finance** - Robert St. Peter, MD

This domain encompasses the identification and management of financial resources necessary to fund health information exchange. This domain includes public and private financing for building HIE capacity and sustainability. This also includes but is not limited to pricing

strategies, market research, public and private financing strategies, financial reporting, business planning, audits, and controls.

3. **Technical Infrastructure** – – Brad Williams

This domain includes the architecture, hardware, software, applications, network configurations and other technological aspects that physically enable the technical services for HIT/HIE in a secure and appropriate manner.

4. **Business and Technical Operations** – Michael Kennedy, MD

The activities in this domain include but are not limited to procurement, identifying requirements, process design, functionality development, project management, help desk, systems maintenance, change control, program evaluation, and reporting. Some of these activities and processes are the responsibility of the entity or entities that are implementing the technical services needed for health information exchange; there may be different models for distributing operational responsibilities. One model that is specifically being addressed is the Patient Centered Medical Home concept.

5. **Legal/Policy** – Jeff Ellis

The mechanisms and structures in this domain address legal and policy barriers and enablers related to the electronic use and exchange of health information. These mechanisms and structures include but are not limited to: policy frameworks, privacy and security requirements for system development and use, data sharing agreements, laws, regulations, and multi-state policy harmonization activities. The primary purpose of the legal/policy domain is to create a common set of rules to enable inter-organizational and eventually interstate health information exchange while protecting consumer interests.

Each work group consists of 10–15 members (legal Work Group – 26 healthcare lawyers) and has its own charter with specific purpose, charges, deliverables, and evaluation criteria. Members of the eHAC serve on at least one of these work groups as prescribed by the ONC. Other interested strategic stakeholders also are members. Work groups will meet monthly through the strategic and operational planning process.

The five chairpersons and four at-large members make up the eHAC steering committee. The steering committee meets monthly approximately one week before the Council meeting.

KDHE and eHAC are supported by an eHealth Consultant team consisting of HIT/HIE content experts as well as process experts. The consultant team keeps the eHAC informed on HIT/HIE issues and facilitates the meeting process. (see attached organizational chart)

Work of the eHAC

Since August, the eHAC has met four times as has the steering committee. The work has primarily focused on: educating and organizing the eHAC and work groups; applying for various funding opportunities made available through ARRA; and assessing the current state of health information exchanges in Kansas and the Kansas City Area to be sure to accommodate early adopters in the statewide effort and avoid duplication of resources.

Proposals Submitted

- **Chronic Disease grant**
    - Purpose – To expand the current Chronic Disease Electronic Management System to include tracking more diseases, increased clinician access, increased patient engagement, bi-directional web-based interfaces and a personal health record.
    - Lead organization – KDHE

- Key Strategic Partners - Providers who mange Chronic Disease and patients with Chronic Disease.
- Funding request – $2.8 Mil over 2 years through a TBD federal grant.

- **Department of Labor Workforce Development – Kansas Healthe-RITE**
  - Purpose – To provide high quality training on multiple levels to meet the needs for electronic health records (EHR), health information technology (HIT) and health information exchange (HIE). Healthe-RITE will train the essential workforce in coordination with the Kansas plan for HIT/HIE, and the Health Information Technology Regional Extension Program.
  - Lead Organization – University of Kansas Center for Health Informatics (Helen Connors)
  - Key Strategic Partners – KDHE (eHAC), KBOR, KDOC, KANSASWORKS, KHA
  - Education Partners – Seven Community/Technical Colleges, Kansas State University, University of Kansas
  - Funding request - $4.3 Mil (Direct Cost) submitted 10/05/09, notification of award or implementation date TBD.

- **State Regional Centers**
  - Purpose – To become a Regional Health Information Technology Center (RC) for the State. The RC will offer technical assistance, guidance and information on best practices to support and accelerate health care provider's efforts to become meaningful users of EHRs. The RC will focus their most intensive technical assistance on clinicians furnishing primary care services, with particular emphasis

on individual and small group practices as well as clinicians providing primary care in public and critical access hospitals, community health centers, and other settings that predominately serve uninsured, underinsured and medically underserved populations.

  - Lead Organization – Kansas Foundation for Medical Care, Inc. – (Larry Pitman)
  - Key Strategic Partners - Over 1200 clinicians/providers in Kansas have requested support services.
  - Funding request – approximately $9 million over four years. Preliminary application submitted 09/08/09. Full proposal submitted 10/30/09. Funding notification 12/08/09. If necessary, resubmission 12/22/09.

- **State HIE Cooperative Agreement Program**
  - Purpose – To support the State Designated Entity (KDHE) to develop the infrastructure to achieve widespread and sustainable statewide Health Information Exchange within and among states through the meaningful use of certifies EHRs. The State HIE Cooperative Agreement Program funds efforts at the state level to establish and implement appropriate governance, policies and network services within the broad national framework to rapidly build capacity for connectivity between and among healthcare providers.
  - Lead Organization – KDHE, the State Designated Entity (SDE) – Aaron Dunkel
  - Key Strategic Partners – KHPA, the eHAC, Work Groups and Consultant team
  - Funding Request- $10 Million. Proposal submitted 10/16/09. Funding notification date 01/15/10

Challenges

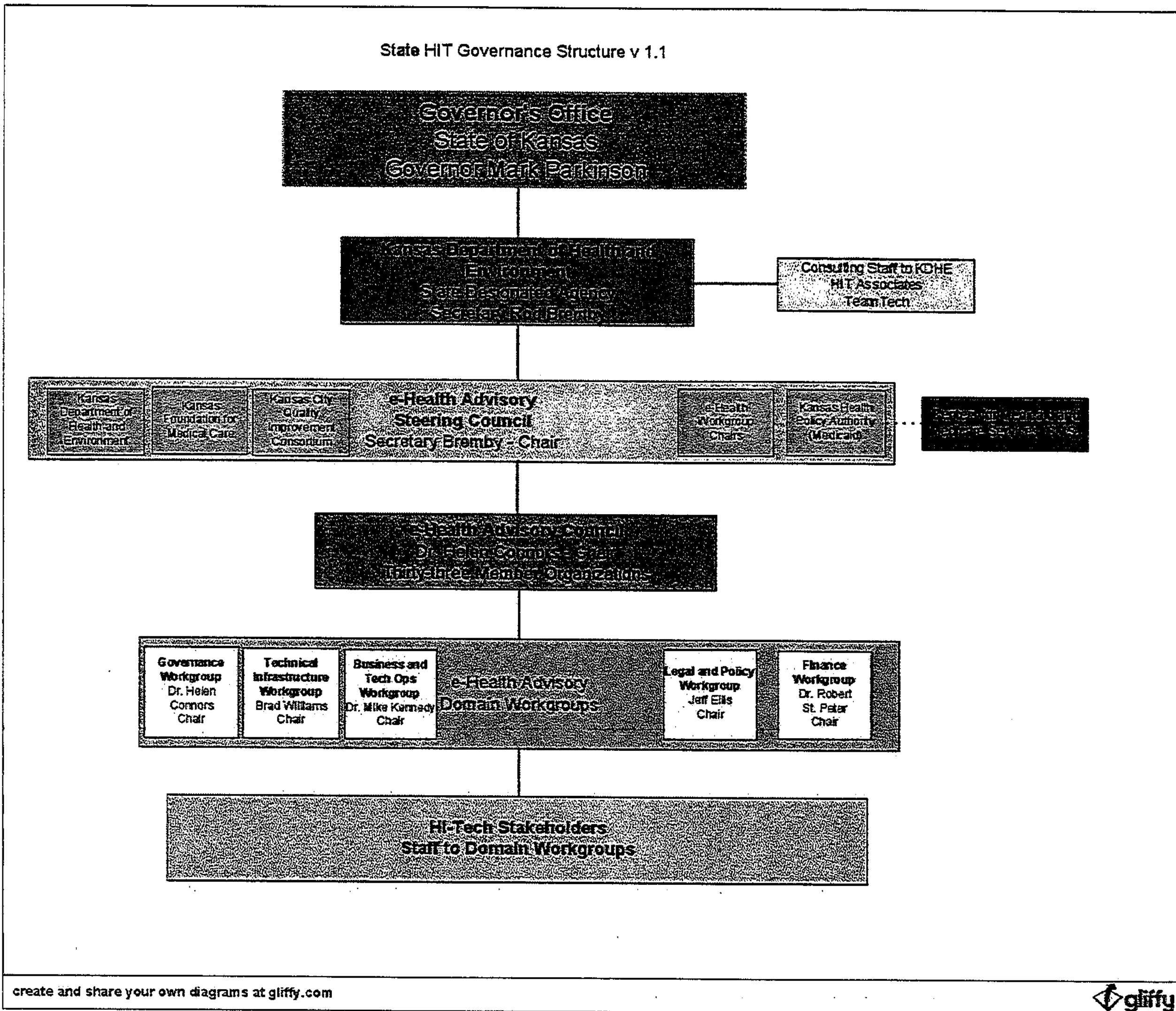
- **Culture Change** – This is a huge cultural shift within healthcare.
- **Early adopter versus laggards** – Rapid Deployment Team (Skunk Works) to capture momentum of the early adopters while strategically and operationally planning to accommodate all health providers across the state.
- **Technical Infrastructure** – The need for Broadband in Rural America is becoming more critical with HIE. Common problems affecting rural broadband, include connectivity issues, technological challenges, and high network costs.
- **Sustainability**- Long term sustainability needs to be addressed up-front.
- **Statutory and Policy Revision -** Statutory and policy revisions are essential to remove barriers and promote adoption of HIT/HIE. Laws need to be harmonized both internally and with federal laws. The legal work group will propose statutory revisions to promote statewide and intrastate HIE that assure privacy and security and protect providers and patients who participate in HIE.

Summary – In summary, there is a great deal of work to be done; however, the structure is in place to get it done. As you can see from the list of participants involved there is a wide variety of stakeholders who stand ready to get it done right.

For more information regarding the work of the eHAC, visit www.KanHIT.org.

e-Health Advisory Council Members

Name	**Association**
Amy Campbell	Kansas Mental Health Coalition
Dr. Andy Allison	Kansas Health Policy Authority
Bill Bruning	Mid-America Coalition on Health Care
Brad Williams	KanEd
Brett Klausman	Midwest Health Management
Cathy Davis	KC Quality Improvement Coalition
Dan Elliott	Kansas Association for the Medically Underserved
Claudia Blackburn	Sedgwick County Public Health Department
Corrie Edwards	Kansas Health Comsumer Coalition
Dennis Lauver	Salina Area Chamber of Commerce
Gary Caruthers	Kansas Medical Society
Helen Connors (chair)	University of Kansas Center for Health Informatics
Jacqueline John	Great Plains Health Alliance
Jeff Ellis	Lathrop & Gage
Dr. Jennifer Brull	Prairie Star Family Practice
Jimmy Brown	Swope Health Services
Jon Rosell	Sedgwick County Medical Society
Karen Braman	Preferred Health Systems
Kevin Sparks	Blue Cross Blue Shield of Kansas City
Larry Pitman	Kansas Foundation for Medical Care
Lynda Farwell	Cotton O'Neil Clinic
Maren Turner	Kansas AARP
Marta Linenberger	Foulston Siefkin
Melissa Hungerford	Kansas Hospital Association
Michael Atwood	Blue Cross Blue Shield of Kansas
Dr. Michael Kennedy	Medical Homes Initiative
Mike Fox	KU Researcher
Dr. Robert St. Peter	Kansas Health Institute
Roderick Bremby	Kansas Department of Health and Environment
Ryan Spaulding	KUMC
Sandy Praeger	Kansas Insurance Commissioner



13-9

JOINT COMMITTEE ON HOME AND COMMUNITY BASED SERVICES OVERSIGHT
UPDATE ON STATEWIDE HEALTH INFORMATION EXCHANGE
OFFICE OF NATIONAL COORDINATOR (ONC)
AND REGIONAL CENTER DESIGNATION

PRESENTED BY
LARRY W. PITMAN, PRESIDENT AND CEO
KANSAS FOUNDATION FOR MEDICAL CARE, INC

NOVEMBER 20, 2009

Good morning Madam Chair and members of the committee. I am Larry Pitman, President and CEO of the Kansas Foundation for Medical Care, Inc. I will be updating you on another segment of the ARRA stimulus package calling for the establishment of approximately 70 Regional Centers throughout the country. We anticipate Kansas will be designated a statewide Regional Center.

The American Recovery and Reinvestment Act (ARRA) stimulus package includes financial incentives for health care providers that attain "meaningful use" with their electronic health record (EHR) systems. It also supports the creation of Health Information Technology Regional Extension Centers. These centers will support physician practices in adopting EHR systems and improving use of current systems to achieve meaningful use criteria and obtain the incentives.

The Kansas Foundation for Medical Care, Inc., (KFMC), a private, non-profit community based organization dedicated to facilitating the improvement of healthcare in Kansas was invited to submit a full proposal to the Office of the National Coordinator for Health Information Technology to serve as the Regional Extension Center for Kansas. If awarded, KFMC will provide expert technical support, subsidized by federal funds to over 1,200 primary care providers who are interested in adopting EHR's or using existing systems to achieve the meaningful use incentives.

What are the Incentives?
Beginning with professional services provided in 2011, physicians who adopt and use electronic health records to improve care may be entitled to:

Medicare: Up to $44,000 per provider, over five years
Medicaid: Up to $63,750 per provider, over six years

How to Earn Incentives?
To be eligible for incentives a provider must:

1. Use a certified EHR in a "meaningful" manner;
2. Exchange health information to improve the quality of care (through a health information exchange, if available); and
3. Report on quality measures.

This must be achieved by 2015 or Medicare disincentives will begin. Those who succeed by 2011 will earn the largest incentives.

Who Can Receive Assistance?

1. **Primary Care Practices** include: Family Practice, Internal Medicine, OB/GYN, and Pediatrics.
2. **Community & Rural Health Centers** that predominately serve the uninsured and underinsured.

Non-priority practices such as specialty clinics can receive unsubsidized assistance from the Regional Centers. Higher fees would cover the cost of the services provided.

Why KFMC?

As a community-based non-profit organization, KFMC is vendor-neutral, has been working with health professionals in Kansas for decades to improve quality of care, and has already helped over 200 Kansas practices adopt and more effectively use EHRs.

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Date: 11/20/09

Wha... d the Project Entail?

KFMC will work on a four- year project from 1/15/09 to 1/15/13, providing direct clinical and technical assistance to primary-care providers in Kansas as they implement Health Information Technology. KFMC will work in collaboration with the Kansas Department of Health and Environment, its eHealth Advisory Council, and the Council membership, comprised of representatives of major healthcare stakeholders in Kansas, and additional healthcare partners to maximize the services and reach of the Kansas Regional Center (RC) program to meet the Office of the National Coordinator's goals.

KFMC will provide direct technical assistance to1200 primary care providers across the state, focusing on those that are in small group practices that provide care to the medically underserved, underinsured, and uninsured. Services provided through the KFMC RC Program include direct on-site assistance to complete Electronic Health Record (EHR) practice readiness assessments, practice work-flow assessments and redesign, certified EHR vendor evaluation and selection with a group purchasing discount, EHR implementation, assistance with meeting the criteria for meaningful use, reporting of clinical quality measures, and connectivity to a Health Information Exchange (HIE). Although Kansas is a largely rural state, with 86% of the 105 counties either frontier, rural, or densely populated rural, KFMC has broad experience in providing EHR implementation support not only in rural settings, but urban and bi-state areas as well. Effective approaches to provide efficient and responsive services will include use of regionally assigned technical and clinical experts, availability of a variety of distance learning tools, and interventions tailored to the unique needs of the special populations served in the rural communities.

Short term program goals include:

- Assisting 1200 priority primary-care providers across Kansas to implement a certified EHR, become meaningful users, and participate in a HIE.
- Development of a coordinated state-wide effort that includes a governance structure that is collaborative and doesn't duplicate services or funded activities.
- Maximizing provider reach with available funding to minimize financial burden on priority providers.
- Assisting in the development and use of standards and best practices to ensure information privacy and security.
- Providing efficient, effective, useful resources to accelerate the providers' capacity to implement a certified EHR and move to meaningful use.

Long term program goals include:

- Development of a sustainable future infrastructure for a Regional Center in KS beyond HHS funding.
- Assisting in the establishment of statewide standards for HIT for Kansas providers. Establishment of meaningful use of Kansas providers to improve healthcare collaboration among providers and increase positive patient outcomes.
- Establishment of a method to allow Kansas consumers reasonable access to electronic personal health record information.

Thank you, I would be happy to answer any questions you have.

Larry W. Pitman
President and CEO
Kansas Foundation for Medical Care, Inc.
2947 SW Wanamaker Drive
Topeka, KS 66614-4193
(785)273-2552
lpitman@kfmc.org

KANSAS
DEPARTMENT ON AGING

Kathleen Sebelius, Governor
Kathy Greenlee, Secretary
www.agingkansas.org

Home & Community-Based Services (HCBS)
Oversight Committee
November 20, 2009

Bill McDaniel, Commissioner
Program and Policy Commission

Senator McGinn and members of the committee, at your October meeting you requested that the Kansas Department on Aging (KDOA) provide an update on the evaluation of the Windsor Place At-Home Care home telehealth pilot project.

A competitive grant was awarded to Windsor Place At-Home Care and the pilot study started in 2007. The second grant period was completed October 31, 2009. The telehealth study will cover three years and will be completed on October 31, 2010. Monte Coffman, Executive Director, will provide details on the grant activities.

In addition to the grant with Windsor Place At-Home Care, KDOA and the Kansas Health Policy Authority have a contract with the University of Kansas Medical Center's Research Institute (KUMC-RI). This evaluation component has been designed to determine the effectiveness of the project, both in terms of cost and quality of life, for this type of delivery system on Home and Community Based Services-Frail Elderly participants living in a community environment. This is also a three-year agreement which started in 2007.

As you can tell from the dates, we are wrapping up the second year of the project and Dr. Ryan Spaulding will present preliminary results of the pilot study. We would ask that you invite us to meet with you later during the 2010 legislative session when we have the results of the first two years.

We continue to believe that telehealth technology, when used in a home environment, can help seniors with chronic diseases actively manage their care and identify the need for preventive intervention before situations become acute. It is our hope that this study will compliment others that have shown remote monitoring of health conditions resulted in fewer hospitalizations and improved functional status, when compared to cases that relied solely on the traditional clinical management style. In year three, we are including the additional research question: What is the rate of nursing home admissions for home telehealth participants, compared to the rate of nursing home admissions for the general HCBS/FE participant population?

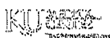
We appreciate your interest in this project and look forward to discussing the results with you in the future.

OFFICE OF THE SECRETARY
New England Building, 503 S. Kansas Avenue, Topeka, KS 66603-3404
Voice: (785) 296-4986 • Toll-Free: (800) 432-353[illegible]
TTY (Hearing Impaired): (785) 291-3167 • E-Mail:

Joint Home and Community Based Services Oversight
Attachment: 5
Date: 11/20/09

Home Telehealth Pilot

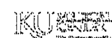
Ryan J. Spaulding, PhD
Director, Center for Telemedicine & Telehealth
Research Associate Professor, Health Policy & Management



Research Objectives

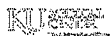
To determine if home telehealth intervention affected:

- Emergency Department utilization
- Hospital utilization
- ED and hospital costs
- Users' perceptions of home telehealth



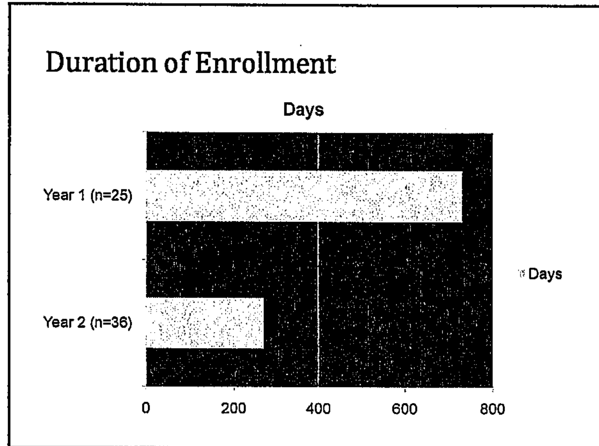
Methods

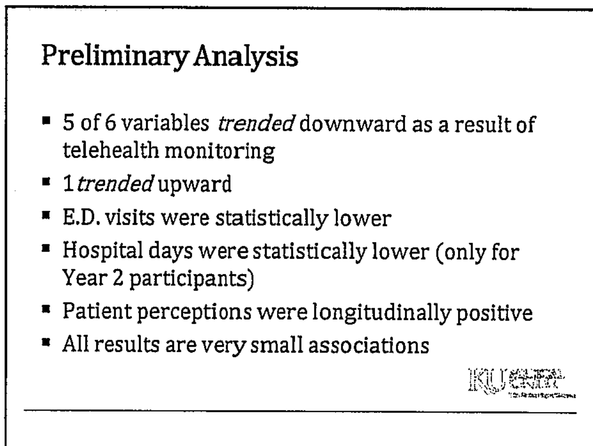
- Compare variables before and during telehealth intervention (pre-post design)
- Collect CMS claims data to track variables
- Conduct 12-item survey at end of each year

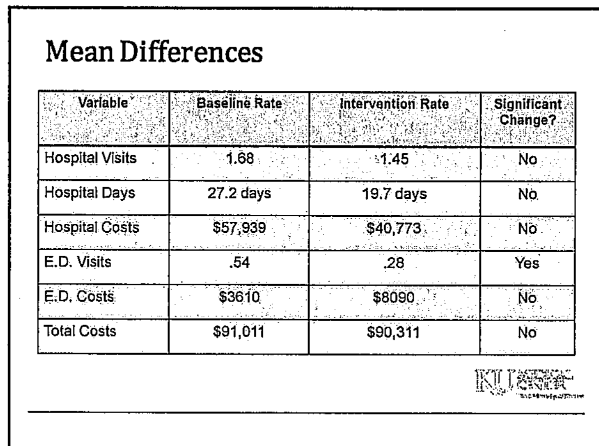


Participants

- All HCBS clients; 91 enrolled, 61 still active
- Age range of 67-96 years; average of 79
- 12 men and 49 women
- Had at least 1 hospitalization prior to enrollment
- 1st group began 9/1/07; 2nd group began 6/1/08
- 14 people died during project; 7 to assisted living or nursing facility; 8 quit; 1 moved







Mean Differences

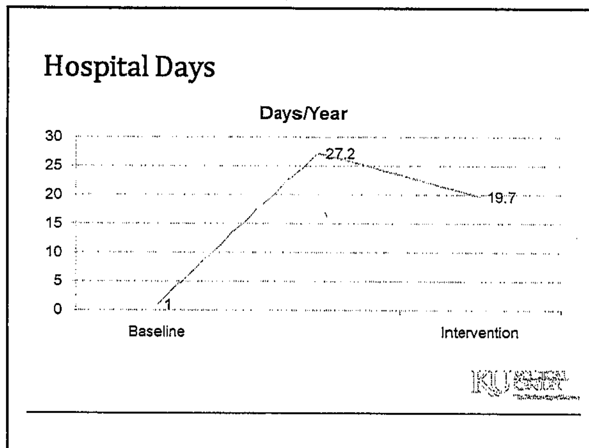
Variable	Baseline Rate	Intervention Rate	Significant Change?
Hospital Visits	1.68	1.45	No
Hospital Days	27.2 days	19.7 days	No
Hospital Costs	$57,939	$40,773	No
E.D. Visits	.54	.28	Yes
E.D. Costs	$3610	$8090	No
Total Costs	$91,011	$90,311	No

Perception Survey (All active participants)

This health monitoring technology improves my health care.	3.06
I would rather go to my doctor than use this technology.	2.09
This technology improves my life.	3.04
I am more involved in my health care as a result of this technology.	3.18
I do not trust this technology to help me with my health.	1.96
This technology will help me live in my home longer.	3.35
Using this technology has been a positive experience for me.	3.33
This technology is easy to use.	3.25
I am confident that this technology will help me if my health starts to decline.	3.25
I feel better able to manage my health care with use of this technology than I did before.	2.93
I have gone to my doctor at least once because of what I found out with the technology.	3.27
I would like to use this technology for as long as I can.	3.31

Perceptions Survey (Year 1 participants only after 2 years)

This health monitoring technology improves my health care.	3.30
I would rather go to my doctor than use this technology.	2.04
This technology improves my life.	3.09
I am more involved in my health care as a result of this technology.	3.35
I do not trust this technology to help me with my health.	2.00
This technology will help me live in my home longer.	3.52
Using this technology has been a positive experience for me.	3.48
This technology is easy to use.	3.39
I am confident that this technology will help me if my health starts to decline.	3.30
I feel better able to manage my health care with use of this technology than I did before.	3.09
I have gone to my doctor at least once because of what I found out with the technology.	3.35
I would like to use this technology for as long as I can.	3.39



Observations

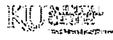
- Very wide age range, variety of conditions
- Statistical models are based on averages; benefits might be "averaged out"
- Likely an optimal age/phase of condition window in which telehealth is effective
- More data/analysis needed to identify the ideal model
- More precise sampling of participants is recommended

Additional Analyses

- More closely study 61 active participants only
- Conduct a month-by-month analysis
- Identify characteristics of long-time participants
- Comparison of nursing home deferrals
- Maintenance of vital signs

Conclusions

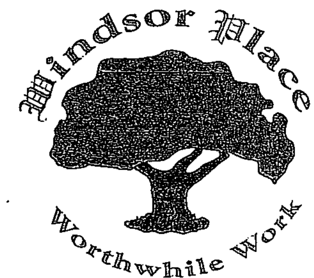
- This is a pilot project
- Pilot projects intended only to provide an indication of feasibility and effectiveness
- Many lessons learned
- These data are not statistically conclusive
- Larger group, better control would provide better data



Joint Committee on Home and Community Based Services Oversight

November 20, 2009

Room 143-N--Statehouse



Joint Home and Community Based Services Oversight
Attachment: 17
Date: 11/20/09

Telemedicine Defined

- Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve patients' health status. Closely associated with telemedicine is the term "telehealth", which is often used to encompass a broader definition of remote healthcare that does not always involve clinical services. Videoconferencing, transmission of still images, e-health including patient portals, remote monitoring of vital signs, continuing medical education and nursing call centers are all considered part of telemedicine and telehealth.
- Telemedicine is not a separate medical specialty. Products and services related to telemedicine are often part of a larger investment by health care institutions in either information technology or the delivery of clinical care. Even in the reimbursement fee structure, there is usually no distinction made between services provided on site and those provided through telemedicine and often no separate coding required for billing of remote services.
- Telemedicine encompasses different types of programs and services provided for the patient. Each component involves different providers and consumers.

Telemedicine Services

- **Specialist referral services** typically involves of a specialist assisting a general practitioner in rendering a diagnosis. This may involve a patient "seeing" a specialist over a live, remote consult or the transmission of diagnostic images and/or video along with patient data to a specialist for viewing later. Recent surveys have shown a rapid increase in the number of specialty and subspecialty areas that have successfully used telemedicine. Radiology continues to make the greatest use of telemedicine with thousands of images "read" by remote providers each year. Other major specialty areas include: dermatology, ophthalmology, mental health, cardiology an pathology. According to reports and studies, almost 50 different medical subspecialties have successfully used telemedicine.

- **Patient consultations** using telecommunications to provide medical data, which may include audio, still or live images, between a patient and a health professional for use in rendering a diagnosis and treatment plan. This might originate from a remote clinic to a physician's office using a direct transmission link or may include communicating over the Web.

- **Remote patient monitoring** uses devices to remotely collect and send data to a monitoring station for interpretation. Such "home telehealth" applications might include a specific vital sign, such as blood glucose or heart ECG or a variety of indicators for homebound patients. Such devices can be used to supplement the use of visiting nurses.

- **Medical education** provides continuing medical education credits for health professionals and special medical education seminars for targeted groups in remote locations.

- **Consumer medical and health information** includes the use of the Internet for consumers to obtain specialized health information and on-line discussion groups to provide peer-to-peer support.

3 Benefits of Telehealth

-Access to care

-Quality improvement

-Efficiency and lower cost of care

Four Key Elements to Telehealth

-Accurate physiological information

-Shared data with patient

-Data-driven coaching/patient education

-Optimized provider involvement

Kansas Medicaid LTC Services

	Nursing Facilities
Medical Clinical Care	RN's ---------------- LPN's
ADL and Personal Care	CNA's ---------------- RA's ---------------- Other Staff
Social Needs	Activity Directors Social Workers

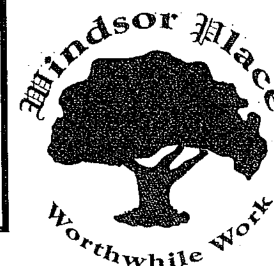
17c

Kansas Medicaid LTC Services

		Home and Community Based Services
Medical Clinical Care	RN's -------- LPN's	VOID
ADL and Personal Care	CNA's -------- RA's -------- Other Staff	Attendant Care Workers ---------------- Homemaker Staff
Social Needs	Activity directors/Social workers	Companion Services (added October 2008)

Kansas Medicaid LTC Services

	Nursing Facilities	Home and Community Based Services
Medical Clinical Care	RN's -------- LPN's	VOID
ADL and Personal Care	CNA's -------- RA's -------- Other Staff	Attendant Care Workers ---------------- Homemaker Staff
Social Needs	Activity directors/Social workers	Companion Services (added October 2008)



17-8

17-9

In 2006, Windsor Place met with and proposed to KDOA Secretary Greenlee and her staff the application of home telehealth and remote monitoring for the purpose of managing chronic diseases more effectively in the home.

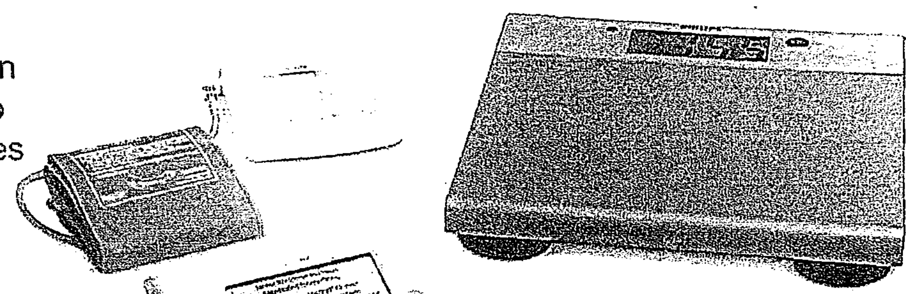
In Feb 2007, a KDOA grant funded our pilot project. On August 1, 2007, the pilot program was operational. Extremely promising results were realized during the pilot's first year.

An extension of this grant was awarded last summer. Results continue to be quite exciting in this paradigm shift.

Award-winning Measurement Technologies
Accurate, Reliable, Unobtrusive and Easy to Use

Blood Pressure & Pulse

Takes readings when patient slides cuff up the arm, then presses "Start" button.

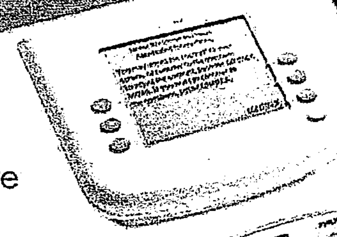


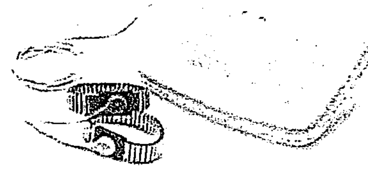
Standard Scale

Low step, a wide, steady platform, a large digital display and voice announcement.

TeleStation

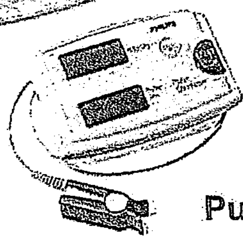
Asks simple health questions. Responses are communicated to the clinical software.





ECG/Rhythm strip

Simple wristbands with snap-on connectors.



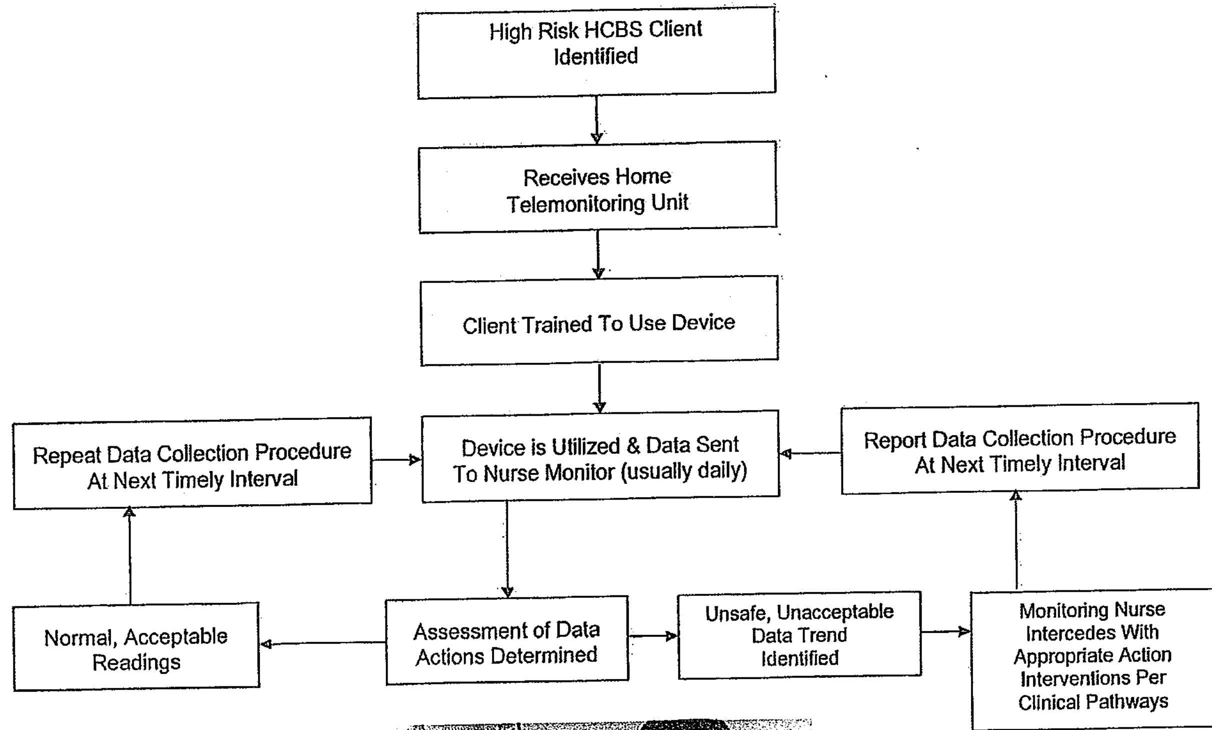
Pulse Oximeter

Spot checks oxygen saturation and pulse within seconds.

Glucose meter connection

Bayer Ascensia Contour 7151B

KDOA-HCBS PILOT PROJECT
Monitoring Process For High Risk HCBS Clients



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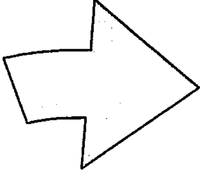
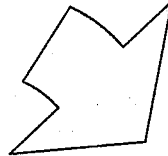
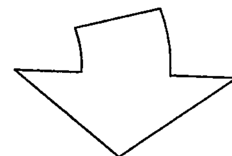
Client's begin Telehealth session



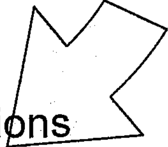
Session Data Transmission



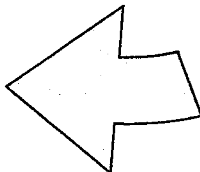
Sent to Nurse's Computer



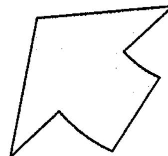
Data Reports Analyzed/Assessed



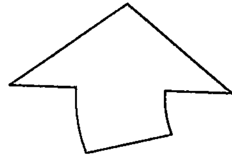
Communications Back to Client



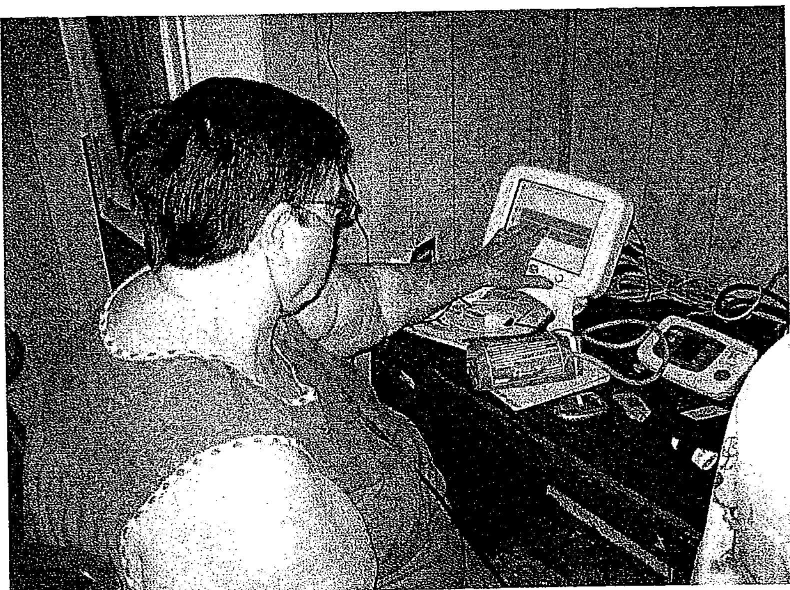
Education Tips



Intervention Actions



Retake Measurements



17-13

MARY's DAY

Mary uses Telehealth equipment to measure her Weight, Blood Pressure, Pulse Oxygen and Blood Glucose readings. A typical day for Mary is as follows:

07:30am Mary wakes, walks into her dining room and sitting relaxed, places the **Blood Pressure** cuff on her arm and presses the START button on the B/P meter. Her B/P is automatically transferred to the TeleStation (main monitor).

07:32 Mary places the **Pulse Oxygen** clip on her finger, presses start and the meter measures the oxygen in her blood. This is transferred to the TS.

07:34 Mary checks her **Blood Sugar**. Once the measurement is taken, she will plug a cable from the TeleStation into the glucose meter. This transmits that reading to the TS.

07:37 Next, Mary gets up to do her **Weight**. In about 10 seconds, this measurement will automatically go to the TS.

07:40 Taking all these measurements in the comfort of her home, Mary has used about **10 minutes** of her day.

The **TeleStation will transmit** the readings it has received from each device via a **TOLL FREE** number and send them to a **secure, password protected website** so that the **TeleHealth nurse can see them**. This transfer happens about 15 – 20 min after the first measurement was taken, giving Mary ample time to do all measurements.

On occasion, Mary will have assessment questions, information or education, or a simple Birthday greeting. She will answer these in a matter of minutes and the TeleStation, as with the measurements, will transmit the answers to the secure website.

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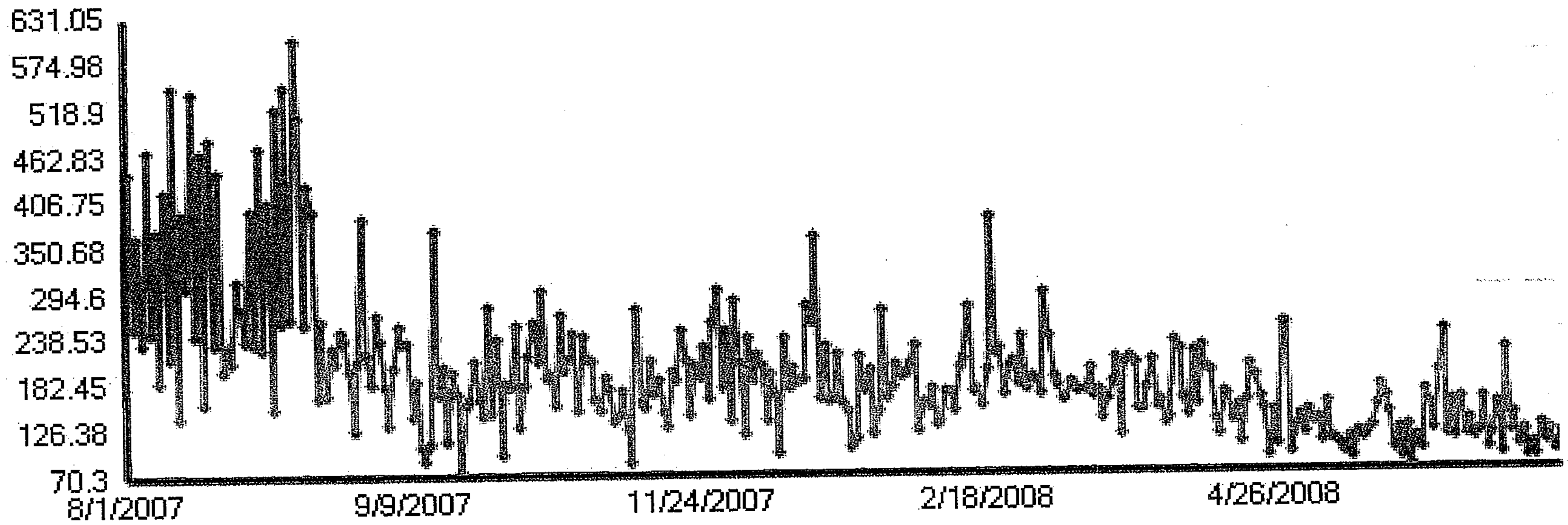
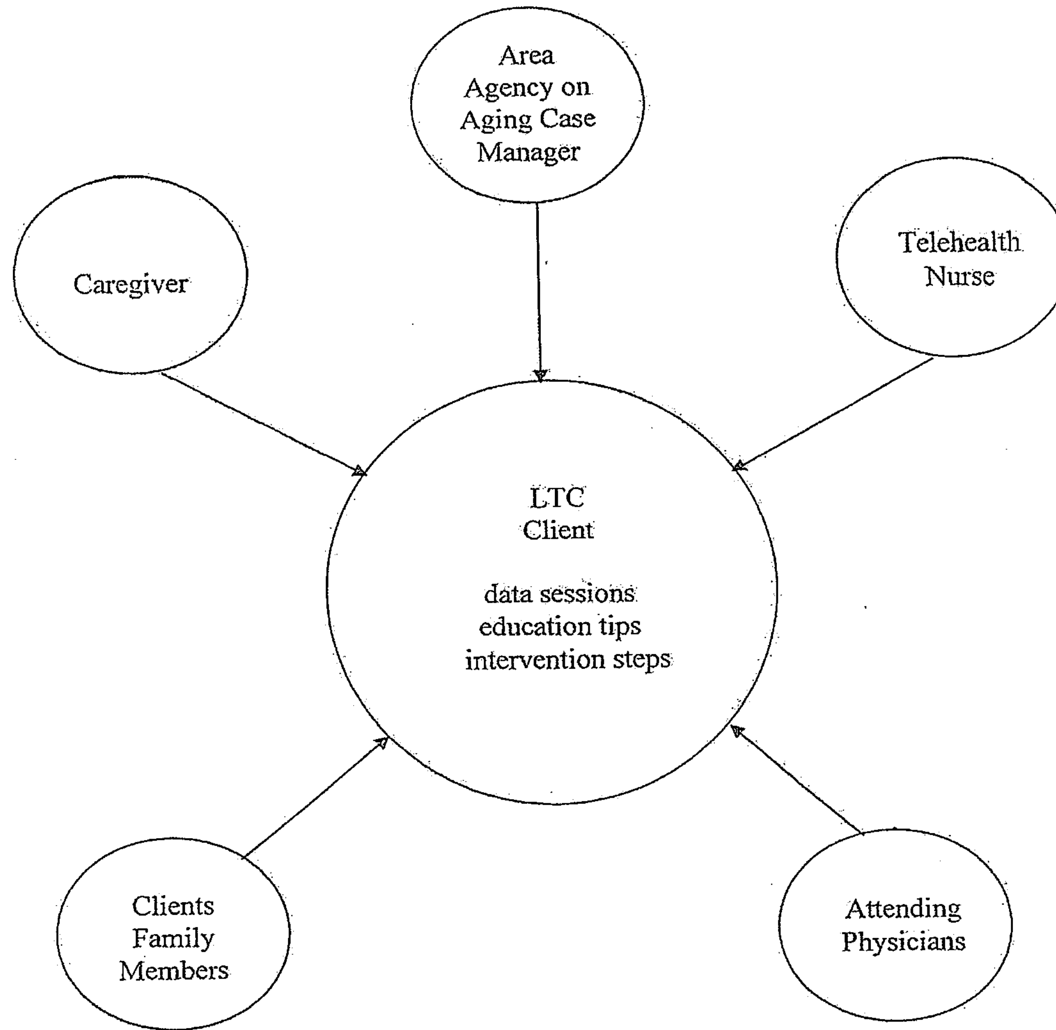


Care Coordination and Integration Expansion



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17-16

Kansas Telehealth Participant Locations

Arma-3
Baxter Springs-2
Chanute-6
Cherryvale-2
Coffeyville-12
Columbus-1
Desoto-1
Edgerton-1
Erie-2
Fall River-1
Frontenac-3
Ft. Scott-3
Galena-5
Girard-1
Howard-1
Independence-5
Iola-1
Lawrence-2
McColouth-1
Mulberry-2
Neodesha-3
Olathe-2
Oswego-1
Parsons-1
Pittsburg-3
Scammon-1
Topeka-1
West Minteral-2
Yates Center-1

Long Term Care

	NF	HCBS
	approx 10,500 people are here approx cost $2950 per month	approx 5800 frail elders are here approx cost $950 per month
	seniors/funding source want to move this trend from NF to HCBS	
medical/clinical needs	RN/LPN's provide care here.	**There is a void of care here.** Telehealth would fill this need and allow seniors to stay in their homes longer.
Personal/ADL needs	CNA/RA's provide care here.	Attendant care and homemakers provide care here.
Social Needs	Activity directors/Social workers	Companion services added Oct 2008

Cost savings opportunities -The monthly cost difference between HCBS and NF is approx $2,000
-If 500 Kansas elders could be deferred from NF placement, the annual savings would be $12,000,000.
(500 x $2,000 x 12 months)

17-18

Long Term Care

	NF	HCBS
medical/clinical needs	RN/LPN's provide care here.	**There is a void of care here.** Telehealth would fill this need and allow disabled persons to stay in their homes longer and out of the hospitals.
Personal/ADL needs	CNA/RA's provide care here.	Attendant care and homemakers provide care here.
Social Needs	Activity directors/Social workers	Companion services added Oct 2008

Cost savings opportunities 1372 PD consumers incurred $24M in Medicaid hospital costs in FY 2008.
Projected FY2009 Medicaid hospital cost for PD consumers is $28M.
If 500 consumers could be averted, savings could be $10.2M annually or more.

17-19

Contact Information:

Monte Coffman

Executive Director

Voice: (620) 252-4926
Fax: (620) 251-5029
Email: m.coffman@windsorplace.net

2921 W 1st Street
Coffeyville, KS 67337

www.windsorplace.net

INFORMATION
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KHI NEWS SERVICE

Plans not so popular in rural areas
In Kansas, about one in 10 Medicare beneficiaries is enrolled in a Medicare Advantage plan - about half the national average.

Praeger backs Medicare Advantage cuts
A key provision in the health reform bill passed late Saturday by the U.S. House calls for redirecting billions of dollars in federal subsidies to Medicare Advantage plans.

Good for some, nightmare for others
Pam Brown's job is to help older Kansans figure out how they can get the most out of Medicare.

What is Medicare Advantage?
When the Balanced Budget Act of 1997 became law, Medicare beneficiaries were given the option to receive benefits through private health insurance plans, instead of through the traditional Medicare program.

KAISER DAILY REPORT
provided by kaisernetwork.org

An Interview With Dr. Donald Berwick: 'We Need To Have More Consequences In the Health Care System'

Pilot project shows promise for cutting Medicaid costs

By Dave Ranney
KHI News Service
Aug. 3, 2009

McLOUTH — Wilma Young, 76, can't stand the thought of moving to a nursing home.

"My doctor's tried to put in me twice, but I beat him both times. I'd rather be right here," she said, seated in the living room-kitchen of her tiny apartment in this town of about 835 people, 25 miles northeast of Lawrence.

Home health aide Carla Butler, left, helps her patient, Wilma Young, adjust the telehealth equipment that records her vital signs and sends the information to a computer in Coffeyville where it is monitored by a nurse. The technology has been effective in reducing hospitalizations and nursing home admissions among the frail elderly. Young and Butler live in McLouth. (Dave Ranney/KHI)

Young is poor and in frail health. She has diabetes, high blood pressure and a weak heart.

She has been able to avoid a nursing home because she has a Medicaid-funded home health aide who looks after her and because, every day, a nurse checks her weight, blood pressure, pulse, blood sugar level, and oxygen intake.

The nurse isn't in McLouth. She's three and a half hours away, in Coffeyville, sitting in front of a computer that helps her keep track of Young's vital signs and those of 74 other senior citizens.

Young, her aide, and the nurse are key players in a two-year, Kansas Department on Aging-funded project aimed at using telehealth technology to help the frail elderly remain in their homes, avoid having to move to nursing homes, and, ultimately, saving the state millions of dollars.

Young's home health aide services cost Medicaid about $1,400 a month. If she moved to a nursing home, the likely costs to the program would be $3,200 to $4,000 a month.

Medicaid is one of the fastest growing portions of the state budget.

Remote monitoring

The monitoring technology — a cigar-box-size modem that plugs into Young's telephone — sends her vital signs to the computer in Coffeyville where they are monitored for hints her condition may be worsening.

"A month or so ago, the nurse noticed that Wilma's blood pressure had been up for about five days in a row," said Monte Coffman, who runs Windsor Place, the Coffeyville-based company that is monitoring Young.

"So she called Wilma's home health aide and, together, they called Wilma's physician and he adjusted her medicine over the telephone," Coffman said. "She's been fine ever since."

Con[illegible]ional Democrats Seek To Maintain Health Overhaul Momentum

KHN Column: 'Don't Overlook The Other Determinants Of Health'

Political Cartoon: 'Now Comes The Senate'

Timeline, Vote Counting Continue To Be Central To Senate Health Overhaul

Neither Young nor her aide was aware of the rise in blood pressure.

"There's no way to say for sure," Coffman said, "but she could have suffered a stroke."

Dramatic results reported

So far, Coffman said, the 75 Medicaid patients taking part in the telehealth project — all of them frail elderly — have experienced 70 percent fewer hospitalizations than they had in the previous year.

"And here's the best part," he said, "only one of the 75 has had to go to a nursing home."

Coffman figures the project, which has cost about $290,000, has reduced the state's Medicaid costs by about $1.5 million.

But Medicaid does not cover the sort of routine telehealth monitoring that Young and the others are receiving as part of the project, which is being paid for thanks to a Department on Aging grant funded by interest collected as part of a government loan program for nursing homes.

Medicare, which Young also qualifies for, won't cover the costs of her telehealth monitoring, either, though it would pay the bills for a hospitalization.

"There are home health-type agencies that are Medicare certified that provide post-acute care," Coffman said. "They use telehealth to monitor their patients, but once they stabilize after, say, 30 to 60 days, the equipment is removed because Medicare won't pay for it."

Saving money

Coffman said the project is saving both Medicare and Medicaid money, even though neither program will pay for the cost-saving services.

"When we keep Wilma from going to the hospital, we're saving Medicare money," he said. "When we keep her out of the nursing home, we're saving Medicaid money."

And it is relatively inexpensive to set up a home for telemonitoring.

Coffman said his company could install the technology and train the aides for about $250 per household.

"After the equipment is installed and up and running, we think we can provide telehealth for less than $6 per day, per person," he said.

The KDoA project is due to end in October. Coffman has proposed expanding it to include 1,000 Medicaid recipients, a mix of frail elderly and people with physical disabilities.

"It would take some time to get up and running, but the preliminary data indicates we could save the state about $20 million a year," Coffman said.

Evaluation pending

But such an expansion would cost about $2.2 million.

Department on Aging officials said they don't have the money to expand the program.

"Our budget is such that we can maintain our current caseloads without having to resort to waiting lists," said KDoA Aging Secretary Marty Kennedy. "Something like this would be a budget enhancement, and those are very difficult to come by this year. But we are hoping to be able to continue to fund the pilot project."

Earlier this year, the state-funded portion of KDoA's budget was cut more than 30 percent.

Kennedy said the department is leaning toward extending — not expanding — the current pilot project another year.

"We're very interested in telehealth," he said, "but I think another year of data would be helpfu[illegible] point."

Dr. Ryan Spaulding, director of the Center for Telemedicine and Telehealth at the University of Kansas Medical Center, Kansas City, plans to evaluate the project.

"It looks promising, but it's still a work in progress," Spaulding said, noting that 75 participants constituted a "pretty small" sample.

"We'll know more in the fall," when the evaluation is completed, he said.

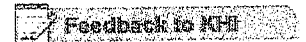
'Duck on a junebug'

The chairman of the House Aging and Long Term Care Committee is looking for a way to fund the expansion without tapping KDoA's budget.

"I'm an avid supporter of this," said Rep. Bob Bethell, R-Alden. "I'm working with Sen. Sam Brownback's office to see if there isn't some stimulus money we can get to fund this. I'm being told there's a lot that hasn't been decided. But as soon as I can get some clarification, I'm going to be all over this like a duck on a junebug."

-Dave Ranney is a staff writer for KHI News Service, which specializes in coverage of health issues facing Kansans. He can be reached at dranney@khi.org or at 785-233-5443, ext. 128.

E-mail this page to a colleague



212 SW Eighth Avenue, Suite 300, Topeka, Kansas 66603-3936 | Phone: (785) 233-5443 | Fax: (785) 233-1168 | mailbox@khi.org
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BREWSTER PLACE

Joint Committee on Home and Community Based Services Oversight
November 20, 2009

Testimony of Tom Akins, VP of Development and Planning
Brewster Place Retirement Community
1205 SW 29th
Topeka, Kansas 66611
274-3397
toma@brewsterplace.org

Mr. Chairman, members of the committee, thank you for the opportunity to present testimony this morning. My name is Tom Akins and I serve as Vice President for Planning and Development at Brewster Place Retirement Community here in Topeka. Since we first opened our doors in 1964, Brewster Place has been just that…a "place"…26 acres located just west of 29th and Topeka serving approximately 375 residents. Two years ago, Brewster decided that concentrating on just those residents at just that location wasn't enough to fulfill our non-profit mission.

After researching different models and laying the groundwork for our efforts, in November 2008 we rolled out a new concept called Brewster at Home. Brewster at Home is all about ***providing the services people need, when they need them, in the place they call home***. Brewster at Home is a membership-based organization that provides three simple but powerful benefits: first, it provides a "passport" to Brewster Place activities, trips, and programs to provide much-needed socialization opportunities; second, it features a "network of providers" – local, trusted partners – who offer (at a discounted price for Brewster at Home members) a myriad of services, including handyman services, home health, companions, nutrition, housekeeping, meals, move management, massage therapy, computer training, and much more; finally, it offers telemonitoring that includes:

- Sensors that can detect and notify a caregiver if a person is potentially unsafe (e.g. have fallen, did not get out of his chair or turn off the stove).
- Health technologies that monitor blood pressure, weight, glucose and other conditions in real time while the person is at home. This enables notification of caregivers immediately of significant changes and reduces the need for doctor's visits.
- Medication dispensers that provide the appropriate medicines at the appropriate time and remind a person to take them – with immediate notification to caregivers if a dosage is missed.

So with a system in place like Brewster at Home, technology that works, and outcomes that are in line with the Department on Aging's goals, what's missing from this picture? **Data.**

Current marketing efforts around telemonitoring focus almost exclusively on the private pay market…if you can afford the technology, you get the technology. For reimbursement to become a reality – whether through Medicaid or through other third party payors – we need statistically valid data to help us establish outcomes and to demonstrate to taxpayers and insurance companies that a front-end investment in technologies that keep elders safe, independent, and in their own homes will actually save money. Much like getting the oil changed in your car every 3,000 miles, an investment in technology-based services helps avoid more costly problems down the road. Insurance companies provide reimbursement for annual physicals for just the same reason.

We are beginning to build an anecdotal body of evidence that supports our belief that telemonitoring services keep people healthier, more independent, and utilizing the emergency room on a much less frequent basis – all while saving the state money.

We think there are partners willing to collaborate on demonstration projects that will provide much-needed data. We believe that a powerful partnership between providers, research-based universities, local health systems, health insurers,

advocacy groups, and grantmakers – working in concert with the state – can give you the information you need to make determinations about the long-term public policy implications of telemonitoring.

A great example of this partnership model is embodied in CAST – the Center for Aging Services Technologies. CAST has become an international coalition of more than 400 technology companies, aging services organizations (including Brewster Place), research universities, and government representatives. Their mission is straight-forward: to lead the charge to expedite the development, evaluation, and adoption of emerging technologies that can improve the aging experience.

At its core, we think the state should insist on the following four items of any demonstration project it supports:

1. Which telemonitoring systems will aid in managing chronic disease?
2. Which telemonitoring systems will help our elders remain in the setting almost all prefer—their home?
3. What staffing patterns will be necessary to support telemonitoring systems?
4. Can the use of telemonitoring systems save money?

Other states are successfully utilizing Medicaid waivers approved by the Centers for Medicare and Medicaid Services. Most promising, perhaps, is a waiver being utilized by the State of Pennsylvania's Office of Long-term Living to provide reimbursement for home telemonitoring for adults ages 60 and older under approval from the Centers for Medicare and Medicaid Services (CMS). This initiative includes a demonstration telemonitoring reimbursement policy to cover a range of services provided by home health, durable medical equipment providers, pharmacies and hospitals through contracts with local county Area Agencies on Aging. State officials in Pennsylvania expect the program to help with a workforce shortage by increasing the number of persons that can be served by homecare staff, while enabling state Medicaid savings by allowing more consumers to remain safely in their homes and delay moves to more expensive skilled nursing care. They believe – as do we – that it's just not feasible for the vast majority of elders who need assistance, but want to stay in their own homes,

to pay for an in-home aide 24 hours a day; instead, technology can help us monitor elders' wellbeing 24 hours a day, seven days a week.

It comes down to this: telemonitoring can provide significant benefits to our elders, including the opportunity to stay healthier and more independent – and it can, we think, save the state significant amounts of money. What ***we*** need is the ability to undertake demonstration projects that will provide us with an opportunity to provide you with the information and data ***you*** need to make sound public policy. As you look to the future of telemonitoring, I would respectfully urge you to seek ways to support demonstration projects, including both policy changes and financial support.

Thank you.

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Joint Committee on Home and Community Based Services
November 20, 2009
Attachment 20

Community Funding for Individuals with Developmental Disabilities (Revised)

All Funding Sources

Item	FY 2007 Actual	FY 2008 Actual	FY 2009 Acutal	FY 2010 Revised Estimate	FY 2010 with Caseload Estimate	Differences	FY 2011 Agency Request	FY 2011 Agency Request without Enhancements and with Caseload Estimate	Differences
State Aid	$ 5,163,174	$ 5,163,174	$ 5,163,174	$ 5,163,174	$ 5,163,174	$ -	$ 5,163,174	$ 5,163,174	$ -
Grants for direct services	13,039,989	13,840,283	14,038,597	4,896,190	4,896,190	-	11,684,364	4,896,190	(6,788,174)
Targeted Case Management*	28,293,720	17,332,367	16,825,254	15,997,554	16,797,983	800,429	15,997,544	17,178,707	1,181,163
Postitive Behavior Supports*	208,657	278,401	7,439	189,660	189,660	-	189,660	189,660	-
ICF/MRs	17,002,709	16,529,934	14,133,796	14,510,625	14,510,625	-	14,510,625	14,510,625	-
HCBS/DD Waiver	248,145,859	274,809,894	293,283,426	304,780,365	304,780,365	-	306,773,224	297,383,397	(9,389,827)
TOTAL	**$ 311,854,108**	**$ 327,954,053**	**$ 343,451,686**	**$ 345,537,568**	**$ 346,337,997**	**$ 800,429**	**$ 354,318,591**	**$ 339,321,753**	**$ (14,996,838)**

State General Fund

Item		FY 2008 Actual	FY 2009 Acutal	FY 2010 Revised Estimate	FY 2010 with Caseload Estimate	Differences	FY 2011 Agency Request	FY 2011 Agency Request without Enhancements and with Caseload Estimate	Differences
State Aid	$ 5,163,174	$ 5,163,174	$ 5,163,174	$ 5,163,174	$ 5,163,174	$ -	$ 5,163,174	$ 5,163,174	$ -
Grants for direct services	13,039,989	13,840,283	14,038,597	4,896,190	4,896,190	-	11,684,364	4,896,190	(6,788,174)
Targeted Case Management*	1,340,621	6,989,229	5,872,276	4,860,854	4,860,854	-	5,594,021	6,120,773	526,752
Postitive Behavior Supports*	83,091	111,583	2,370	57,628	57,619	(9)	66,320	67,576	1,256
ICF/MRs	6,751,358	6,671,098	4,950,539	4,409,053	4,409,053	-	5,074,075	5,074,075	-
HCBS/DD Waiver	98,535,966	110,934,150	102,684,931	92,607,514	92,607,514	-	107,272,461	103,989,026	(3,283,435)
T[illegible]	**$ 124,914,199**	**$ 143,709,517**	**$ 132,711,887**	**$ 111,994,413**	**$ 111,994,404**	**$ (9)**	**$ 134,854,415**	**$ 125,310,814**	**$ (9,543,601)**

* Included in Human Services Consensus Caseload process

Joint Home and Community Based Services Oversight
Attachment: 21
Date: 11/20/09

Detailed Estimates of Optional Spending in Medicaid

Includes Medicaid Spending in all Agencies (KHPA, SRS, KDHE, KDOA)

Optional Services

	Actuals 2008		Projections 2009		2010	
Adult Optional Services Description	**SGF**	**All Funds**	**SGF**	**All Funds**	**SGF**	**All Funds**
Ambulatory Surg Ctr	$ 343,604	$ 782,698	$ 361,881	$ 829,660	$ 380,182	$ 879,439
Maternity Center	4,719	11,655	4,967	12,354	5,215	13,096
Pharmacy	68,618,318	163,027,604	72,248,095	172,809,260	75,872,251	183,177,815
Vision	460,148	1,132,393	484,372	1,200,337	508,497	1,272,357
Dental	705,236	1,869,661	741,962	1,981,841	778,328	2,100,751
Local Health Dept	126,376	335,303	132,956	355,422	139,472	376,747
Attendant Care for Indepent. Living	2,441	6,046	2,569	6,409	2,697	6,793
Hospice	10,188,875	25,040,244	10,725,357	26,542,658	11,259,714	28,135,218
CMHC	2,255,924	5,004,267	2,376,320	5,304,523	2,497,083	5,622,795
Psychologist	44,830	117,910	47,167	124,985	49,483	132,484
Transportation	2,928,558	6,515,146	3,084,797	6,906,055	3,241,481	7,320,418
Chiropractor	84	207	88	219	93	232
Podiatrist	8,201	20,091	8,633	21,297	9,064	22,575
Hearing Services	124,286	300,425	130,845	318,450	137,386	337,557
Equip,Supplies,Orthotics/Pros.	4,519,226	10,926,562	4,757,718	11,582,156	4,995,546	12,277,085
FQHC's, RHC's	2,005,405	4,655,612	2,111,813	4,934,949	2,218,225	5,231,046
Alcohol & Drug Treatmt	230,520	576,877	242,627	611,489	254,669	648,179
Dietitian	5	13	6	14	6	15
Head Start	-	-	-	-	-	-
Physicial Therapist	169,961	377,104	179,031	399,730	188,129	423,714
Behavior Managment	-	-	-	-	-	-
Head Injured Rehab. Facility	3,295,256	8,178,844	3,468,524	8,669,575	3,640,979	9,189,750
Local Education Agencies	26	68	28	72	29	76
TargetCase Mgmt -CMRCs	280,482	695,122	295,233	736,829	309,916	781,039
CDDO's	5,060,769	12,526,656	5,326,971	13,278,256	5,591,978	14,074,951
TargetCase Mgmt -Frail Elderly	3,617,662	8,941,331	3,807,995	9,477,810	3,997,494	10,046,479
NF Pre Screening	-	-	-	-	-	-
Managed Care (HW, PIHP, PAHP, PACE)*	7,838,668	20,439,811	8,247,889	21,666,200	8,653,653	22,966,172
PCCM Case Mangement	99,040	212,670	104,347	225,430	109,681	238,956
Nursing Facility - MH	13,153,630	15,294,918	13,897,128	16,212,613	14,664,276	17,185,370
ICF-MR	6,684,898	16,563,177	7,036,481	17,556,967	7,386,462	18,610,385
HCBS	171,271,601	424,843,978	180,277,954	450,334,617	189,242,495	477,354,694
State Psych Hospital	234,857	581,906	247,209	616,820	259,505	653,830
State ICF-MRs	11,370,734	28,195,631	11,968,696	29,887,369	12,563,897	31,680,612
Total Optional Services	**$ 315,644,342**	**$ 757,173,932**	**$ 332,319,658**	**$ 802,604,368**	**$ 348,957,886**	**$ 850,760,630**

Summary

Optional Services	$ 315,644,342	$ 757,173,932	$ 332,319,658	$ 802,604,368	$ 348,957,886	$ 850,760,630
Optional Populations	362,042,178	925,137,267	383,764,709	980,645,503	402,757,392	1,039,484,233
Less Crossover	(136,256,970)	(324,321,565)	(144,432,388)	(343,780,859)	(151,684,429)	(364,407,710)
Total Optional Medicaid Spending	541,429,550	1,357,989,634	571,651,979	1,439,469,012	600,030,849	1,525,837,153
Total Medicaid spending	$ 981,579,148	$ 2,425,432,536	$ 1,040,473,897	$ 2,570,958,488	$ 1,102,902,331	$ 2,725,215,997
Optional as a % of Total Medicaid	55.2%	56.0%	54.9%	56.0%	54.4%	56.0%

*Total growth for 2009 and 2010 are consistent with KHPA Caseload total growth (6% per year).
Estimates differ from KHPA caseload estimates in the following ways:

Services for children are excluded, since all spending on children is mandatory.
Services administered by and funded through SRS, KDOA and KDHE are included.
Growth was assumed at a simple, uniform 6% rate across all Medicaid programs.

Data Prepared By: Kansas Health Policy Authority

Optional Populations (detailed totals for FY 2008 only)

Optional Populations	Medikan		Working Healthy		Breast and Cervical Cancer		Medically Needy Aged		Medically Needy Disabled		Medically Needy Families		ADAP		TB		FC aging out		SCHIP	
Adult Optional Services Description	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds
Ambulatory Surg Ctr	$ 72,785	$ 72,785	$ 1,618	$ 4,284	$ 5,737	$ 15,545	$ 17,551	$ 49,741	$ 55,305	$ 132,274	$ 1,495	$ 3,832	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Maternity Center	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Pharmacy	8,801,263	8,801,263	671,757	1,778,375	139,542	378,123	1,502,107	4,257,057	4,539,425	10,856,997	104,349	267,479	73,785	7,601,411	-		15,891	37,410	-	-
Vision	4,021	4,021	6,362	16,842	1,635	4,431	36,687	103,972	63,188	151,126	3,756	9,627	-	-	-	-	135	266	-	-
Dental	831	831	4,815	12,747	971	2,630	307	870	120,604	288,451	1,172	3,004	-	-	-	-	264	664	-	-
Local Health Dept	15,284	15,284	366	968	1,743	4,723	835	2,366	7,397	17,691	1,666	4,271	-	-	-	-	111	279	-	-
Attendant Care for Indepent. Living	915	915	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Hospice	20,606	20,606	1,047	2,771	19,653	53,256	6,614,281	18,745,253	1,112,816	2,661,534	223	571	-	-	-	-	-	-	-	-
CMHC	369,581	369,581	82,816	219,243	215	583	63,245	179,239	607,692	1,453,424	1,158	2,967	-	-	-	-	-	-	-	-
Psychologist	(9,109)	(9,109)	573	1,517	-	-	5,531	15,675	8,697	20,800	-	-	-		-		-	-	-	-
Transportation	256,081	256,081	38,625	102,253	1,535	4,159	149,766	424,446	513,982	1,229,296	6,092	15,617	-	-	-	-	93	235	-	-
Chiropractor	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Podiatrist	-	-	52	137	-	-	3,175	8,997	1,380	3,300	-	-	-	-	-	-	-	-	-	-
Hearing Services	5,955	5,955	1,170	3,099	-	-	49,480	140,229	13,583	32,488	-	-	-	-	-	-	-	-	-	-
Equip,Supplies,Orthotics/Pros.	235,980	235,980	21,068	55,773	4,187	11,346	743,682	2,107,637	808,951	1,934,778	3,738	9,582	-	-	-	-	12	30	-	-
FQHC's, RHC's	505,867	505,867	17,612	46,626	7,151	19,377	104,156	295,184	226,846	542,551	6,653	17,055	-	-	-	-	402	1,011	-	-
Alcohol & Drug Treatmt	-	-	1,156	3,060	-	-	160	454	13,021	31,142	133	340	-	-	-	-	-	-	-	-
Dietitian	-	-	-	-	-	-	-	-	1	3	-	-	-	-	-	-	-	-	-	-
Head Start	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Physicial Therapist	52,124	52,124	506	1,339	134	363	2,468	6,994	21,642	51,763	2,537	6,503	-	-	-	-	-	-	-	-
Behavior Managment	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Head Injured Rehab. Facility	296	296	98	261	-	-	16	46	2,322,808	5,555,489	-	-	-	-	-	-	-	-	-	-
Local Education Agencies	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
TargetCase Mgmt -CMRCs	-	-	5,231	13,849	-	-	7,045	19,967	108,590	259,716	-	-	-	-	-	-	-	-	-	-
CDDO's	-	-	102,094	270,279	-	-	104,682	296,675	1,820,651	4,354,472	-	-	-	-	-	-	78	196	-	-
TargetCase Mgmt -Frail Elderly	615	615	3,275	8,669	446	1,208	1,191,400	3,376,495	901,524	2,156,187	-	-	-	-	-	-	-	-	-	-
NF Pre Screening	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Managed Care (HW, PIHP, PAHP, PACE)*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
PCCM Case Mangement	43,610	43,610	4	10	-	-	74	210	535	1,280	-	-	-	-	-	-	-	-	-	-
Nursing Facility - MH	18,517	18,517	7,675	9,030	60	71	2,152,028	2,531,798	4,851,206	5,707,301	202	237	-	-	-	-	65	76	-	-
ICF-MR	8,497	8,497	1,037	2,746	4	11	485,106	1,374,817	4,620,060	11,049,853	14	37	-	-	-	-	30	76	-	-
HCBS	105	105	20,626	54,603	7,880	21,352	20,303,292	57,540,697	59,114,765	141,385,501	-	-	-	-	-	-	1,707	4,298	-	-
State Psych Hospital	597	597	88	233	-	-	149,743	424,379	1,931	4,618	14	37	-	-	-	-	-	-	-	-
State ICF-MRs	2,816	2,816	194	514	17	46	300,523	851,700	8,599,228	20,566,877	18	45	-	-	-	-	-	-	-	-
Optional Services	$ 10,407,236	$ 10,407,236	$ 989,865	$ 2,609,229	$ 190,911	$ 517,227	$ 33,987,339	$ 92,754,898	$ 90,455,826	$ 210,448,911	$ 133,220	$ 341,203	$ 73,785	$ 7,601,411	$ -	$ -	$ 18,788	$ 44,541	$ -	$ -
Mandatory services for optional populations	14,723,228	14,723,228	1,707,858	4,532,589	1,091,606	2,958,067	114,919,163	329,254,688	72,946,182	180,361,656	1,330,791	3,411,500	856	88,190	327,261	334,419	1,585,138	3,993,161	17,122,197	60,678,503
Total services	$ 25,130,464	$ 25,130,464	$ 2,697,723	$ 7,141,818	$ 1,282,517	$ 3,475,294	$ 148,906,502	$ 422,009,586	$ 163,402,008	$ 390,810,567	$ 1,464,011	$ 3,752,703	$ 74,641	$ 7,689,601	$ 327,261	$ 334,419	$ 1,603,926	$ 4,037,702	$ 17,122,197	$ 60,678,503

Staff Note: Mandatory Services are only required if any services are offered to the optional population.

Mandatory Acute Care Benefits Include:

Physician services
Laboratory and x-ray services
Inpatient hospital services
Outpatient hospital services

Early and periodic-screening, diagnostic, and treatment (EPSDT) services for individuals under 21
Family planning and supplies
Federally-qualified health center (FQHC) services
Rural health clinic services
Nurse midwife services
Certified pediatric and family nurse practitioner services

Mandatory Long-Term Care Benefits Include:

Institutional Services: Nursing facility (NF) services for individuals 21 or over

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	Actuals		*Projections**			
	2008 Total Optional Populations		2009 Total Optional Populations		2010 Total Optional Populations	
Adult Optional Services Description	**SGF**	**All Funds**	**SGF**	**All Funds**	**SGF**	**All Funds**
Ambulatory Surg Ctr	$ 154,491	$ 278,461	$ 163,760	$ 295,168	$ 172,372	$ 312,878
Maternity Center	-	-	-	-		-
Pharmacy	15,848,119	33,978,116	16,799,006	36,016,803	17,658,816	38,177,811
Vision	115,783	290,286	122,730	307,703	128,829	326,165
Dental	128,984	309,197	136,701	327,748	143,556	347,413
Local Health Dept	27,401	45,582	29,045	48,317	30,589	51,216
Attendant Care for Indepent. Living	915	915	970	970	1,024	1,028
Hospice	7,768,626	21,483,991	8,234,743	22,773,031	8,635,167	24,139,412
CMHC	1,124,706	2,225,037	1,192,188	2,358,539	1,254,020	2,500,051
Psychologist	5,691	28,883	6,033	30,616	6,269	32,453
Transportation	966,173	2,032,086	1,024,144	2,154,011	1,076,734	2,283,252
Chiropractor	-	-		-		-
Podiatrist	4,606	12,298	4,883	13,035	5,122	13,818
Hearing Services	70,189	178,671	74,400	189,392	78,085	200,755
Equip,Supplies,Orthotics/Pros.	1,817,618	4,299,354	1,926,675	4,557,315	2,023,532	4,830,754
FQHC's, RHC's	868,687	1,381,044	920,808	1,463,906	970,036	1,551,741
Alcohol & Drug Treatmt	14,470	31,936	15,338	33,852	16,119	35,883
Dietitian	1	3	1	3	1	3
Head Start	-	-		-		-
Physicial Therapist	79,411	117,747	84,176	124,812	88,713	132,301
Behavior Managment	-	-		-		-
Head Injured Rehab. Facility	2,323,219	5,555,832	2,462,612	5,889,181	2,586,148	6,242,532
Local Education Agencies	-	-		-		-
TargetCase Mgmt -CMRCs	120,867	279,683	128,119	296,464	134,586	314,252
CDDO's	2,027,505	4,651,343	2,149,155	4,930,424	2,257,827	5,226,249
TargetCase Mgmt -Frail Elderly	2,097,259	5,534,505	2,223,095	5,866,575	2,332,353	6,218,570
NF Pre Screening	-	-		-		-
Managed Care (HW, PIHP, PAHP, PACE)*	-	-		-		-
PCCM Case Mangement	44,223	45,110	46,876	47,817	49,492	50,686
Nursing Facility - MH	7,029,753	8,267,030	7,451,539	8,763,052	7,862,590	9,288,835
ICF-MR	5,114,748	12,436,037	5,421,633	13,182,199	5,692,715	13,973,131
HCBS	79,448,375	199,006,556	84,215,277	210,946,950	88,400,611	223,603,767
State Psych Hospital	152,373	429,864	161,515	455,656	169,332	482,996
State ICF-MRs	8,902,796	21,421,999	9,436,964	22,707,319	9,909,791	24,069,759
Optional Services	$ 136,256,970	$ 324,321,565	$ 144,432,388	$ 343,780,859	$ 151,684,429	$ 364,407,710
Mandatory services for optional populations	225,785,208	600,815,702	239,332,321	636,864,645	251,072,963	675,076,523
Total services	$ 362,042,178	$ 925,137,267	$ 383,764,709	$ 980,645,503	$ 402,757,392	$ 1,039,484,233

Data Prepared By: Kansas Health Policy Authority