Approved: February 4, 2010
Date

MINUTES OF THE HOUSE AGING AND LONG TERM CARE COMMITTEE

The meeting was called to order by Chairman Bob Bethell at 3:30 p.m. on January 26, 2010, in Room 784 of the Docking State Office Building.

All members were present except:
Representatives Donohoe–excused
Representative Hill--excused.

Committee staff present:
Doug Taylor, Office of the Revisor of Statutes
Estelle Montgomery, Kansas Legislative Research Department
Iraida Orr, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Judith Holliday, Committee Assistant

Conferees appearing before the Committee:

Anne-Marie Hughey, Legislative Policy Advocate, SE Kansas Independent Living Resource Center
Mitzi McFatrich, Executive Director, Kansas Advocates for Better Care
Karren Weichert, Executive Director, Midland Care
Tom Laing, Executive Director, InterHab
Dr. Janet Williams, President, Community Works
Kathy Lobb, Self Advocate Coalition of Kansas
Jerry Slaughter, Executive Director, Kansas Medical Society
Michael Oxford, Executive Director, Topeka Independent Living
Richard Shank, Government Affairs, Alliance for Kansans with Developmental Disabilities

The following persons submitted written testimony:
Jane Rhys, Executive Director, Kansas Council on Developmental Disabilities
Melissa Ness, on behalf of St. Francis Community Services

Others attending:
See attached list

Chairman Bethell asked Anne-Marie Hughey, Legislative and Policy Advocate, SE Kansas Independent Living Resource Center (SKIL), to begin her testimony. (Attachment 1) Ms. Hughey testified in opposition to the Governor's 10% Medicaid cut , which was devastating to people with physical disabilities eligible for the Medicaid Home and Community Based Services (HCBS) program through the Physically Disabled (PD) Waiver.

Ms. Hughey testified that the changes in 2008 regarding a freeze on the PD Waiver, the wait list, and escalating admissions to nursing facilities were a major setback. The Governor's cuts effective January 2010 may cause internal cuts including wage freeze, reduced mileage reimbursement, and unfilled positions. In addition, there may be limits to Personal Assistant (PA) services and Assistive Services, a loss of chore services and Meals-on-Wheels, and closures of Centers for Independent Living.

Mitzi McFatrich, Executive Director, Kansas Advocates for Better Care provided testimony in opposition to the proposed Medicaid cuts to the frail and elderly Kansans. (Attachment 2) Ms. McFatrich told the Committee that the 10% only took effect on January 1, 2010, but combined with prior budget cuts, seriously impacted the access to long-term care, choice of care setting and services, and cost to the state for long-term care placement and services.

Medicaid is the safety net for poor, elder citizens. Medicaid eligibility applications should be completed within 30-45 days but is now running at 60 days; this will continue or increase with reduced staffing. Reduced or pending reimbursement negatively impacts a nursing home's ability to provide adequate care for all residents living at the facility. There is no retroactive reimbursement for HCBS, so the elder must pay or forego the services.

Ms. McFatrich encouraged the Legislature to be proactive by looking at beds available versus number needed; address access to services and match consumer desire with public policy offerings that are more cost effective; support public policy that encourages oversight agencies to provide adequate safety for elders living in nursing facilities or their homes; and stabilize the workforce to ensure continued quality care.

Karren Weichert, Executive Director, Midland Care PACE, testified in opposition to the cuts which would impact the PACE program. (Attachment 3) She explained the objective of PACE in providing care to preserve independence and function for individuals, help them remain in the community, and to delay long-term institutional care.

The Midland PACE program bears full risk of the cost of the participant's care. This care includes nursing home, long-term care services, inpatient hospital, outpatient hospital, physician services, laboratories, x-ray services, pharmacy, transportation, durable medical equipment, hospice services–everything covered by the State Medicaid plan.

PACE rates result in a 36% savings over nursing home placement. However, PACE has not received a rate increase since 2007 and has already taken a 25% reduction in rates recommended by the states actuarial firm; add in the Governor's 10% Medicaid cut, and there is no way to recoup or absorb the reductions and stay in business. The longer-term effect will be determined over the next several months but the near-term effect will be staff layoffs and wage freeze, a delay in some medical specialty services, and a higher patient to staff ratio.

In response to questions regarding nursing homes turning away patients because they are on Medicaid, Ms. Weichert responded that there is difficulty in finding placement. Even though PACE is required by statute to continue providing services to all individuals who meet the criteria, nursing homes and providers are not required to accept the Medicaid rate, therefore reducing choice and incurring higher costs for PACE to obtain necessary services.

Tom Laing, Executive Director, InterHab, testified in opposition to the Medicaid cuts and proposed an alternative approach to the budget challenge. (Attachment 4) He addressed the Administration's cuts in reimbursement for HCBS DD Waiver services, which freed up $2.3 million in the State General Fund (SGF) but eliminated $5.4 million from the federal match–funds vital to the state.

InterHab recommends a $2.3 million reduction in the remaining pool of unmatched State General Fund dollars in the Developmentally Disabled (DD) system. This money is utilized to provide support services and SGF aid for those with DD who do not qualify for the HCBS DD Waiver. This proposal to use unmatched SGF funds avoids the unnecessary loss of Federal funds to the State. This proposal does not reduce the Administrations SGF reduction and does not spare the community DD system from absorbing it's fair share of allotment cuts. The proposal does save community DD providers and the State from the unnecessary loss of $5.4 million in federal assistance.

Mr. Laing stressed that their approach will not be painless. Persons with DD will lose access to services, the waiting list is at 4,000, and reimbursement rates trail years behind. He suggested additional funding steps:

- Funding to restore cuts from the 2009 legislative session;
- Funding to restore the current allotment cuts discussed today;
- Funding to begin the process of reducing and eliminating the State DD waiting list;
- Funding to assure necessary resources to provide quality care and services to persons with disabilities.

Mr. Laing told the Committee they can be a 'bully pulpit' on this issue.

Dr. Janet Williams, President, Community Works, testified as an opponent of the Medicaid cuts. (Attachment 5) *communityworksinc* provides Home and Community Based Services (HCBS) to people with traumatic brain injuries (TBI) and other physical disabilities (PD). Kansas was the first state to provide a TBI waiver, and she commended the State for its forward thinking. However, the 10% cut represents a complete about face to this achievement.

The Kansas Health Policy Authority (KHPA) reports that the TBI waiver saves $21,500 per person, per month

($257,000 per year) compared to institutional alternatives. In one month, 300 people in the community with the same support needs cost the same as 22 people in a rehabilitation setting. Since they were saving the State so much money and growing her company by 39%, she could not have envisioned having to downsize her staff, and cut pay and benefits.

She expressed concern that the state is going in the wrong direction and hope that legislators would stand up and do the right thing. Attached to her testimony were articles on two persons receiving services through communityworksinc.

Kathy Lobb, Legislative Liaison, Self Advocate Coalition of Kansas, testified as an opponent to the cuts and addressed the Committee on the devastating effect Medicaid cuts have made to her and other people relying on Medicaid funded services. (Attachment 6) She pointed out that cuts will cost the state more in the long run. As an example, a single trip to the emergency room because they couldn't afford to go to the doctor will be more expensive than the basic services would have been in the first place.

Ms. Lobb told the Committee she was born with her disability, and if not for Medicare and Medicaid she could not live independently in the community. Taking away the services may force her into a setting costing the state much more in dollars, and robbing her of her independence.

Jerry Slaughter, Executive Director, Kansas Medical Society (KMS), testified in opposition to the Governor's Medicaid cuts. (Attachment 7) The KMS represents 4,500 physicians with the goal to encourage doctors to stay in the programs. Mr. Slaughter provided the Committee with statistics on the ultimate costs to the State with the cuts implemented.

The majority of physicians participate in Medicaid, a safety-net program which serves low-income families, children, the aged and disabled. Compared to other states, our participation rate is high, even though Medicaid reimbursement averages 20% below Medicaid rates. These cuts will cause physician practices to re-evaluate their ability to absorb Medicaid patients into their practices. While many physicians will maintain their commitment to Medicaid if the cuts are temporary, the capacity of practices to continue to accept Medicaid will diminish if the cuts are perceived to be long term.

Mr. Slaughter told the Committee that roughly 30% of our population is covered by public health programs. Therefore, Medicaid is not a stand-along program and the decisions on medical practice's capacity to absorb Medicaid patients is influenced by what happens with the other public programs.

Mr. Slaughter stated that if the cuts appear to be indefinite or made deeper, there will be attrition in the provider network, resulting in more care delivered in the hospital emergency room at a much higher cost.

Chairman Bethell told the Committee that in his area some doctors do not take Medicaid, so they donate their services to avoid all of the complex paperwork.

Michael Oxford, Executive Director, Topeka Independent Living Resource Center (TILRC), testified before the Committee in opposition to the Governor's Medicaid cuts. (Attachment 8) TILRC is a civil and human rights organization whose mission is to advocate for justice, equality and essential services for a fully integrated and accessible society for all people with disabilities. It provides HCBS, direct services, and individual and policy advocacy services, without regard to age or type of disability.

Mr. Oxford shared his concerns about the threat to his agency caused by the loss of revenue and the impact on people with disabilities who are waiting to receive services or have their services capped or cut. However, when the Governor's 10% cuts to Medicaid reimbursement was announced, TILRC made a commitment that they would not cut in-home worker wages or lay off staff.

Mr. Oxford explained the implications of the Medicaid cuts to the Americans with Disabilities Act (ADA), and the *Olmstead* court decision which requires that the state provide goods, benefits and services appropriate to the needs of an individual with a disability, and specifically, in the context of provision of long term care under state programs.

Minutes of the House Aging and Long Term Care Committee at 3:30 p.m. on January 26, 2010, in Room 784 of the Docking State Office Building.

Cuts made across the board were implemented with no thought given to *Olmstead* or to state law. Lack of a comprehensive, effectively working plan leaves many gaps and potential violations in meeting *Olmstead* requirements. The state is at risk of violating civil rights under the ADA and of violating state law.

The following are areas in which the greatest impacts to his agency will be realized:
Home health services; nutritional programs such as meals on wheels; assistive services including durable medical equipment; sleep cycle support; and youth services. The nursing home diversion project, which provided a minimum level of support necessary to help people remain in the community until they were offered HCBS, was successful and all people using this program remained in their homes. With the cuts, the program was eliminated.

Mr. Oxford stated the importance for data collectiion, reporting and adequate oversight and planning. The population aged 55 to 64 will grow by 75% in 2050, those aged 65-74 will almost double, those aged 75-84 will more than double, and those aged 85 and older will more than quadruple by 2050. As the need for long term care increases over the next 40 years, the need for systematic, comprehensive long range planning is critical to meet the needs. This issue will not go away.

Richard Shank, Government Affairs, Alliance for Kansans with Developmental Disabilities, testified as an opponent to the proposed Medicaid cuts. He advised the Committee on the part Medicaid has played in helping medically fragile people thrive and live productive and happy lives. (Attachment 9) Mr. Shank stated that the Alliance is feeling the effects of the cuts which have a ripple effect in the communities that they serve.

Mr. Shank told the committee that health insurance premiums continue to rise at a rate of more than 10% annually. The direct support professional staff, which is the backbone of these organizations, is reduced to the level that vulnerable folks could be at risk. Layoffs and cutbacks are stretching resources in an organization where every worker is needed. Employee training has been reduced, along with fringe benefits including health and life insurance. Even with all the cuts, the organizations are required to provide quality service to clients and are working long hours to accomplish that mandate.

The following persons submitted written testimony as opponents:
Jane Rhys, Executive Director, Kansas Council on Developmental Disabilities (Attachment 10)
Melissa Ness, on behalf of St. Francis Community Services (Attachment 11)

The next meeting is scheduled for January 28, 2010.

The meeting adjourned at 5:15 p.m.

AGING AND LONG-TERM CARE COMMITTEE
GUEST LIST

DATE: 1-26-2010

NAME	FIRM REPRESENTED
~~Jane Marie Hugh~~	SKIL
Kathy Cooper	RCIL
~~Karen Wescott~~	Midland Care PACE
Tammy Hines	Midland Care PACE
Mike Orford	Topeka Independent Living Resource Center
Jim Snyder	SRS
Mitzi McFarland	KABC
Jeni Light	Intern for Rep Horst
Rui Jia	Intern for Rep. Horst
Kathy Hobbs	SACK
Craig Kinton	SACK
Tammy Hammond	Rosewood Services
Amanda Fellers	Rosewood Services
Janet Williams	communityworks inc
Travis Lowe	Little Gov't Relations
Hannah Sanders	KHPA
Kathy Outlaw	KSNA

Please Sign in Black ink

Testimony on 10% Cut to Medicaid Providers
To
Aging & Long-Term Health Committee
By
Anne-Marie Hughey

Chairman Bethell and Members of the Committee, my name is Anne-Marie Hughey and I am the Legislative Policy Advocate for SKIL Resource Center and I am also here representing the Kansas Association of Centers for Independent Living (KACIL).

The Governor's announcement of the 10% cut in Medicaid beginning January 1, 2010 was the second devastating blow for people with physical disabilities who are eligible for the Medicaid Home and Community Based Services (HCBS) program through the Physically Disabled (PD) Waiver.

The first significant setback to people with physical disabilities was delivered in December 2008:

- December 1, 2008 – a freeze was placed on the PD Waiver by Social & Rehabilitative Services (SRS), which meant the beginning of a waiting list.
- The Legislature instructed SRS to lift the freeze as of March 1 2009 and institute a rolling waiting list – 2 off the waiver, 1 on the waiver.
- As of January 1, 2010 approximately 1,800 individuals are on the PD waiver waiting list. Some of whom have been waiting over a year.
- As of January 1, 2010 we have seen 314 new admissions to nursing facilities, which costs the State 2 – 3 times as much as HCBS.
- To date, we know of 50 people who have died while waiting for services.

So now how is the 10% Medicaid cut effective January 1, 2010 affecting the KACIL member Centers for Independent Living (CILs)? Many of the CILs are looking to make cuts internally, rather than put their consumer's health and safety at risk. CIL's are also looking to absorb as much of the cut as possible in order to stave off, as long as possible, reducing the wages of personal care attendant, who are already making below poverty wages. Following are the operational cuts most KACIL members initiated as of January 1 or will initiate shortly.

- Reduction of work hours for some CIL employees.
- Wage freeze CIL employees.
- Reducing CIL employees' mileage reimbursement.
- CIL Lay-offs and requests for voluntary lay-off, retirement.
- Open center positions not being filled.
- Freeze on hiring for all CIL positions.

Just considering the first three items, many CIL staff, who are currently still employed, are looking at a minimum of a 10% reduction in wages, which reduces the amount of state income tax paid and could be viewed, by the CIL employee, as an increase in their payroll taxes.

How is the 10% Medicaid cut affecting CIL consumers who are on waivers or on the PD waiver waiting list?

- Personal Assistant (PA) services limited to 10 hours/day, which affects over 200 consumers across the state and may affect the consumers' health and safety. (Additional hours will be allowed under a specific crisis exception, see attachment A.)
- Assistive Services, such as grab-bars in the bathroom, ramps, etc., will be limited to those individuals whose situations meet the "critical" condition definition. (Definitions included in attachment A.)
- Chore Services, such as snow removal, lawn care, etc., will no longer be available.
- Loss of Meals-on-Wheels service because providers won't accept the lower reimbursement rate.
- If or when CILs have to cut PA wages, it is going to be much more difficult for a person on the PD Waiver to find individuals to be willing to provide PA services to them.

Unfortunately this **MAY** only be the beginning for the operational cuts CILs are facing, as well as the cuts to personal assistants' wages. CIL are waiting for the first reduced reimbursement payment before they can accurately assess how the 10% Medicaid cut will truly affect the consumers they serve and their overall operations.

Another factor to be considered by this committee, and the legislature as a whole, beyond the 10% Medicaid cut and its affect on all the consumers CILs serve, is the Governor's proposed budget to reduce the CIL's state base funding by $1.1 million. If this cut is implemented consumers access to the services shown on the "CIL Fact Sheet" (See attachment B) may be significantly limited due to closures of Centers for Independent Living.

Thank you for the opportunity to provide you with this information. I will be happy to stand for questions.

Attachment A[1]

ASSISTIVE SERVICES

Critical situations are defined as and limited to:

1. Consumer is a recipient of state policy MFP funding to access HCBS/PD or HCBS/TBI waiver services. The Assistive Services purchase is critical to the consumer's ability to return to the community from the nursing facility and is a necessary expenditure within the first three months of the consumer's return to the community. Planning for the use of any Assistive Service shall occur prior to a person's return to the community, when applicable. In all cases, the Targeted Case Manager must provide documentation that demonstrates how the Assistive Service is necessary to remediate the previously-described situations.

2. Consumer previously left waiver services for a Planned Brief Stay, and the Assistive Services request is critical to the consumer's ability to return to the community from the nursing facility or medical facility and is a necessary expenditure within the first three months of the consumer's return to the community. Planning for the use of any Assistive Service shall occur prior to a person's return to the community, when applicable. In all cases, the Targeted Case Manager must provide documentation that demonstrates how the Assistive Service is necessary to remediate the previously-described situations.

3. Consumer's situation has met the criteria for, and there has been an SRS *confirmation outcome* of one of the following situations:
   a. An Adult Protective Services investigation outcome of abuse, neglect or exploitation; or
   b. A Children and Family Services investigation outcome of abuse or neglect.
   ---OR---
   c. The consumer is a *recent* victim of domestic violence that is documented by the Targeted Case Manager.

PERSONAL SERVICES:

Effective January 1, 2010, Personal Services is available to HCBS/PD waiver consumers up to and including a maximum of ten (10) hours per 24-hour time period. All Personal Services requests that exceed ten (10) hours per 24-hour time period require prior authorization from the HCBS/PD Program Manager and must meet one or more of the following criteria as applicable to the consumer's specific situation.

1. The time allotted for Personal Services is critical to the remediation of the consumer's abuse, neglect, or exploitation, or domestic violence issue;
2. The time allotted for Personal Services is critical to the consumer's ability to remain in the community after leaving the Federal MFP Demonstration Grant; AND
3. The time allotted for Personal Services is a necessary expenditure within the first three months of the consumer's return to the community.

---

[1] Received from SRS 12/30/2009

Criteria for approval of Personal Services that exceeds ten (10) hours per 24-hour time period are as follows:

1. Consumer is a recipient of state policy MFP funding to access HCBS/PD or HCBS/TBI waiver services. Personal Services that exceed ten (10) hours per 24-hour time period shall be critical to the consumer's ability to return to the community from the nursing facility and is a necessary expenditure within the first three months in the community.

2. Consumer is transitioning from the Federal MFP Demonstration Grant program, is currently, and requires Personal Services that exceed ten (10) hours per 24-hour time period as critical to the consumer's ability to safely remain in the community.

3. Consumer previously left waiver services for a Planned Brief Stay in a long term care facility and Personal Services in excess of ten (10) hours per 24-hour time period, is critical to the consumer's ability to return to the community from the long term care facility.

4. Consumer's situation has met the criteria for, and there has been an SRS *confirmation outcome* of, one of the following situations:
   a. An Adult Protective Services investigation outcome of abuse, neglect or exploitation; or
   b. A Children and Family Services investigation outcome of abuse or neglect.
   ---OR---
   c. The consumer is a *recent* victim of domestic violence that is documented by the Targeted Case Manager.

5. Consumer has a documented and approved health and safety need that requires more than a total of (10) hours per 24-hour time period. Related needs include two-person transfers, certain medical interventions, or supervision for elopement that is likely to result in danger to self or others.

All increases in Personal Services for the HCBS/PD waiver that relate to a temporary exacerbation of health/functional changes are subject to the November 1, 2009 policy that limits increases to the same time period of a Planned Brief Stay, i.e. the month of request and the following two months.

Attachment B

CENTER FOR INDEPENDENT LIVING
FACT SHEET

- There are twelve Centers for Independent Living in Kansas and a satellite center in Prairie Village KS operated by The Whole Person, Kansas City, MO.

- Centers for Independent (CILs) are non-profit, consumer controlled, community based, non-residential organizations that work with individuals of all ages with all types of disabilities in order that they may have the opportunity to lead independent and productive lives in the community of their choice.

- CIL's foundation is built on the independent living philosophy. Thereby as a consumer-controlled organization, the CIL's board, decision making staff and staff as a whole must be comprised of 51% of people with disabilities.

- CILs are mandated by the state to provide five core services
    - Systems and Individual Advocacy
    - Peer Support
    - Independent Living Skills Training
    - Deinstitutionalization
    - Information and Referral

- Twelve of the CILs in Kansas receive their base funding through Title VII, Part C of the Rehabilitation Act, or through Kansas Rehabilitation Services[1] or both. CILs provided consumers requesting the any of the above five core services and non-Medicaid reimbursable services) free of charge.

- Responding to the particular needs of the community where the center is located, additional services may be offered:

    - Benefits Counseling
    - Assistive Technology Centers
    - Equipment loan programs
    - Computer Training
    - Housing Assistance
    - Home Modifications
    - Employment Skills Development
    - Targeted Case Management
    - Attendant Care Payroll Services

[1] The Whole Person does not receive funding through KRS.

KANSAS CENTERS FOR INDEPENDENT LIVING

IL Center of NE Kansas
521 Commercial Suite C
Atchison, Kansas 66002
(913) 367-1830 (Voice/TTY)
(913) 367-1430 (Fax)
www.ilcnek.org

Center for IL for SW Kansas
1802 E. Spruce St.
P.O. Box 2090
Garden City, KS 67846
620-276-1900 (Voice)
620-371-0200 (Fax)
www.cilswks.org

LINK, Inc.
2401 East 13th Street
Hays, KS 67601
(785) 625-6942 (Voice/TTY)
(785) 625-2334 (FAX)
www.linkinc.org

Coalition for Independence
4911 State Ave
Kansas City, KS 66102
913-321-5140 (Voice)
913-321-5182 (Fax)
www.cfi-kc.org

Independence, Inc.
2001 Haskell Avenue
Lawrence, KS 66046
785-841-0333(Voice)
785-841-1046 (TTY)
785-841-1094 (Fax)
www.independenceinc.org

Prairie Independent Living Center
17 South Main Street
Hutchinson, KS 67501
620-663-3989 (Voice)
620-663-9920 (TTY)
620-663-4711 (Fax)
www.pilr.org

Resource Center for Independent Living
PO Box 257
1137 Laing
Osage, KS 66523
785-528-3105 (Voice)
785-528-3665 (Fax)
www.rcilinc.org

SKIL Resource Center
1801 Main St.
PO Box 957
Parsons, KS 67357
620-421-5502 (Voice)
620-421-0983 (TTY)
620-421-3705 (Fax)
www.skilonline.com

The Whole Person
7301 Mission Road
Prairie Village, Kansas 66208
913-262-1294 (Voice)
913-262-2392 (Fax)
913-262-1294 (TTY)
www.thewholeperson.org

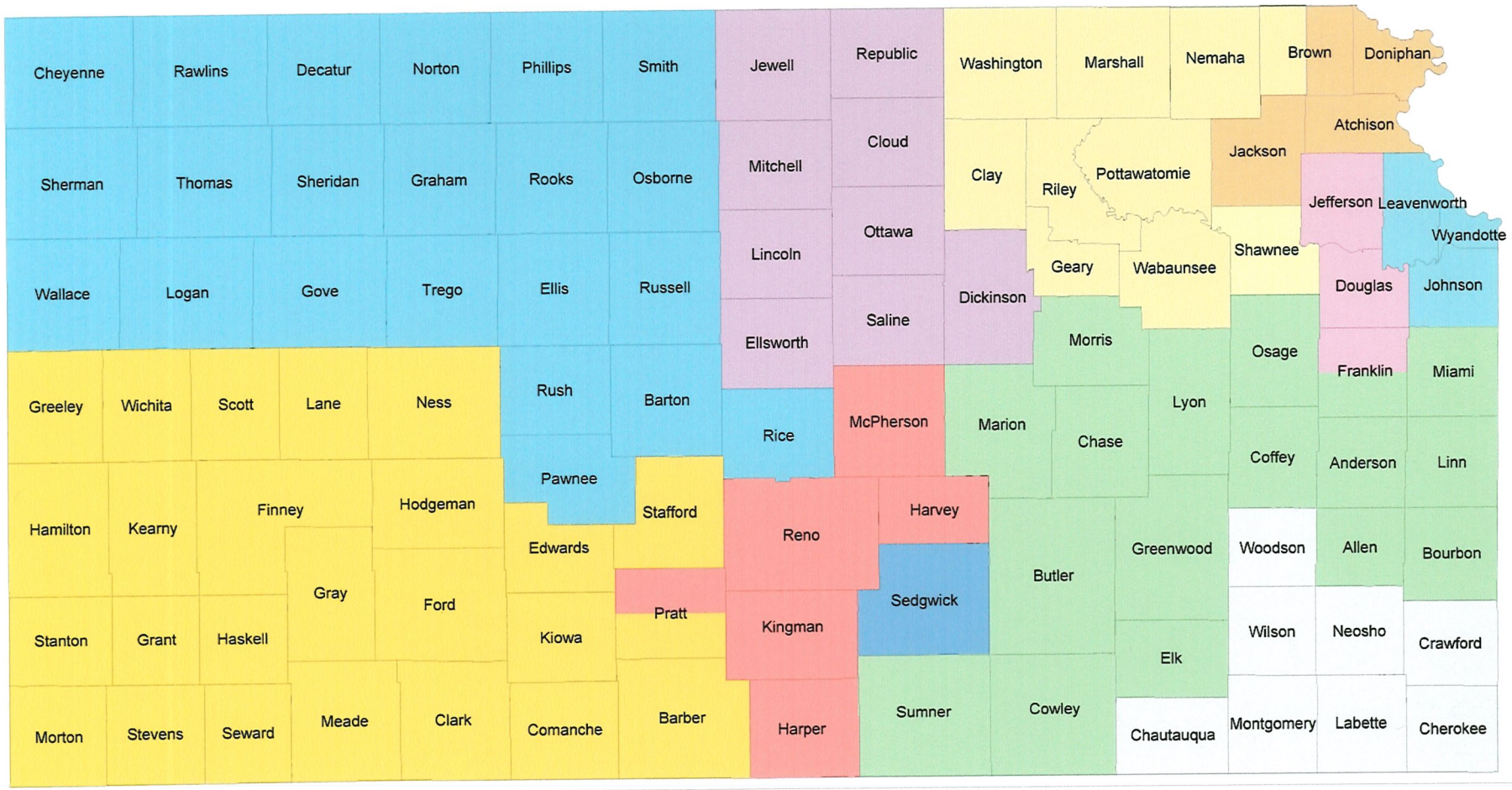
Independent Connections
1710 W. Schilling Road
Salina, Kansas 67401
785-827-9383 (Voice/TDD)
785-823-2015 (Fax)
www.occk.com

Topeka IL Resource Center
501 Southwest Jackson St.
Suite 100
Topeka, Kansas 66603-3300
785-233-4572 (Voice/TTY)
785-233-1815 (TTY)
785-233-1561 (Fax)
www.tilrc.org

Three Rivers
408 Lincoln Street
PO Box 408
Wamego, KS 66547-0408
785-456-9915 (Voice/TTY)
785-456-9923 (Fax)
reception@threeriversinc.org
www.threeriversinc.org

Independent Living Resource Center
3033 W. 2nd St. North
Wichita, KS 67203
316-942-6300 (V)
www.ilrcks.org

KANSAS CENTERS FOR INDEPENDENT LIVING



Kansas Centers for Independent Living

- Center for IL for SW KS
- Prairie Independent Living Center
- SKIL Resource Center
- Independent Living Resource Center
- Resource Center for Independent Living
- The Whole Person
- Access to Living/Coalition for Independence
- Independence Inc
- Topeka IL Resource Center
- IL Center of NE KS
- Three Rivers
- Independent Connection
- LINK
- * Dual color counties served by more than one CIL

SOCIAL SERVICES ACRONYMS

AAA	Area Agency on Aging
ADL	Activities of Daily Living
CDDO	Community Developmental Disability Organization
CIF	Children's Initiatives Fund
CIL	Center for Independent Living
CMHC	Community Mental Health Center
CMS	Center for Medicare and Medicaid Services
CSS	Community Supports and Services (a division of SRS)
DD	Developmental Disability
FE	Frail Elderly
FMAP	Federal Medical Assistance Percentage (currently KS FMAP is 60%/40%)
FPL	Federal Poverty Level
HCBS	Home and Community Based Services
IADL	Instrumental Activities of Daily Living
KDOA	Kansas Department of Aging
KHPA	Kansas Health Policy Authority
MH	Mental Health
PIL	Protected Income Level
PD	Physical Disability
SGF	State General Funds
SRS	Social and Rehabilitative Services
TANF	Temporary Assistance for Needy Families
TBI	Traumatic Brain Injury
VR	Vocational Rehabilitation

Kansas Advocates
for
Better Care

"Advocating for Quality Long-Term Care" since 1975

AGING AND LONG-TERM CARE COMMITTEE
TESTIMONY FROM KANSAS ADVOCATES FOR BETTER CARE
Mitzi E. McFatrich, Executive Director
January 19, 2010

Representative Bob Bethell, Committee Chair and Members of the Committee, thank you for the opportunity to testify on the impact the Governor's allocation of a 10% reduction to Medicaid providers has on frail and elder Kansans.

The 10% reduction took effect only recently on January 1, 2010, but this combined with the prior budget cuts is having a significant and serious impact on access to long-term care, choice of long-term care setting and services, and increased cost to the state of long-term care placement and services.

Medicaid is the safety net for poor, elder citizens. I heard others' testimony that their fear is if these cuts are long-lived, we will lose infra-structure. From a consumer perspective, I would assert that we have already lost infrastructure. The cuts that have been made have already meant that poor and frail Kansans have lost choice and independence, that families who provide so much care and shoulder much of the cost of care must provide more or have loved ones lose independence. Prior cuts have meant that Kansas Dept. on Aging decided to do off-site desk reviews of certain survey deficiencies rather than inspectors going back into nursing homes and thereby ensuring nursing homes make the corrections needed to comply with state and federal requirements. So the question is not will we lose infrastructure, but how much infrastructure will we lose.

Although my testimony includes concerns about certain state agencies' abilities to fulfill their functions related to long-term care, it is not my intent to criticize their will, but to point out the results of lacks in funding.

Determination of Eligibility on Medicaid applications is to be completed within 30-45 days.
--For some months the determination process has been lagging behind, running at 60 days and there is every reason to expect that this will continue or the increase with reductions to staffing.
--This is a financial challenge for nursing homes that are providing care without reimbursement while eligibility is pending and has a negative impact on their ability to provide adequate care for all residents living in the facility.
--In the instance of nursing homes, they will be reimbursed if the person qualifies.
--In the instance of HCBS, there is no retro-active reimbursement, so the elder must pay for the services during the processing time or forego the services.

II. Loss of HCBS funding
--550 consumers have been or will shortly be impacted by these cuts.
--The impacts will be loss of choice and independence for elders who would prefer to remain in their homes.
--Elders who need a high level of care will be forced into nursing home care, at a significantly greater cost to Kansas.
--Families who provide care and assume some of the costs of care will be stretched farther with the accompanying costs in healthcare for them and increased stress in familial relationships.
--Reduction in number of Adult Protective Services offices to serve elders.

III. Loss of 10% Medicaid cost-reimbursement to nursing homes
--Impact will be felt pretty immediately by consumers. Homes are likely to reduce staff to address the shortfall. Nursing care provided by nurses, cna's, cma's, etc. have the greatest impact on quality of care and quality of life issues for elders and other residents. So even though the facilities/providers receive the cuts, the pain and suffering will be felt by the residents, along with the potential for increased injury to direct care workers.
--The time between surveys at a nursing home seems to be trending upward as the budget shrinks. KDOA is within the 15 months allowed by CMS, but two years ago KDOA was more likely to be in a nursing home within 12 months. I can't emphasize the importance of oversight enough to the safety and health of residents who live in nursing homes.
--KDOA has been expecting the retirement of a substantial number of surveyors. It takes a new surveyor perhaps 1-2 years to become as a knowledgeable and experienced surveyor. With reductions to the budget for training and travel, that time will be longer and offer residents less health and safety oversight than they had previously.

IV. Reduction to State Long-Term Care Ombudsman staff
--Loss of one staff position during this fiscal year.
--Already two ombudsmen short of the national recommendation of 1 ombudsman for each 2,000 residents.
--LTC Ombudsman don't advocate for residents in nursing homes for mental health, or for Kansas veteran's

V. Demographic shift and downturn in the economy is a critical time to invest not shrink services.
--Increase in Kansans of an age to need greater assistance is continuing to climb upward.
--10 % allocation results in loss of Medicaid funding available to serve this population and drives them into the highest cost for care category.

VI. Be pro-active. I would encourage the Committee to:
-- look at the number of licensed nursing home beds available versus the number needed and adjust based on current and project demographics.
--look at issues of access and how to match consumer desire for services with public policy offerings that are more cost effective.
--look at how the workforce can be stabilized as nursing home jobs shrink with the budget reductions. The migration of workers will exacerbate the need for care and quality people to provide the care, especially in rural areas.
--support public policy that encourages oversight agencies such as, Adult Protective Services, the police and sheriff's department, local prosecutors, the attorney general's office, surveyors, ombudsmen, and others to better integrate their investigations and oversight functions to provide adequate safety for elders living in nursing facilities or in their homes.

Thank you for the opportunity to testify today. I am here as the Executive Director of Kansas Advocates for Better Care (KABC). For 35 years, KABC has voiced concerns raised by frail and elder Kansans and our members, about nursing homes, assisted living and other long-term care services. KABC members and volunteers, long-term care consumers and advocates recognize the difficult job you have in balancing the state's budget with dramatically declining revenues. But a balanced budget must not be built upon Kansans who are the frailest and least able to care for themselves. If it is the results will be disastrous and shameful.

MIDLAND
CARE

Aging and Long-Term Care Committee
Impact of 10% Medicaid payment Reductions to PACE
Midland Care PACE
Karren Weichert, CEO
January 19, 2010

Chairman Bethel and Members of the Committee,
Thank you for the opportunity to share with you today the impact of the recent 10% reduction on Medicaid payments most significantly to the PACE program. Midland Care PACE (Program of All-inclusive Care for the Elderly) has been operating since 2007.

The fundamental objective of PACE is to maximize the health and well-being of older adults with complex chronic medical conditions and long-term care needs. The PACE focus is to maximize independence and function for individuals in our care, help them remain in the community, and to prevent or reduce the need for long-term institutional care.

PACE participants must meet the basic requirements:

- Meet Kansas nursing home criteria
- Be 55 and older,
- Are able to live safely at home with supports
- Live in the PACE defined service area (for Midland that is Douglas, Jefferson, Jackson, Pottawatomie, Wabaunsee, Osage and Shawnee counties.

As a PACE provider, we bear the full risk of the cost of the participants' care. PACE Medicaid payments are based on actuarial development of PACE Upper Payment Limit (UPL) methodology. This process utilizes historical fee-for-service data adjusted for the populations and services covered by the PACE program. **The PACE UPL encompasses a comprehensive benefit package including nursing home, long-term care services, inpatient hospital, outpatient hospital, physician services, laboratories and x-ray services pharmacy, transportation, durable medical equipment and hospice services. Essentially everything covered by the state Medicaid plan must be provided by the PACE provider.** The UPL is the average cost per member per month for an individual receiving Medicaid services through the nursing facility and home and community based services and fee for service programs. The methodology is approved by the Centers for Medicare/Medicaid. **In Kansas, once that rate has been determined it's been discounted an additional 25% to the provider**.

Currently, PACE rates in the state are already set at a level that results in 36% savings over nursing home placement. Unlike other providers, who may limit or deny access altogether due to the decreased reimbursement, PACE is prohibited by federal statute from doing so regardless of the cost of care. Providers with whom we contract, are not required by statute to accept the

HOUSE AGING & LONG TERM CARE
DATE: 1-26-2010
ATTACHMENT: 3

MIDLAND
CARE

Medicaid rate from the PACE entity – resulting in less choice for participants and higher costs for PACE to obtain necessary services.

If nursing home beds are in demand, the nursing home can refuse the fixed payment of Medicaid reimbursed residents in favor of private-pay. With a decrease in payment in the waiver programs and other Medicaid programs, earlier nursing home placement is likely resulting in homes operating at or near capacity. With high demand, private-pay residents pay more and the nursing home potentially gets more profit or at the very least has the ability to offset some of their loss. **As a PACE provider, our primary population is Medicaid. If an individual chooses to privately pay, they can only be charged the equivalent of the Medicaid and Part D portions so PACE providers have no opportunity to make up any losses on the private pay side.**

Within the seven counties we serve, the average nursing home Medicaid payment with the 10% reduction is $3,625 dollars per month. For that same population, our PACE program will be paid just about half that amount ($1855); and we bear full-risk for every medical and long-term need of the participant and must pay for nursing home placement if the participant needs dictate such placement.

We have not received an increase in our rates since 2007 and now are experiencing a 10% decrease. The cut will seriously affect Midland's ability to maintain financial viability. Essentially, what it will mean for our organization in the near-term is a layoff of staff and freezing of wages. The longer-term affect will be determined over the next several months but at the very least there will be a delay in some medical specialty services and a higher patient to staff ratio. The impact to our organization at current rates and enrollments would be a decrease in reimbursement in excess of $180,000.

We are requesting that as cuts in all areas are implemented consideration would be given to the fact that PACE already takes a 25% reduction on the rates recommended by the state's contracted actuarial firm; that PACE has no way to recoup or absorb the reductions; and that statute requires all Medicaid/Medicare services continue to PACE participants and that all individuals who meet criteria must be enrolled.

I understand the state is experiencing very difficult times financially, but I would ask that you reconsider the impact these cuts will have on the frailest and most vulnerable population within our state – not just PACE participants, but all those for whom you have heard testimony today and last week.

Thank you for your time and consideration, and I'm happy to stand for any questions.

January 14, 2010

WWW.INTERHAB.ORG

TO: House Aging and Long-Term Care Committee

FR: Tom Laing, Executive Director

RE: 10% Cut in Medicaid Developmental Disabilities Reimbursements

Chairman Bethell, and members of the Committee, thank you for this opportunity to speak with you regarding the Administration's recent decision to order a ten percent reduction in Medicaid reimbursements to the Home and Community-Based Developmental Disabilities Waiver (HCBS DD Waiver). InterHab believes that an alternative approach exists in meeting the current budget challenge, and we urge the Committee take action on the proposal we bring to you today.

First, it is important to compare the Administration's proposal to what the members of InterHab recommend:

Administration Proposal:

The Administration implemented a 10% reduction in reimbursements for HCBS DD Waiver services, which frees up $2.3 million in State General Fund dollars (the State portion of the Medicaid "match" funding that has been cut from the Waiver).

However, the reduced reimbursement also eliminates $5.4 million in Federal dollars (the Federal "match" – currently $0.70 of every HCBS DD Waiver dollar spent in Kansas). These Federal funds are vital to the state, and have flowed into every county in the support of Kansans with developmental disabilities.

InterHab Proposal:

The members of InterHab recommend a $2.3 million reduction in the remaining pool of unmatched SGF dollars in the DD system (utilized to provide day, residential and family support services, and SGF State Aid for those persons with DD who do not qualify for the HCBS DD Waiver). Our proposal to use these unmatched SGF funds avoids the unnecessary loss of Federal funds to the State.

Comparison:

InterHab's proposal does not reduce the Administration's SGF reduction and therefore does not spare the community DD system from absorbing its "fair share" of allotment cuts ordered by the Governor.

HOUSE AGING & LONG TERM CARE
DATE: 1-26-2010
ATTACHMENT: 4

The InterHab proposal does, however, save community DD providers and the State from the unnecessary loss of an additional $5.4 million in Federal assistance.

While this approach is preferable in a fiscal sense, it is definitely not painless. Persons with DD and their families will lose access to valuable services. This approach will protect as many individuals as possible, under current budget constraints.

In other words, this is the *better* of two bad choices.

Summary:

We urge your efforts to advise the Administration to adopt our proposal.

However, so that there is no mistake, please understand, we oppose cutting the DD system, irrespective of the approach. We have more than 4,000 persons on the waiting list and reimbursement rates that trail years behind every economic measurement of adequacy or reasonableness.

In addition to the Governor's budget allotments in November, SRS ordered additional cuts as well – eliminating dental care for Waivers, as well as cutting back on supportive home care, and respite care.

The community DD system is overloaded, and underfunded, and we have had very little success persuading either the Administration or the Legislature of the challenges we face. Simply put, we are doing everything we can to meet the goal of the State's policy that persons should be able to live and receive services in a community-based setting. It is **past time** for the State's leaders to do everything they can, if our quality-based community network of services is to survive.

This session, we hope you will seriously examine the Governor's proposal to bring additional revenues into the State's treasury and improve upon it. His is a decent first step, but many more steps must be taken.

- *We need funding to restore the cuts instituted in the 2009 legislative session.*
- *We need funding to restore the current allotment cuts we have been discussing today.*
- *We need funding to begin the process of reducing and eliminating the State DD waiting list.*
- *We need funding to assure the resources that are needed to hire the persons who are needed to provide high-quality services and supports for persons with disabilities.*

We need funding, and we need you.

The Committee's role in advising the House on the long term care commitments of the State is critical, and we need you to take a lead role in assuring an end to discrimination against persons with developmental disabilities who need home and community based services.

Thank you for your thoughtful consideration of our testimony. I would be happy to answer any questions you might have.

com ityworks inc. 7819 Conser Pl • Overland Park, KS 66204 • 913.789.9900 • commw com

Existing to assist individuals with disabilities to live,
work and play in the community...

Testimony to the House Committee on Aging and Long Term Care Medicaid provider reimbursement cuts January 26, 2010

Janet M. Williams PhD
communityworksinc

Chairperson Bethell and members of the House Committee on Aging and Long Term Care, my name is Dr. Janet Williams and I really appreciate your time today. I own a home health agency called communityworks inc. with offices in Overland Park, Lawrence, Leavenworth and Topeka. We provide Home and Community Based Services to people with traumatic brain injuries (TBI) and other physical disabilities (PD). We are currently providing services to over 400 people, in over 400 communities across Kansas. We get to prove every day that community living for people with brain injuries and other disabilities is possible. As the first state in the United States to provide a TBI waiver, the State of Kansas needs to be commended for their forward thinking. Today I am here to tell you that the 10% Medicaid cuts represent a complete about face in what Kansas represents.

Top 5 things I want you to know about the 10% Medicaid cuts:

1. **The entire philosophy and system of care has been damaged by these cuts. Kansas has been known nationally for being a state at the forefront in making quality services available to people with the most significant disabilities in the community. While it's great that Kansas saves significant dollars by setting up such an extensive community support system, that's not why anyone in this room does it. We do it because it's the right thing to do.**

2. **According to the Kansas Health Policy Authority (KHPA) the traumatic brain injury waiver now saves $21,500 per person PER MONTH ($257,000 per year) as compared to institutional alternatives. In one month 300 people in the community with the exact same support needs cost the same as 22 people in a rehabilitation setting.**
3. **As a business person I am willing to step up and work with anyone with a disability who wants to live in their own home. Since we were saving the State of Kansas so much money we never thought the rug would be pulled out with only 5 weeks notice.**
4. **The 10% cut is $800,000 in an $8 million budget. You would think that being able to stand up in front of 70 staff 13 days before Christmas and thank them for saving the State Kansas millions of dollars, for supporting more than 100 people to leave institutions in one year and growing a company by 39% would be cause for celebration. It was not. In the very next sentence I had to tell staff their pay was cut by 5% percent, three of their coworkers would lose jobs and we would be cutting their benefits and mileage. It was a day I thought I'd never experience. It was a day I never want to experience again.**
5. **We as a culture and a state are going in a catastrophically wrong direction. I know that I am just one illness or accident away from total financial devastation, just like the people I meet every day who want a job to be able to buy paper towels, who try to get into nursing homes, who try to get out of nursing homes and so on, for need of a little real compassion from those voted in to do the right thing. While it would be nice to have a hero, having legislators stand up and do the right thing will do.**

Consumers speak Topeka Capitol Journal

BY JAN BILES
Created January 24, 2010 at 4:54pm
Updated January 24, 2010 at 11:00pm

JoRita Brokmann

Topeka resident JoRita Brokmann says she would be "up a creek" without the help of communityworks inc.'s services.

Brokmann, 48, received a traumatic brain injury in May 2007 when she was severely beaten and sexually assaulted by a man who kicked down the door and entered her home. She had broken bones around her eyes and nose and had to be hospitalized.

As a result of the brain injury, her memory is sketchy, and she has trouble focusing and organizing tasks. She also has diabetes and has struggled with back problems for a number of years.

Under the Home and Community-Based Services traumatic brain injury waiver, communityworks is providing a personal care attendant, transitional living specialist, cognitive therapist and case management to Brokmann, whose goal is to be able to work someday.

Brokmann lives in low-income housing for those who are elderly or have disabilities. She receives Supplemental Security Income benefits, food assistance and a medical card. Because of cuts to Medicaid, she has lost dental and assistive services.

If not for the HCBS waiver, she said she'd be in a nursing home, which costs about $6,000 a month, or about $2,500 more a month than community-based services.

Brokmann said she doesn't understand why the Medicare budget, which funds HCBS programs, was slashed by 10 percent on Jan. 1 when so many people need the services.

"We're all people and not just some kind of number to cut," she said.

Bradley Edwards

Topeka resident Bradley Edwards' life changed June 3, 1987. That is the day he was in a accident on Interstate 70 in Kansas City, Kan., that left him hospitalized with a crushed face and traumatic brain injury.

Nine weeks of rehabilitation at area hospitals and five operations to repair the damage to his body followed. Because of the accident, he lost his job as a courier, but he was able to get a job as a security guard once he began recuperating.

"Then I started having trouble with my legs and lost feeling from my knees to my pelvis," he said, adding that he began to have seizures that prevented him from working.

Edwards, 52, lost his home and was sleeping on the floor of a bookstore when he was referred to communityworks.

While he is waiting to be approved for disability services, Edwards lives on $100 a month, with half of that amount going toward rent for his low-income housing apartment. He receives food assistance, and a church helps buy medical supplies, such as catheters, that aren't covered by Medicaid.

Communityworks provides a personal care attendant, transitional living specialist and cognitive therapist, who are helping him work on improving his memory, expressive language and writing skills. His goals focus on becoming medically stable and coordinating his care.

In a previous round of cuts to Medicaid, Edwards lost dental, nutritional and assistive services. He said he owes about $250,000 in medical bills.

Edwards, who has no family, said the state seems to have money for a $249 million renovation of the Statehouse, but not enough to provide needed services to the poor and those with disabilities.

"It makes no sense to me," he said.

Lisa Bailey

In 1992, Lawrence resident Lisa Bailey was riding her horse over a practice jump when the horse fell. Bailey, now 56, wasn't wearing a helmet. She was transported to The University of Kansas Hospital, where she was diagnosed with traumatic brain injury.

After being in a coma for a week, she was admitted to Kansas Rehabilitation Hospital in Topeka. Eventually, she returned to her job in the environmental chemistry lab at Professional Service Industries in Lawrence. When the lab closed, she found herself hunting for a job. She applied for several openings before being hired as an employment specialist at Cottonwood Inc., a not-for-profit agency serving those with developmental disabilities. But Bailey couldn't seem to adjust to the workplace: She would get lost in the building and would become distracted easily. She lasted a month.

"It was the first time it really hit," she said, referring to the permanency of her brain injury.

Bailey became isolated and lost her home to foreclosure. About 10 years ago, she was referred to communityworks inc., which helped her move into low-income housing and provided a personal care attendant, transitional living specialist and speech-language therapy.

Three years later, after marked improvement, Bailey was hired by communityworks as a transitional living specialist. She also works as a cognitive therapist for Minds Matter LLC, a Shawnee Mission company that provides various therapies to those with disabilities.

"It's hard to believe now that I needed to be taken care of. I was unable to make decisions and did not know what to do next." she said. "Communityworks provides the support you need to get back into life instead of closing the doors and sitting in the dark."

Jan Biles can be reached at (785) 295-1292 or jan.biles@cjonline.com.

Programs for disabled face cuts

BY JAN BILES
Created January 24, 2010 at 4:41pm
Updated January 24, 2010 at 11:00pm

LAWRENCE — WyLma "Darlene" Mortell's dream is simple: She wants to work at a job that pays her enough to buy paper towels.

What most Kansans consider a household necessity is a luxury to Mortell.

"I want a job. I've been wanting one for a long time. I want to be where I can pay my bills without worry," the 53-year-old Lawrence resident said. "I'm tired of doing without necessities. I'm tired of living without."

Mortell has traumatic brain injury as well as a host of other health concerns — muscular dystrophy, asthma, diabetes, kidney problems and seizures. She uses a wheelchair and has difficulty with expressive language and memory. She takes 11 medications a day.

In spite of those obstacles, she is determined to re-enter the workforce and is relying on services provided by communityworks inc. under the Medicaid-funded Home and Community-Based Services waiver for those with traumatic brain injury to help achieve that goal.

However, communityworks inc. — like many agencies that serve Kansans with disabilities through Medicaid-funded programs — was forced to cut its budget by 10 percent on Jan. 1 in response to the state's budget crisis.

In his State of the State address earlier this month, Gov. Mark Parkinson said the state should raise the sales tax by 1 cent for 36 months to offset the estimated $400 million shortfall in the budget. After that, he said, Medicaid cuts likely could be restored.

Janet Williams, president of communityworks inc., said the agency is a service provider for those with disabilities in Kansas and Missouri to help them transition from medical care to supported living. The agency teams with physicians, hospitals, government and mental health agencies, businesses and families to develop support systems that help clients increase self-sufficiency at home and in the community.

The control of the plan is given to the individual client and its staff develops a support system to help them attain their goals.

Communityworks provides services to about 400 people, ranging in age from 9 to mid-70s.

To reduce its budget by 10 percent, Williams said staff — except for personal care attendants — took a 5 percent cut in pay, with the other 5 percent trimmed from employees' benefits, such as health insurance. Three employees were laid off.

"As a business consumer, it makes us reluctant to now know what's coming," Williams said, adding that 98 percent of the services the agency provides are Medicaid-reimbursed.

Williams said those with traumatic brain injuries have two options: Go to a rehabilitation hospital that costs $25,000 a month, or stay in the home and receive services from a community-based waiver program that costs on average $3,500 a month — $21,000 less. Williams said about 300 Kansans receive services provided by the HCBS waiver for those with brain injuries.

The idea of the waiver is to get speech, occupational therapy and behavior therapy at home where they will use the skills and then to phase them out of the program," she said.

Most people, she said, receive waiver services from 21/2 to three years.

Each week, Mortell works with a cognitive therapist, who develops strategies to improve her memory and organizational skills, and a transitional living specialist, who is helping to prepare her to live independently. Communityworks also provides a personal care attendant.

Mortell wants to get to a place where she can work part-time again. In the past she answered phones and did filing for Oxy-Med Inc., a medical supply company in Lawrence. She also did secretarial work for Lawrence Community Shelter on a volunteer basis and lends a hand at Jubilee Cafe and Lawrence Interdenominational Nutrition Kitchen, which provide free meals to those in need. In the past, she served on the Public Transit Advisory Committee for the city of Lawrence.

Mortell said she has a hard time understanding how business executives can give themselves huge bonuses or how cities can worry about fixing roads and sidewalks when the money can be used to help the poor and disabled.

"Let them be in our shoes and let them know how it feels," she said. "People don't understand unless you've been there."

COMMUNITYWORKS

Communityworks inc. helps those with disabilities transition from medical care to supported living.
The agency teams with physicians, hospitals, government and mental health agencies, businesses and families to develop support systems that help clients increase self-sufficiency at home and in the community.
The control of the plan is given to the individual client and the agency's staff develops a support system to help them attain their goals.
Services offered include case management/advocacy; independent living counseling and skills training; referral to community resources; peer support; physical, occupational, speech and cognitive therapies; personal care assistance; drug and alcohol counseling; overnight support; and employment support such as job coaching, job placement and job support.
Program costs are on a fee-for-service basis.
For more information about communityworks inc., call (866) 428-6757.

HCBS WAIVER

The Home and Community-Based Services waiver for people with traumatic brain injury helps them after they have left intensive medical care so they can stay in their homes and live independently.
HCBS serves those ages 16 to 55 who meet the criteria for head injury rehabilitation hospital placement and financial guidelines for Title 19.
The waivers can be used for:

— Personal services, such as someone to help with shopping, dressing, etc.
— Assistive services, like medical equipment or home modifications
— Transitional living services, such as training in cooking, social skills or managing medical needs
— Rehabilitation therapies, such as physical or occupational therapies
— Head-injury targeted case management

Jan Biles can be reached at (785) 295-1292 or jan.biles@cjonline.com.

Self-Advocate Coalition of Kansas

Promoting empowerment and Independence.

My name is Kathy Lobb. I am a self advocate from the Self Advocate Coalition of Kansas, and I am a Medicare & Medicaid recipient. The recent cuts to Medicaid have been devastating to myself and other people who rely on Medicaid funded services. We cannot afford any more cuts in this area, and need the cuts that have been made restored. People have been losing basic and necessary services because of the current cuts. We understand that times are tough with the State budget, but these kinds of cuts are not the solution to our current budget problems.

Cutting Medicaid services to people who need them will cost the state more money in the long run. A single trip to the emergency room because we couldn't afford to go to the doctor will cost the state more money than if the basic services were in place to begin with.

I am fifty three years old, and was born with my disability. I have lived with my disability all my life, but if was not for Medicare & Medicaid I could not live alone. I need very basic services to live independently in the community. Taking away those services may force me to move into a setting that ultimately costs the state more money while robbing me of my independence.

Tough choices need to be made. Revenue enhancements need to be implemented for the long term health of the State's economy.

Sincerely
Kathy Lobb

Kathy Lobb

Legislative Liaison

HOUSE AGING & LONG TERM CARE
DATE: 1-26-2010
ATTACHMENT: 6

2518 Ridge Court Rm 236
Lawrence, KS 66046

1-888-354-7225
785-749-5588
Fax: 785-843-3728

KANSAS MEDICAL SOCIETY
Established 1859

To: House Committee on Aging and Long Term Care

From: Jerry Slaughter
Executive Director

Date: January 19, 2010

Subject: Medicaid Provider Reimbursement Cuts

The Kansas Medical Society appreciates the opportunity to appear on the subject of the 10% cut in Medicaid provider reimbursement which was ordered by Governor Parkinson in late November. The reimbursement cut, which took effect January 1st, is expected to save the state general fund (SGF) approximately $18 million in the remaining months of the current (FY 2010) fiscal year. Because the cut will also have the effect of reducing the amount of federal matching funds that would otherwise be available, the total impact on Medicaid providers is estimated to be $58 million in FY 2010. For the upcoming fiscal year, FY 2011, the 10% reduction will save the SGF about $50 million, and the impact on providers will be roughly $150 million.

First, the physician community understands the seriousness of the financial challenges facing our state, and that there are no easy decisions for policymakers when it comes to balancing the needs of the state with the resources which are available. Medicaid - which serves about 315,000 low income families and their children, the aged and disabled – particularly in the midst of a recession, is a critical safety net program that must be adequately funded to protect this vulnerable population.

We are fortunate in Kansas that the vast majority of physicians participate in the Medicaid program. Although there are some areas where we need to shore up the network somewhat, we have made very positive strides forward in recent years in assuring access to care for the covered population. The physician participation rates are high compared to most other states, even though Medicaid reimbursement is on average about 20% below Medicare rates, and well below rates (as much as 30-40%) paid by private insurers. Medicaid rates were helped considerably by the hospital assessment program, enacted in 2004, and finally implemented in 2006. After thirty years of virtually no enhancements, funds made available from the hospital assessment program were added to the physician fee schedule, which was a major factor in keeping physician participation high.

623 SW 10th Avenue • Topeka, Kansas 66612 • 785.235.2383 • KMSonline.org

Although the provider community understands the difficult position the state is in, the 10% cut ordered by the governor will likely cause physician practices all across the state to re-evaluate their ability to absorb Medicaid patients into their practices. Many physician practices we have talked with have indicated that if the cuts are temporary, they will do their best to maintain their commitment to Medicaid. However, if the cuts are perceived to be long term – or if it appears more cuts are possible – we can expect a significant erosion of the capacity of physician practices to continue to accept Medicaid.

Some context is very important here. Medicaid is not the only public program that affects physician practices. The Medicare program, which covers those 65 and over, also has tremendous influence on medical practices. Medicare, though it pays better than Medicaid, is still well below private insurers, and for physicians, Medicare fees have been essentially frozen for the past seven years. Another public program which serves a significant segment of our population in several areas of the state is the TRICARE program, which provides health benefits for the military and their dependents. TRICARE also reimburses providers on the Medicare fee schedule.

Medicaid covers about 315,000 Kansans; Medicare covers about 410,000 Kansans, and TRICARE roughly 125,000 individuals. Together these publicly financed health programs cover nearly 850,000 Kansans, or 30% of our population. And the number of Medicaid enrollees is continuing to grow, with the S-CHIP expansion that took effect January 1, and the significant Medicaid expansion that is a part of the federal health care reform legislation. In the very near future, nearly a million Kansans, or a little more than a third of our population could be covered by these public programs. Health care providers understand this dynamic, and must plan accordingly for it. That is why one cannot look at the Medicaid program as a stand alone public program, and why decisions on a medical practice's capacity to absorb Medicaid patients is heavily influenced by what is happening in the other public programs.

We will continue to encourage physicians to maintain their commitment to Medicaid, in order to assure continued access to care for the population served by this important public health care program. However, if the cuts appear to be of indefinite duration, or if they are made deeper, it is likely that the program will begin to see attrition in the provider network, which will result in more care being delivered in hospital emergency departments, at much higher costs to the program.

Thank you for the opportunity to offer these comments, and we would be happy to respond to any questions.

Topeka Independent Living Resource Center

785-233-4572 V/TTY • FAX 785-233-1561 • TOLL FREE 1-800-443-2207
501 SW Jackson Street • Suite 100 • Topeka, KS 66603-3300

The Intersection between Budget Cuts to Services and Civil Rights of People with Disabilities under the "Olmstead" Decision

Presented to:
The House Committee on Long Term Care and Aging,
Representative Bob Bethel, Chair

January 26, 2010

Provided by: Mike Oxford, Executive Director
Topeka Independent Living Resource Center

Advocacy and services provided by and for people with disabilities.

The Topeka Independent Living Resource Center (TILRC) is a civil and human rights organization whose mission is to advocate for justice, equality and essential services for a fully integrated and accessible society for all people with disabilities. TILRC provides direct services, including Home and Community Based Services (HCBS), as well as individual and policy advocacy services. TILRC is cross-age; cross-disability. We provide services and advocacy without regard to age or type of disability.

I appreciate the opportunity to provide input to the committee today about this incredibly important topic. I share concerns similar to those of many others about the threat to my agency caused by the loss of revenue and the impact on people with disabilities who are waiting to receive services, or who are having their services capped or cut. When the Governor's 10% Medicaid reimbursement was announced, TILRC committed to not cutting in-home worker wages and not laying off staff. This is why for the first time since 1994 (my tenure as Director), I submitted a deficit annual budget to my Board of Directors. Given the state of the economy, cutting wages and eliminating jobs doesn't seem to make sense.

There is another aspect to the budget cuts along with the direct negative impacts on providers and consumers. There are very serious *Olmstead* and Americans with Disabilities Act (ADA) implications to these budget cuts, federal Medicaid implications, as well as state law implications. The ADA requires that goods, benefits and services be provided by the state "*in the most integrated setting appropriate to the needs of an individual with a disability*" [28 CFR, Part 35, subpart B, 35.130(d)]. The US Supreme Court in the *Olmstead* case determined the impact of this requirement in the context of provision of long term care under state programs. Basically, for a state to comply with *Olmstead*, states should ensure that:

1. People who are residing in nursing facilities and other institutions must be afforded the opportunity to choose to receive alternative home and community services and supports if the treating professional(s) agree that this choice is appropriate.
2. People with disabilities who are at imminent risk of having to enter a nursing facility or other institution must be afforded the opportunity to choose appropriate home and community services and supports.

Finally, the Supreme Court in its decision stated that a comprehensive, effectively working plan for provision of long term care, handling waiting lists, setting priorities and budgeting, would be an affirmative defense to complaints of discrimination under this section of the law. The "*most integrated*" requirement is not just tied to the Medicaid programs or federal funds. It applies to all state-funded or state-sponsored programs and services. This requirement to provide alternative home and community services and supports is not boundless, however. Fundamental alterations to programs are not required of states to meet this requirement, nor are undue financial burdens.

For many years, Kansas has supported growth in home and community programs and services. Budgets have grown to meet need. Waiting lists have been nominal to non-existent (except for the DD Waiver. New programs have been put into place such as Money Follows the Person. Existing programs have been liberalized; caps on amounts and costs of services removed and "crisis" exceptions put into place. Historically, then, the state has felt that an "Olmstead Plan" is unnecessary.

Lack of need for a comprehensive effectively working plan for providing LTC in the most integrated setting appropriate should be reconsidered. Cuts to home and community services and supports and related budget cuts have happened in a vacuum without regard to *Olmstead*. The across-the-board cuts highlight the problem. These cuts were not implemented according to plan, they were "across-the-board." No thought was given to *Olmstead* or to state law. There is no attempt to track and report whether the cuts place people at imminent risk of entering a nursing facility or institution, or whether they are preventing people from exercising their rights to leave nursing facilities or institutions. The state deserves credit for maintaining both the state and federal Money Follows the Person programs to support people choosing to leave a facility or institution as well as maintaining its "crisis and critical exception" policies. However, lack of a comprehensive, effectively working plan leaves many gaps and potential violations in meeting *Olmstead* requirements. The state is at risk of violating civil rights under the ADA and of violating state law.

State law since 1989, fully a decade before *Olmstead*, states "*Priority recipients of attendant care services shall be those individuals in need of in-home care who are at the greatest risk of being placed in an institutional setting*"(K.S.A. 39-7,100).

Consider the following impacts the budgets cuts have created within my agency and the people we serve:

Home Health Services – We are having a very difficult time finding services for people who want and need home health due to difficulty self directing and complicated medical conditions. Home Health agencies are unwilling to provide the service for 90% of their cost. Some people really need home health to protect health and safety.

Nutrition – Our local meals-on-wheels provider has threatened to cut the service because of the cost. We understand they are negotiating with SRS and Aging to restore the cut or to be able to raise their price (which would obviate the purpose of, and circumvent the need for, the cut in the first instance). Nutritional programs such as meals on wheels have historically been a low-cost service alternative for HCBS consumers.

Assistive Services including durable medical equipment (DME) – DME Providers are holding applications for wheelchairs and other kinds of mobility aides for Medicaid recipients while they negotiate with SRS and Aging. In the meantime, people are not getting medically necessary devices and equipment and there is a very real fear that providers will not accept payment of 90% of the invoice.

A related issue with assistive services is that they have been eliminated except for "critical situations." This policy is well intended to cover some *Olmstead* and related requirements and to meet contractual obligations of the MFP program and stimulus funding, but it does not cover all of the imminent risk situations and state law requirements to serve as a priority those most at risk of entering an institution or nursing facility.

Sleep Cycle Support – TILRC has had several individuals on the FE Waiver who only use sleep cycle support services. This one, low cost, relatively limited service was the only publicly supported service that protected the health and safety of these individuals and prevented them from entering a nursing facility. Anecdotally, individuals have begun to explore assisted living and nursing facility options because of the loss of the service.

Lack of targeting those most at risk and in imminent risk - By capping hours on the various Waivers, current policy fails to meet federal and state requirements to provide priority supports to people most at risk of institutionalization. While similar to assistive services, people can appeal the cuts on a case-by-case basis according to specific criteria that is the same for for personal services as for assistive services, the fact is that those with the greatest needs are put at risk while those with lesser needs are protected.

As a consumer-driven organization, we have a tendency to look first to the impact budget reductions and program restrictions have on the people using community-based services and supports. As stated earlier, our board remains committed to maintaining current wages for in-home workers. Since the people our agency employs internally are people with significant disabilities, we also remain committed to avoiding layoffs or staffing reductions within our operations. Some of the program reductions we will need to make include:

Youth services – For many years, TILRC has offered a summer youth program called "The George Wolf Program" named after a much loved agency Board President who passed away untimely. This program offers paid internships to youth with a variety of disabilities who learn about disability rights, disability laws and programs and learn to be effective advocates. This program has no funding source; the agency supports the project with discretionary funding. The 10% cut to the reimbursement rates forced us to cut over 30% the number of youth we could support. Further loss of revenue will likely eliminate this 12 year old program that draws over 40 applications to participate annually.

Nursing Home Diversion Project – When the state first instituted a waiting list for PD Waiver services in December 2008, our agency allocated resources to support a small project for consumers waiting to receive HCBS. We provided homemaker services to people on the waiting list, to ensure people who would be waiting for months would receive basic supports such as weekly meal preparation, housekeeping, and other non-medical supports. In so doing, we were able to help people keep their homes in a condition that ensured they would not encounter health or safety risks, offer people an opportunity to have weekly meals prepared in advance, and provide supports so family and informal supports could maintain employment. The idea behind this project was to provide a minimum level of supports necessary to help people remain in the community until they were offered HCBS. The program was successful; all the people using this program had remained in their homes. We were using discretionary funds to support this program; with the budget losses associated with the 10% Medicaid reimbursement reduction, it was necessary to eliminate this program.

Our agency has a high level of investment in Home and Community Based Services in Kansas. We are committed to the program as it represents our state's commitment to the integration of people with disabilities. We have been involved in this program since its inception. We continue to participate as stakeholders and consultants to policymakers to improve program efficiencies and services. In that capacity, we offer these final thoughts for the committee's consideration:

State budget cuts across the past few years may have exacted a toll on the Department of Social and Rehabilitation which may make management of HCBS programs less efficient and less responsive. Under current staffing, it appears that state staff may have been reduced down to a level that oversight, data collection, monitoring and enforcement are hindered. If the state could collect and make available things like wages, benefits, any administrative fees and surcharges and related information, this would help consumers, workers and others make better informed decisions. Further, the state and other planners, for example, could track any geographic variation in growth, service utilization, wages, and so on. Without this capability, consumers, workers and others may be missing important information relevant to their decision making around choosing providers, managing budgets and services and choosing where to work. This may sound odd, coming from a "service provider", but more data collection, reporting and oversight may be needed. Do SRS and Aging have enough staff to really optimally oversee and manage these large programs?

As additional service reductions are implemented in an attempt to contain program costs, accompanying regulations and policy memorandum are not generated in a contemporaneous manner. Without policy memorandum, appeals of these decisions are likely and are likely to succeed. During an appeal phase, the services remain in place. No cut occurs. No savings accrues.

A lot of appeals will clog up the system since the state agencies are not staffed to handle this load and this will result in a lengthy appeals period when no savings can accrue. Another factor is that individuals without a savvy, aggressive case manager or some other advocacy assistance will not know how, to or whether to, appeal anyway.

The importance of the need for data collection, reporting and adequate oversight and the critical need for planning can not be overstated. It has been well documented for over a decade that demand is going to grow substantially over the next thirty to forty years due to the aging of America and given the correlation between age and increasing disability; disability and need for assistance. National averages show that the population aged 55 to 64 will grow by 75% in 2050 while those aged 65 to 74 will almost double in 2050 and those aged 75 to 84 will more than double. Most dramatically, the population aged 85 and older will more than quadruple by 2050. (Kassner, E. and Bectel, R.,"Midlife and Older Americans with Disabilities: Who gets help? A Chartbook", AARP Public Policy Institute, 1998.)

Projections show a doubling in the need for long term care over the next 40 years. (Kaye, Harrington, LaPlante, "Long Term Care: Who Gets It, Who Provides It, Who Pays, And How Much", Health Affairs, Jan., 2010). The mounting pressure on the budget of this growing need for assistance calls for long range planning that moves Kansas to a community first system that is most cost effective, prevents or delays institutionalization and maintains and promotes independent functioning. This planning must include workforce issues in order to ensure that an adequate supply of good workers is available to meet the growing demand and so that informal supports provided by family is protected and promoted. The majority of all services and supports are provided "informally" by family (*Ibid*) According to the Paraprofessional Health Institute, direct service workers are one the fastest growing occupations and demand for these kinds of workers will outstrip supply by 2016. (PHI Facts No. 1, "Occupational Projections for Direct-Care Workers 2006-2016", April, 2008).

The need for systematic, comprehensive, long range planning is critical to meet this long term issue; budget cycle to budget cycle, crisis mode no longer makes sense for an issue that is not going to go away. It will remain and grow for another thirty to forty years. Kansas needs an Olmstead Plan!

SHANK TESTIMONY
Testimony by Richard Shank of Hutchinson representing the Alliance for Kansans with Developmental Disabilities

To: Aging and Long Term Care Committee

GOOD AFTERNOON, I AM RICHARD SHANK APPEARING ON BEHALF OF THE ALLIANCE FOR KANSANS WITH DEVELOPMENTAL DISABILITIES.

DURING THE PAST MONTH, IT HAS BEEN MY GOOD FORTUNE TO WORK WITH THE ALLIANCE, AND IN PARTICULAR, ON THE ISSUES AFFECTING THE TEN PERCENT REDUCTION IN MEDICAID FUNDING.

THEWORDS DEVELOPMENTAL DISABILITY IN SOME WAY TOUCHES THE LIVES OF NEARLY EVERY FAMILY IN KANSAS. FOR ME PERSONALLY, I REMEMBER GROWING UP ALONGSIDE A COUSIN WHO WAS AFFECTED FROM BIRTH WITH DEVELOPMENTAL DISABILITIES.

THESE ARE ALL SPECIAL PEOPLE IN OUR SOCIETY AND ALTHOUGH THEY ARE FRAGILE IN A MEDICAL SENSE, THEY HAVE THRIVED THANKS IN LARGE PART TO THE MEDICAID PROGRAM AND ARE LIVING PRODUCTIVE AND HAPPY LIVES.

IN VISITS TO TWO ORGANIZATIONS THAT DEAL WITH CLIENTS AFFECTED BY DEVELOPMENTAL DISABILITIES, I ADMIT TO BEING A LITTLE OVERWHELMED WITH THE DISABILITIES OF SOME OF THOSE THAT I MET BUT AM TOTALLY IMPRESSED WITH THE CALIBER OF PEOPLE THAT WORK IN THESE ORGANIZATIONS.

HAVING ATTENDED A LEGISLATIVE FORUM IN HUTCHINSON ON SATURDAY IN WHICH CHAIRMAN BETHELL AND SPEAKER OF THE HOUSE MIKE O'NEAL PARTICIPATED, WE WERE ALL MADE AWARE OF THE TOUCH DECISIONS THAT YOU MUST MAKE DURING THE NEXT THREE MONTHS.

MEMBERS OF THE ALLIANCE ARE FEELING THE EFFECTS OF THE CUTS WHICH ARE HAVING A RIPPLE EFFECT IN THE COMMUNITIES THAT THEY SERVE.

--HEALTH INSURANCE PREMIUMS CONTINUE TO INFLATE AT AN ANNUAL RATE OF MORE THAN TEN PERCENT.
--DIRECT SUPPORT PROFESSIONAL LABOR, THE BACKBONE OF THESE ORGANIZATIONS HAS BEEN REDUCED AND FURTHER REDUCTIONS PUT VULNERABLE FOLKS AT RISK, WHICH COULD RESULT IN LIFE AND DEATH ISSUES.
--IN AN ORGANIZATION WHERE EVERY PERSON IS NEEDED, LAYOFFS AND CUTBACKS ARE STRETCHING RESOURCES.
--UNEMPLOYMENT INSURANCE IS ON THE RISE BY SEVERAL HUNDRED PERCENT AND ONE FACILITY WILL NEED TO CUT $60,000 FROM THEIR BUDGET JUST TO PAY THOSE COSTS.
--HOLIDAYS HAVE BEEN REDUCED TO TWO PER YEAR.
--IT HAS BEEN NECESSARY TO REDUCE TRAINING BOTH FOR EMPLOYEES AND CLIENTS.
--MANY CLIENTS WILL NO LONGER BE SERVED IN SMALL RESIDENTIAL SETTINGS AND IT MAY BE NECESSARY TO INCREASE THE NUMBER PER HOME BY AS MUCH AS 50 PERCENT.
--FRINGE BENEFITS OF EMPLOYEES, INCLUDING HEALTH AND LIFE INSURANCE, HAVE BEEN REDUCED.

CUTS OR NO CUTS, THE ORGAIZATIONS ARE REQUIRED TO PROVIDE QUALITY SERVICE TO THEIR CLIENTS AND ARE WORKING LONG HOURS TO ACCOMPLISH THAT MANDATE.

AS ONE ALLIANCE MEMBER TOLD ME, SHE JUST HOPES TO HAVE ENOUGH REVENUE AT THE END OF THE MONTH TO PAY BILLS.

WE REALIZE THERE IS A SPIRITED DEBATE UNDERWAY TO ADDRESS THESE ISSUES AND WE LOOK FORWARD TO A DIALOGUE WITH YOU, CHAIRMAN BETHELL AND YOUR COMMMITTE.

THANK YOU FOR PROVIDING THIS OPPORTUNITY TO TELL OUR SIDE OF THE STORY.

Kansas Council on Developmental Disabilities

MARK PARKINSON, Governor
KRISTIN FAIRBANK, Chairperson
JANE RHYS, Ph. D., Executive Director
jrhys@kcdd.org

Docking State Off. Bldg., Rm 141,
915 SW Harrison Topeka, KS 66612
785/296-2608, FAX 785/296-2861
htpp://kcdd.org

"To ensure the opportunity to make choices regarding participation in society and quality of life for individuals with developmental disabilities"

HOUSE COMMITTEE ON AGING AND LONG TERM CARE
January 14, 2010

Testimony in Regard to November Allotments on Medicaid Programs for people with Developmental Disabilities.

Mr. Chairman, Members of the Committee, I am providing this testimony on behalf of the Kansas Council on Developmental Disabilities regarding the reduction in funding for the Kansas Developmental Disabilities Medicaid Waiver.

The Kansas Council is federally mandated and funded under the Developmental Disabilities Assistance and Bill of Rights Act of 2000. Members are appointed by the Governor and include primary consumers, immediate family, and representatives of the major agencies who provide services for individuals with developmental disabilities. Our mission is to advocate for individuals with developmental disabilities to receive adequate supports to make choices about where they live, work, and learn. As a member of the Big Tent Coalition we support the 2010 Priorities developed by the Big Tent.

A Developmental Disability occurs before age 22, is lifelong, and results in major substantial functional limitation in three or more areas of major life activity such as self-care, mobility, and economic self-sufficiency. These disabilities require lifelong supports, they are not curable nor do persons get better as they get older.

Since the cuts in funding recently took place, there is not a lot of hard data at this time to show the effect. However, service providers and former service providers have been telling us what is occurring in their communities and we are greatly concerned. First I would refer you to Department of Social and Rehabilitation Services (SRS) Secretary Don Jordon's testimony just

yesterday to the House Appropriations Committee regarding their projections on the effect of the 10% cut in Medicaid waiver rates:

> *The 10% rate reduction to the Medicaid Home and Community Based Services waiver programs will have several effects on providers. We will see larger group living arrangements as providers move individuals from 2-4 bed homes into 5-7 bed homes to decrease the number of necessary staff. Consumers may see an impact on the quality of care due to a higher staff to consumer ratio in day and residential settings. . . . smaller providers may be forced out of business regardless of their financial position. Individuals who self-direct their services will not be able to find attendants due to the decrease in the hourly rate.*

This is currently happening – I was notified by a former staff member that the Community Developmental Disabilities Organization (CDDO) "has make job reductions so the Employment Services has been cut. They have also cut recreation, enrichment center along with certain other individuals." This person had lost their job due to cuts. The people who formerly had employment services and recreation services are either not receiving those services or receiving a reduced amount of services.

In addition, reduction in Medicaid rates reduces the amount of federal funding the state receives. The 10% reduction to the community Developmental Disabilities Medicaid rate of $2.3 million State General Funds also reduce us by $5.4 million in federal funds for a total of $7.7 million all funds. We "save" $2.3 million in state funds but **lose $5.4 million in federal funds**.

<u>Interhab's Alternative Proposal</u>

Restore the 10 % reduction in Medicaid of $2.3 million, also restoring $5$5.4 million in federal funds.

Reduce State General funds. These funds are for people who are not on the DD Waiver. Coupled with a reduction in DD Grants that go only to CDDOs, the State could save the same amount of money and reduce the impact to persons with Developmental Disabilities. I would defer to Tom

Laing, of Interhab, regarding specific questions because he represents the CDDOs and Community Service providers who proposed this alternative and who are seeing the effects of the Medicaid reductions.

As always, we appreciate your time and patience and would be happy to answer any questions.

Jane Rhys, Ph.D., Executive Director
Kansas Council on Developmental Disabilities
Docking State Office Building, Room 141
915 SW Harrison
Topeka, KS 66612-1570
785 296-2608 jrhys@kcdd.org

Saint Francis Community Services
Serving Children and Families Since 1945

Testimony: Aging and Long Term Care

January 26

Thank you for the opportunity to submit testimony. **Saint Francis Community Services** has a rich history of serving troubled youths and their families over 60 years. We provide a range of services from family preservation, reintegration/ foster care foster care homes, which we do so under contract with the state, as well as, drug and alcohol services, and residential services and community supports. Through those programs last year we served over 2000 children and families, in 54 rural and frontier counties, with 12 offices and over 550 full and part time employees. In July of this year our Family Preservation Services expanded into Region 3 based on the SRS designation. St. Francis is a non-profit organization.

2010 POLICY AGENDA~

SERVING A RURAL POPULATION

The needs, perspectives and culture of our rural and frontier population shall be reflected in decisions and policies that shape services to children and families at all levels.

MENTAL HEALTH AND BEHAVIORAL SERVICES

All children in the child welfare system will have access to quality, and timely mental health and behavioral health services designed to sustain and reunite families.

MANAGING POSITIVE SYSTEMS CHANGE

System changes that impact children and families must be adequately funded, accompanied by plans to build system capacity, and have a process for monitoring and evaluating performance against outcomes.

For more information contact
mlness@connections-unlimited.net

The system serving children and families will reflect regional differences, ensure access to critical services and effectively manage change

As the legislature moves forward with deliberations on how to address the significant budget shortfall, we believe it is our obligation to provide legislators with the impact their decisions are having on services that are critical to the state. Specifically those services that respond to the needs of some of Kansans most vulnerable children and families.

Every single provider affected by these cuts is faced with untenable choices. Choices that affect who will get services and who won't knowing that the need far outstrips the available resources. As one of the organizations that provides foster care, family preservation and adoption services for the child welfare system, these cuts come on top of a substantial reduction in the contract which required a considerable reduction in staffing and restructuring that has put a strain on our capacity to meet service outcomes.

In addition to testimony already heard by this committee impact to SFCS is felt primarily in our outpatient services and our Psychiatric Residential Treatment Centers (PRTF). By way of example:

- Because other services on which we rely to serve our population are also impacted by Medicaid cuts such as mental health services. We are experiencing significant cost shifts which we will not be able to absorb over the long term without making additional cuts in the scope of services.

- Mental Health Centers can no longer financially support a sliding fee schedule for court ordered services. As a result we have been required to pick up responsibility for services that are critical to achieving reintegration and permanency. These include Parenting Evaluations, Psychological evaluations and others.

- The 10% cut has also affected the rate for outpatient services to children in foster are through our clinic. Services affected include individual, group and

HOUSE AGING & LONG TERM CARE
DATE: 1-26-2010
ATTACHMENT: 11

family therapy. The rate was already below our actual costs for providing services. As a result we are concerned about how this will hinder our ability to bring families together sooner.

- Children on the MR/DD waiver are no longer eligible for respite care. A service that provides needed support for caretakers. SFCS is picking up the cost to help parents avoid placement disruptions but will have to make cuts in other areas to compensate.

- Our PRTF services are a cost based system. Consequently, it forces us to reduce expenses such as staff and compliment of services. This reduction in the rates will impact future reimbursement and ability to pay for services if the state builds future payments on the reduced cost. In other words as each month passes with the reduced rates we continue to lose ground in providing services as the monthly losses continue to accumulate.

It is also important for the committee to keep in mind that since the PRTFs are cost based the reductions not only have a current year impact, but have an impact in the following year. The reductions are compounded and will actually result in reductions of greater than 10%.

It is difficult to understand how the strategy of reducing Medicaid rates will aid the state in making up the shortfall in the FY 2011 budget. In fact we believe it is quite the opposite. The loss of these dollars will fuel an erosion of basic supports and key intervention services that in the long run will be more costly to the state than the savings generated in the short term.

As you gather information, it is our hope that this committee will seek alternatives to leaving a significant amount of Medicaid dollars on the table. These dollars provide a critical foundation for helping us meet our child welfare outcomes in the state as well as support for all of the collateral services on which we rely.

Conclusion

We are very aware of the potential $400 M shortfall in the FY 2011 budget. We understand that this legislature and state leadership will have to look at a variety of options to ensure stability and recovery for our state. To that end, we hope this testimony provides information you need that must be factored into the eventual choices this legislature must face.

Please feel free to contact us if you have any further questions.

Respectfully submitted,

Melissa L. Ness JD MSW