MINUTES

JOINT COMMITTEE ON CHILDREN'S ISSUES

September 12-13, 2002
Room 514-S—Statehouse

Members Present

Senator Sandy Praeger, Chair
Representative Brenda Landwehr, Vice Chair
Senator Paul Feleciano, Jr.
Senator David Jackson
Senator Nick Jordan
Senator Janice Lee
Representative Sue Storm
Representative Roger Toelkes
Representative Bob Tomlinson

Members Absent

Representative Gerry Ray

Staff Present

Hank Avila, Kansas Legislative Research Department
Emalene Correll, Kansas Legislative Research Department
Audrey Nogle, Kansas Legislative Research Department
Mike Corrigan, Revisor of Statutes Office
Almira Collier, Committee Secretary

Thursday, September 12
Morning Session

The Chair called the meeting to order and thanked Representative Landwehr for chairing the August meeting.

Staff called attention to the written testimony requested from the Reverend Art Campbell (Attachment 1) and reported the Department of Social and Rehabilitation Services had worked with the family, and the daughter is now in a residential program. The Department has also worked with Ms. Homewood in getting needed mental health services for her son and is continuing to look for a more structured placement for him.

Foster Care—Response to Issues Raised at August Meeting

Laura Howard, Assistant Secretary, Department of Social and Rehabilitation Services, presented written testimony (Attachment 2) giving an update of the Child Welfare and Mental Health Partnership Planning Process. Ms. Howard stated the Partnership Planning Process, begun in the spring of 2001, was designed specifically to study how the child welfare and community mental health systems, along with other community partners, could collaborate effectively at the local level to meet the mental health needs of children and youth in the child welfare system who have serious emotional disturbances. Much of the initial work was about relationship building, understanding the different languages used by the two systems, and stressing with all parties the importance of permanency for those in the child welfare system. The group, recognizing there are barriers between the child welfare and the mental health systems, reached a consensus that change was warranted and that partnerships needed to be built slowly and carefully between the two systems at the local level, with the first collaborative efforts focused on children with the highest mental health needs. Two target populations were chosen for initial community planning and collaboration:

- Children who experience serious emotional disturbance who also need home and community based supports and services; and

- All children in the adoption contract.

To implement the changes recommended by the Partnership Planning Group, changes were made in the way mental health services for the two target populations are funded. Instead of contractors having direct fiscal responsibility for mental health services provided by the community mental health centers to children in these populations, the community mental health centers now have direct billing access to Medicaid through the child's medical card for reimbursement of the mental health services provided to the two target populations.

Ms. Howard noted all contractors and community mental health centers have submitted the required local partnership plans. The plans submitted early have been accepted and implemented, with the remainder to be implemented this fall. Since October 2001, 528 foster care children have been identified as experiencing serious emotional disturbance and in need of in-home and community-based services or supports. Of these children, 80 percent are currently receiving community based services through the community mental health system.

Steps have been taken to ensure there is monitoring and oversight of the Partnership Process and to create a means for community mental health centers and contractors to work through any issues that may arise. These steps include development of a Professional Judgement Resolution Process involving both an informal local resolution process and a formal process; provision for administrative services oversight by The Consortium, Inc.; hiring of a state level wrap-around collaborator to assist all parties involved; development of a Child Welfare and Mental Health Oversight Steering Committee with broad representation to monitor the implementation of the Child Welfare and Mental Health Partnership Planning Process and to ensure that problem solving can occur as needed (see attachment to Attachment 2 for questions to be addressed by the oversight committee); bringing together the original Partnership Planning Group to review the progress of the Partnership and to make further recommendations; creation of a Mental Health Quality Management staff to monitor community mental health center licensing, regulatory, and contractual responsibilities and to assist consumers and other community members with concerns, complaints, and access issues; and implementation of an outcomes tracking process. The Child Welfare and Mental Health Partnership is seen as a process of improvement based on continual monitoring.

One strength resulting from the Partnership Planning Process is the development of a check list contractors can use to help identify children who may be in the seriously emotionally disturbed (SED) group and may have some specialized mental health needs. Training in understanding and use of the check list for mental health center staff and the Department of Social and Rehabilitation child welfare staff was provided in the fall of 2001. This has led to a more consistent application of the criteria to identify SED children and a clarification of the SED definition.

Ms. Howard noted that a proviso to the Department of Social and Rehabilitation Services appropriation considered, but not passed, by the 2002 Legislature included:

- Direction to the Department to ensure the community mental health centers work with the contractors in identifying the needs of and developing plans for families; and

- Direction to require the centers to contract with a child welfare contractor to provide needed services if the center does not have sufficient capacity to provide such services.

The Department of Social and Rehabilitation Services, which did not take a position on the proposed proviso, believes there are existing contractual and new licensing regulatory requirements already in place to address these two concerns. The current Community Mental Health Center Mental Health Reform Contract requires the centers to contract with other service providers in certain situations, and a provision in the new licensing regulations allows the Secretary of Social and Rehabilitation Services to assess a center's refusal to affiliate with another provider, but does not allow the Secretary to impose such an affiliation.

Ms. Howard called attention to a second collaborative initiative focused on children with disabilities. A work group, the Community Focus on Children with Disabilities Work Group, composed of child welfare contractors and community developmental disabilities service providers, has been working to identify and overcome policy barriers between the two systems. Communication between members of the two systems has improved, and day-to-day collaboration has increased. Rules regarding guardianship and reimbursement which interfered with children with disabilities achieving permanency have been adjusted. Provisions have been added to the FY 2003 Social and Rehabilitation Service/Community Developmental Disabilities Organizations Contract to ensure contractors and community developmental disabilities organizations work together to identify children and youth with developmental disabilities and to ensure such children receive the services and supports needed. This group, which has been expanded to include the community mental health system, will be working over the next six months to develop a set of comprehensive policy recommendations to address issues for children with both a developmental disability and a mental illness or behavior disorder.

Afternoon Session

The meeting was reconvened by the Chair at 1:40 p.m.

Mental Health Rules and Regulations

Ms. Howard presented written testimony (Attachment 3) giving background information relating to the reasons for updating the licensing regulations for community mental health centers that originally became effective in 1991 and the process utilized by the Department in developing the proposed changes. An attachment to the testimony outlines the key provisions of the proposed regulations. It is anticipated the regulations will be adopted later this month after changes and deletions based on comments received from the Joint Committee on Administrative Rules and Regulations (Attachment 3, page 3) and the public hearing held last week have been made. Examples of changes which will be made based on these comments are the addition of language relating to foster parents or family members as consumers in some processes and the deletion of failure to pay as a reason for denial of services by a community mental health center. Due to confusion about the proposed regulations relative to affiliates and affiliate licensure, all provisions related to licensed affiliated community services providers will be removed from the regulations before adoption and will be given further study. In the present system, the Department licenses community mental health centers which can choose to enter into business relationships with other mental health service providers. The original proposal of the Task Force created in 1998 to review and make recommendations for changes in the licensing regulations, would have established a new category, Licensed Affiliate Community Service Provider, but did not require a provider entering into a relationship with a mental health center to be licensed. The impetus for this change was a belief that it might lead to new affiliations and expanded

consumer choice. Removing all provisions related to this new category will allow for further discussions by the stakeholders based on concerns and questions that have been raised.

In response to a question, Ms. Howard stated the intent is to bring the Task Force together for a dialogue on the changes made, based on comments received before adoption of the regulations. One regret relating to the process is the length of time that elapsed between receipt of the Task Force's recommendations and the issuance of the proposed regulations which led to the mis-perception that a number of changes had been made. Another is not bringing the Task Force together to review the proposed regulations prior to making them available for public comment.

Committee members stressed the importance of discussing the regulations pertaining to affiliate licensure with all the stakeholders until everyone is comfortable in believing that the Department of Social and Rehabilitation Services and any others involved in enforcement can explain what the regulations mean and how they are to be implemented.

Ms. Howard, answering a question, stated in the proposed regulations there are: A clear articulation of consumer rights; requirements for community mental health centers to make consumers aware of their rights; and a process for dissatisfied consumers to make complaints known. An appeals process is spelled out for those cases in which a resolution cannot be reached at the community mental health center level within the specified time limit. On the broader issue of authority to take action against a licensee, the Department has the authority to give a center not in compliance with licensing regulations a provisional license and to require corrective action plans. Although this authority is not specifically stated in the licensing statute, the agency staff attorney and the Attorney General feel, under a variety of statutory provisions, the agency has the right to take actions against a community mental health center. Some language is included in contracts with the centers that spells out the authority to take different actions. Ms. Howard stated she would furnish the Committee material regarding the statutes on which the staff attorney is basing this authority. It was suggested the Committee might want to determine whether or not the Legislature needs to give the Department more specific authority to take action that does not rise to the level of revoking or denying a license.

Sandra C. Hazlett, Director of the Integrated Services Division, Economic and Employment Support, Department of Social and Rehabilitation Services, presented written testimony (Attachment 4) providing information on the trend of child-only cases, *i.e.*, cases in which parents or caretakers choose to seek assistance only for the children and not for themselves, within Temporary Assistance for Needy Families. The only circumstance in which there would be a child-only case with a parent in the household is when the parent receives supplemental security income. Currently, there are 1, 648 such cases. In all other child-only cases, the child is being cared for by someone other than the parent. The non-parent caretaker may seek assistance only for the child, in which case only the child's income is considered, or for themselves as well, in which case the caretaker's income is also considered and the case is no longer a child-only case. There are fewer than 100 cases in which the nonparental caretaker has sought assistance for himself or herself.

Ms. Hazlett noted, contrary to the trend in many states, the child-only relative cases in Kansas have remained fairly constant over the past two years, with a slight decline despite growth in the overall assistance caseload. This is due to the fact that Kansas, unlike most states, invested much of the temporary assistance for needy family funds in child welfare services from the beginning of welfare reform. These services include family emergency services, family preservation services, permanent guardianship subsidies to relatives or others willing to provide a permanent home for a child, and allowing relatives caring for children in the child welfare system the choice of applying for assistance for a child or becoming a foster parent and receiving the higher foster care rates. In conclusion, Ms. Hazlett stated Kansas uses the cash assistance funds effectively to maintain or reintegrate children with their parents when at all possible and to support relatives who have assumed the responsibility of caring for young relatives. Only about 170 families have actually reached the 60-month cash assistance time limit, and all but three of these families have qualified for a hardship exemption so benefits are continuing for the whole family.

Dental Programs

Joyce Cussimanio, Kansas Children's Cabinet and Trust Fund, presented written testimony about the Access to Baby and Child Dentistry (ABCD) program adapted from a successful program begun in 1995 in Spokane, Washington (Attachment 5). The ABCD program, being piloted in three Smart Start Kansas communities, is supported by a public and private partnership committed to a three-year learning cycle which teams local communities with funding provided by Kansas Children's Cabinet ($15,000 per site through Smart Start Kansas funds), United Methodist Health Ministry Fund ($25,000 per site), and the Department of Social and Rehabilitation Services. Of the grant equaling $40,000, $5,000 is set aside to fund activities within the context of the pilot project that may not meet the requirements of the Medicaid administrative match. The remaining $35,000 goes to match dollar for dollar Medicaid administrative dollars. Since administrative dollars are different than actual service dollars, there are specific requirements that must be met.

There are three major elements of the project that pilot sites must address:

- Preventive and treatment services;
- Care coordination and case management; and
- Increased access to dental care, including enlisting additional dentists to work in the project.

Referring to the first element, Ms. Cussimanio stated, at a minimum, children must receive an annual screening exam, treatment for identified problems, and an application of fluoride varnish. Parent education, assistance in making dental appointments, making reminder calls, providing transportation and child care if needed, and making follow-up contacts are services under the second element. Achieving the third element is a challenge since not many dentists are trained to treat very young children and many dentists do not realize the

importance of seeing very young children. To address this, a partnership was formed through the Kansas Dental Association with the University of Missouri at Kansas City to provide training for dentists on dental care for young children. Also, sites are looking at incentives for dentists to participate in the project. Although the project had a slow start, some small differences have been realized.

Addressing questions and concerns raised by Committee members, Ms. Cussimanio stated providing transportation and babysitting for other children in the family, reminders of appointments, family education about the importance of dental care, and having a champion of the project from the local dental community has helped create some interest and openness on the part of dentists where initially there was resistance. A dental clinic for indigents just created in Lawrence is a part of the Douglas County project. Kansas is a little ahead of Washington in terms of reimbursement for dentists, but the system for payment needs to be streamlined. It is hoped that what is learned in the pilot sites about what does and does not work can be shared across the state.

Discussion of Foster Care Issues

A summary of the issues identified by the August 28 roundtable participants (Attachment 6) and a copy of "Foster Parent Regional Advisory Meeting Concerns" compiled by the Kansas Foster and Adoptive Families, Inc. (Attachment 7) submitted by Sandy Clear at the August meeting, were distributed. Staff identified the following four recurrent underlying issues from the August meeting (Attachment 6, page 3):

- Communication is inadequate at all levels of the system and among all parties involved in the system;

- Funding, while more integrated than in the past, remains an issue that underlies other perceived problems in the child welfare system;

- While there is data about contractors and other parties meeting stated or contractual goals, very little is known about what happens to individual children and families in the system; and

- There continue to be concerns about social workers and case managers not visiting children regularly or at all, not returning calls from foster care providers in a timely manner, and being inexperienced.

While there have been some improvements in the system since the Legislature first began to look at issues relating to the change in how we handle our child welfare system in Kansas, there are still some apparently legitimate criticisms. Most of the roundtable participants believe the system is better than before the change and some improvements have taken place since the inception of the new system. However, everyone more or less agreed there are still some issues that need to be addressed, some of which may require

legislative direction or action to rectify. Other issues perhaps can be handled by the agencies involved, given a little prodding from the Legislature.

Other materials distributed by the staff for Committee consideration included: copies of Section 10, the definition section of HB 2945 as introduced (Attachment 8) and as amended by the Federal and State Affairs Committee (Attachment 9), and a memo from staff comparing the definition sections in Attachments 8 and 9 and current law (Attachment 10). Staff noted last year the Committee expressed concern about how abuse and neglect are defined in actual practice when deciding if a child is to be removed from the home in an emergency or in other circumstances. Also, a number of conferees appearing before the Committee expressed concerns about how their own cases or cases they knew about had been handled. At that time, the Committee asked that additional consideration be given to whether or not certain definitions needed to be clarified or changed. The definition section of HB 2945 reflected this request. A subcommittee of the House Federal and State Affairs Committee studied the bill and proposed amendments, many of which were adopted by the full Committee. The Committee Report was adopted by the House. However, there was a "gut and go" amendment which failed on final action, leaving the definition issue unresolved. It was noted, since the Judicial Council Advisory Committee is wrapping up work on the Juvenile Code and has not yet begun work on the Children in Need of Care Code, it will be some time before the Council will submit any recommendations relative to definitions. The Committee asked staff to draft a letter from the Committee to the Judicial Council suggesting special consideration be given to the definition section of HB 2945.

Reference was made to the fact that the Department of Social and Rehabilitation Services has indicated the Department is studying the issues noted above internally and hopes to have some recommendations in the near future.

Also included for Committee consideration was a draft proviso, minus references to fiscal years, dealing with mental health services issues, adopted by the House Subcommittee on Social and Rehabilitation Services appropriations, but not included in the final appropriation bill (Attachment 11). This type of language could be introduced as a bill. It was noted Ms. Howard had spoken to this issue, in part, in earlier testimony relating to an update of the Partnership Planning Process.

Reference was made to the continuing concern about what is actually being measured in evaluations of the foster care system. Current evaluations are based on system performance measures, *i.e.*, what percent of children receive needed services within a specified time or what is the average length of stay in the system. What is not being looked at, in part because of the expense, is the outcome for individual children while in the system and after leaving the system, *i.e.*, how many finish school, are employed, or enter the juvenile justice or criminal system. Two possible steps to move toward the latter type of evaluation noted were the Department of Social and Rehabilitation Services and the Juvenile Justice Authority sharing files or tracking a specified number of children for a specified period of time. The following points were noted. A limited sample, with a few key questions, can produce a high degree of confidence when the results are applied to the larger population. A few states are considering collectively seeking grant funds for this type of tracking. In any study focusing on individuals there are issues of confidentiality. What

has happened to children not placed in foster care needs to be included in any follow-up study. Because of the expense of this type of study, intermediary steps may need to be taken to reach the goal of determining what happens to the children who are or have been in the foster care system. Emphasis was given to the fact that an evaluation of the system's performance without data relating specifically to the outcomes for the children does not provide adequate data about cost effectiveness.

Ms. Jacobson indicated an interest in participating in discussions relating to evaluations of the system, noting the agency feels measurement of safety and permanency, the goals of the child welfare system, is being done. Going beyond these goals involves a different perspective.

Responding to a question, Ms. Howard stated there are provisions for community mental health centers to utilize other providers including, under the proposed regulations, provision to pay the providers. Mental health centers receive the federal portion of Medicaid, but their grant is considered the state part. A qualified provider receives both the state and federal portion. In response to a further question, she stated in parts of the state there have been issues relating to the ability to provide certain services such as attendant care. Concerns have also been expressed about time lags between a referral to a center, scheduling of the initial visit, and initiation of services. It is hoped the Steering Committee will look at these issues to determine to what extent this varies between sections of the state and whether or not there are any patterns relating to time lags.

In response to a question about the eight domains referred to in earlier testimony, Ms. Jacobson stated a domain refers to a particular subject matter, such as abuse and neglect investigations, covered in a particular class. Classes range from one day to five days in length, depending on the subject matter covered. It takes 15 months to complete all eight domains.

Concern was expressed about issues relating to serving persons from a multiplicity of cultures and persons who speak other languages. Ms. Jacobson stated a work group is addressing the impact of population shifts and language and cultural differences. Resources in communities are being identified. In one community, members of a predominantly Spanish speaking church trained agency staff in minimal conversational Spanish and serve as interpreters as needed. Some area offices are considering including a second language appropriate to the community as a special job qualification. Also, the Department is in the process of publishing forms and brochures in multiple languages.

HealthWave

Ms. Howard presented written testimony (Attachment 12). Ms. Howard stated in the spring of 2002, the State Children's Health Insurance Program (Title XXI) was blended with the state's Medicaid Capitated Managed Care Program (Title XIX) to provide a seamless managed health care option for families. In July 2002, HealthWave, the blended program, was available in 62 counties to Title XIX beneficiaries and in 105 counties for Title XXI beneficiaries. To date, over 100,000 children have come into either the HealthWave

program or have come into Medicaid because of HealthWave outreach. HealthWave plans are paid a capitated rate for each enrolled person as an incentive to provide more aggressive preventive health care services. Persons enrolled in HealthWave have a primary care physician to coordinate their health care service needs.

The outreach strategy has been modified, with Maximus now responsible only for marketing activities, including public service announcements, radio advertisements, and mass production of applications, brochures, and posters. The central office of the Department of Social and Rehabilitation Services has partnered with area offices to conduct outreach activities through a one-time allocation of $250,000. Some area offices have contracted with community outreach groups that already had an infrastructure in place to provide outreach activities. A list of primary outreach activities on which each area office is focusing is attached to the written testimony (Attachment 12). Unfortunately, the fiscal environment does not allow additional funds for area offices which play a key role in outreach. Six existing, full-time staff have been assigned to Wichita health clinics serving low-income uninsured patients to inform the public about agency programs and to assist people with the HealthWave application process.

Specific steps have been taken to address the issue of children who temporarily disenroll from HealthWave for various reasons. A policy change now allows HealthWave enrollment to be retroactive for children who complete the re-enrollment process within a month following the scheduled re-enrollment date. Data showed that a large portion of disenrollment happened inadvertently through "preventable administrative error." Children automatically and unintentionally lost HealthWave coverage when their temporary assistance for needy families eligibility changed. This issue has been addressed by delinking medical coverage from assistance benefits. Also, through Maximus, more functions are being centralized within the clearinghouse in a program called Family Medical Centralization.

Ms. Howard referred to the survey of new HealthWave enrollees, based on data available prior to October 2001, which indicated more people enroll in HealthWave through the clearinghouse than through area offices and that children who enroll in HealthWave through the central clearinghouse tend to have lower rates of temporary disenrollment. However, people in the lower income categories tend to enroll through area offices, and the area office continues to be a key source of information for this group. Responding to the survey data, the Department formed a team which is studying the role of both the clearinghouse and the area offices and how to strengthen the relationship between the two groups. Some recommendations should be available in about eight weeks.

There are two components to the formal evaluation of HealthWave. One is an annual, federally mandated, written evaluation following a template prepared by the National Association of State Health Policy. The other component is an on-site review by the Centers for Medicare and Medicaid Services. The report from the Kansas on-site visit has not been received, but the reviewers, when they were here, were complimentary of the simplified application, the way the two programs were blended, and the changes made to guard against disenrollment.

Ms. Howard stated a concern for the future is on-going adequate resources for the program. Kansas has been able to use unspent funds accrued due to starting the program in the first year. However, no later than early next fiscal year, Kansas will be spending more than the annual amount of the federal block grant. At that point, unless the amount of the block grant is increased, Kansas will be faced with significant policy changes to sustain a successful program. Since some states are not spending their allotment, there may not be much impetus in Congress to increase funding.

A suggested solution is to make Medicaid eligibility up to 150 percent of the poverty level and move SCHIPP eligibility from 150 to 200 percent. The added cost to the state would be the difference between a 60-40 match and a 72-28 match. Another possibility would be to access the pot of unused moneys from other states.

In response to a question, Ms. Howard stated a significant factor in the growth of HealthWave is the decrease in the number of people disenrolled. More Medicaid eligible children are entering the program than children at the slightly higher income level, at a ratio of almost two for one.

The meeting was adjourned until 9:00 a.m., September 13.

Friday, September 13
Morning Session

The meeting was called to order by the Chair at 9:20 a.m.

John Anzivino, Vice President and Interim Project Manager, Maximus, presented written testimony relative to the scope of responsibility assigned to Maximus and Maximus HealthWave activities during the past year (Attachment 13). Mr. Anzivino stated Maximus responsibilities are carried out by the following components: mailroom, call center, premium collections, eligibility determination, quality assurance and training, and marketing.

Speaking to these components, Mr. Anzivino reported approximately 571,831 pieces of outgoing and incoming mail were handled. Working closely with the state agency, steps have been taken to improve the mailroom for more efficient handling of mail, especially priority mail. The number of calls received in the call center ranged from 6,166 in July to 43,572 in January, with a total of more than 245,000 calls received during the year. Approximately 68,760 beneficiaries have been enrolled with a primary care provider or in a managed care program. The Maximus eligibility contract work was expanded in 2001 to include three additional types of medical coverage. Applications and reviews increased from 3,440 in August to 4,895 in October. Case maintenance requested changes dramatically increased from 663 in August to over 3,000 in October. During the year, more than 65,800 applications and reviews were processed and more than 41,000 case maintenance requests completed.

The Quality Assurance and Training Department for the HealthWave Clearinghouse provides quality reviews and training activities as well as policy tracking, reporting, survey development, grievance monitoring, and referrals. Training sessions are provided monthly for new and existing employees. Quality reviews are conducted weekly and monthly, with reports submitted to appropriate groups. Any deficiencies identified are addressed in training sessions. When a consumer expresses dissatisfaction, it is documented and forwarded to the Quality Assurance and Training Department. Grievances are reviewed and steps taken to solve the issues.

In fiscal year 2001, Maximus performed all outreach and marketing activities for the HealthWave project. However, in fiscal year 2002, Maximus was assigned only the marketing portion of the outreach contract. The remaining portion was given to the area offices. The various marketing activities are outlined in the written testimony (Attachment 13).

During the question and answer period, Mr. Anzivino provided the following information. Eligibility determinations are done by Maximus staff for Title XXI. Applications for Title XIX are reviewed by Maximus staff, logged into the system, and forwarded to the Department of Social and Rehabilitation Services. If the applicant is not eligible for Title XIX, the form is processed as Title XXI and handled by Maximus staff. Because of concerns and complaints, the application form has been simplified and call center staff continue to be available to assist persons in completing the form.

Federal regulations require an annual review of each case to determine continuing eligibility. If still eligible, the person is re-enrolled. If a child is disenrolled, every attempt is made to re-enroll the child with the same physician. Notification of reviews are sent out in ample time for the forms to be returned and, again, center staff are available to assist families with this process. The goal is not to have anyone disenrolled who is still eligible. Reference was made to a state which continues eligibility without an annual review. Instead, an audit is done to determine compliance. Mr. Anzivino stated it is his understanding an annual review is required, but the state in question may have secured a waiver.

The original contract was a three-year contract based on a flat rate with options for renewal. There is no specific provision in the contract to adjust the flat rate when there is a significant increase in workload. However, some adjustments have been made in the flat rate because of the significant increases noted earlier.

When a complaint comes in, an attempt is made to resolve it immediately. If the client is not satisfied or it is a continuing problem, it becomes a grievance. Maximus takes steps to resolve grievances or outstanding issues or refers them to appropriate parties to address. About 90 percent of the approximately 150 grievances have been referred. About 75 percent of grievances involve access to care, timeliness of being seen, or getting the preferred physician. These are referred to the state agency which works with other organizations for resolution.

Case maintenance involves changes, *i.e.*, when a person leaves a family or there is a birth in the family, which may require a review of eligibility.

FirstGuard Health Plan

Joy Wheeler, President, First Guard Health Plan, presented written testimony giving the scope of the program, with statistical information, and outlining the continuing challenges (Attachment 14). Ms. Wheeler stated, since FirstGuard Health Plan took over Horizon Health Plan in 1999, membership has increased from 29,300 to 88,400 members—60,700 in Title XIX and 27,700 in Title XXI. The primary goal of FirstGuard is to provide a seamless network for Title XIX and Title XXI members. There are continuing efforts to expand the provider network throughout Kansas. This network is served through provider education meetings and a website which allows providers easy access to helpful information, often eliminating the need for phone calls. Paper claims are paid within 24 days and electronic claims within five days. The Plan has a retail pharmacy in 100 counties.

Ms. Wheeler discussed services provided to members which include a welcome call during which a simple health assessment is made, with information forwarded to a management nurse. A Customer Care representative, supported by a Care Management Nurse and the FirstGuard Medical Director, is on call 24 hours a day, 7 days a week. Health related education is provided in various ways. There is also access to an extensive transportation network for transportation to appointments or to pick up prescriptions. Special programs address chronic diseases, cancer, and pregnancy. Ms. Wheeler noted that a satisfaction survey indicated 63.4 percent of adults, compared to a national average of 67.1 percent, rated the Plan as excellent or very good.

Continuing challenges, Ms. Wheeler noted, are misdirected calls to FirstGuard Health Plan because of confusion about who to call and the lack of network participation by Rural Health Clinics due primarily to past payment issues with the state agency. Steps are being taken to address both of these issues. Also, FirstGuard has great concern for provider reimbursement levels which are significantly below the national level and the impact this may have on the program.

Because of several questions raised regarding rural health clinics, Dick Morrissey, Department of Health and Environment, is to be asked to appear at the next meeting to talk about these clinics. Ms. Wheeler will also provide the Committee with additional information about rural health clinic participation in the program.

Responding to a question, Ms. Wheeler stated the contract with the Department of Social and Rehabilitation Services is a two-year contract, but reimbursement rates are renegotiated every year. This is a problem in Kansas because Medicaid rates historically have been so low. The increase in medical malpractice insurance rates and the state's budgetary constraints are also factors.

Ms. Wheeler, in answer to a question, stated FirstGuard also has Medicaid Title XIX in about 70 counties. Efforts to increase this number have not included counties with a low enrollment and resistance on the part of the providers due to the possible low return for the effort expended.

Kansas Health Institute

Robert St. Peter, M.D., President, Kansas Health Institute, presented an outline of the Institute's testimony, including charts and graphs, that cover two parts of a large, three-year project (Attachment 15). Dr. St. Peter stated Kansas is one of seven states looking comprehensively at children's health insurance issues as part of a federally funded initiative. The project, which is very comprehensive, looks at a number of issues including enrollment and disenrollment, children's health care needs and insurance coverage prior to enrollment, member satisfaction with the program, and member perspective of quality and access. Focus groups involving families from high-risk groups and interviews with some of the provider groups will be a part of the project.

Dr. St. Peter introduced Andy Allison, an economist with the Kansas Health Institute, who emphasized that data being shared relative to enrollment and disenrollment covers the period before the major changes referred to in the Maximus testimony. Plans are to revisit the issues of enrollment and disenrollment after the changes have been phased in. Packets containing more extensive information about the project are available upon request.

Mr. Allison, referring to the charts in Attachment 15, shared the following information. Of those entering the Title XXI HealthWave program during the first 30 months, 27 percent were actually new to public health insurance. Thirty-seven percent of those leaving the program transferred back into the Medicaid program with no break in coverage. The survey of 800 families just completed will provide information about what happened to those children who left public health insurance at the time of disenrollment. Medicaid income cutoffs, which vary by the age of the child, coupled with the fact many families have children of different ages means one family can have children eligible for different programs. Last year 22 percent of HealthWave families also had a child in Medicaid. Referring to the chart at the bottom of page 4, which shows the percentage of children entering the combined Title XIX and Title XXI program who remain in the program, the conferee noted some leave almost immediately after enrollment, and there is a significant drop at 12 months when children should be re-enrolling.

In discussion, raising the income eligibility for all age children in Title XIX to 150 percent of the federal poverty level, which would change the 70-30 match to 60-40, and increasing Title XXI from 150 to 200 percent was suggested. This was the original recommendation, but there was some concern this would be viewed as expanding an entitlement program. However, it has been verified that the federal block grant allows a state to expand its Medicaid program in response to the HealthWave program and then drop back to the old eligibility levels at a later date. The entitlement would not be expanded since it would not be a permanent change. Mr. Allison stated this was a provision he did not think had been changed.

Answering a question, Mr. Allison stated it would be difficult to determine the administrative cost savings of collapsing the three income eligibility levels into one level. This change would involve reprogramming the system and training workers to handle the transition. Also, if the change significantly increased the number of enrollees, there might

be an increase in administrative costs. However, it might have a positive effect on retention in the program.

It was noted the objective is to enroll uninsured children in a health plan so they can get immediate or preventive care. Yet, the legislative body is keeping people out of the system by the imposition of income eligibility ceilings. Raising the income ceiling and simplifying the system should be considered.

Mr. Allison stated that integrating the two programs and developing a joint application for both programs has made it invisible to the family as to the program they are going into and has simplified the enrollment process. To the extent possible, provider networks have been integrated so children in different eligibility categories can see the same physician.

The conferee stated some children will drop out automatically because, for example, they move out of the state, they turn 19, or they find other insurance. However, preventable administrative errors, referred to in earlier testimony, are an important factor in disenrollment. A possible response to this might be consolidating enrollment case management in the clearinghouse where the disenrollment rate has been much lower, in part because the clearinghouse does not have to deal with other programs such as Temporary Assistance for Needy Families. Other responses might be better training of agency field workers on program eligibility rules and updating the Department of Social and Rehabilitation Services information system, which is over ten years old.

The fact that 25 percent of the children leaving public health insurance at the 12-month enrollment return to the program within three months suggests there are unintended gaps in coverage due to the enrollment process itself. In response, the state agency has made coverage retroactive for children re-enrolling within one month of their re-enrollment date. Other responses might include improving the re-enrollment process to reduce the incidence of dis-enrollment or to implement a passive re-enrollment policy. Information gathered in the follow-up study just completed will provide information relative to whether dis-enrollment is due to the respondent or the re-enrollment process.

In response to a question, Dr. St. Peter stated the information being presented today is from a baseline survey of over 1,300 new enrollees in Title XIX and Title XXI done in late 2000 and 2001. New was defined as persons who had not been in the program in the previous six months. The Institute completed follow-up interviews of 800 families in June of this year and is in the process of analyzing the data. An interesting finding is that families who, according to FirstGuard and state agency data, were dis-enrolled were not aware of the dis-enrollment. Data from the survey should provide some understanding of this phenomenon.

Mr. Allison continued by calling attention to the graph on page 7 of Attachment 15 which indicates how parents heard about public health insurance. Two surprising facts stand out. One is the low percentage that heard about the program from a teacher or school and the other is the high percentage that heard about it from a Department of Social and Rehabilitation Services office or worker even though the enrollment process had been

moved to a central clearinghouse. It was noted providers could probably be more effective by giving information to their uninsured patients.

The conferee stated the initial survey results indicate most respondents thought the application was very or somewhat easy to read, it was easy to collect the required information, and it took less than 30 minutes to complete the application after the information was collected. About 10 percent of the respondents from both programs said they needed help to complete the application. Fifty-four percent of those in HealthWave compared to 30 percent in Medicaid called the 800 number for clarification, to request material, or to get assistance in completing the application. Overall, 86 percent of those calling were satisfied with the help they received. However, one out of five Medicaid callers felt they did not get the help they needed. This information is based on calls prior to the big increase in volume of calls reported earlier.

Information relating to parents' knowledge about covered benefits indicates the need for educating parents about the services covered. This is especially true in regard to dental services, mental health services, and emergency room visits for both populations, plus immunizations for the HealthWave population.

It was noted that in the Florida passive enrollment program, which applies only to CHIP, potentially there could be families receiving benefits who would not be eligible if there were a more active re-determination process and who possibly should be moved into another program. Having passive enrollment in the Medicaid program could lead to an audit showing ineligible children were covered which might result in a Medicaid penalty.

A question was raised about the ability to compare seeing a doctor versus using the emergency room. The conferee stated new enrollees were asked about all uses of medical services during the year before enrollment. The second survey asked for the same information for the year following enrollment. This information will indicate the number of visits to each and provide data for comparison.

Responding to a question, Ms. Wheeler stated there is a lot of information in the packet sent to new enrollees and on the membership card. Mr. Allison stated the survey just completed will provide information relative to family perception of the information packet. Questions included what was in the packet, was it understandable, and was it everything you needed.

In answer to a question, Dr. St. Peter stated the analysis of the follow-up survey should be completed in four to six months. It was noted that it would be helpful to have this information prior to the next session of the Legislature. Dr. St. Peter indicated that, knowing this is an important issue, every effort will be made to make the information available.

Mr. Allison stated, in answer to a question, there are some families without phones. Some surveys try to find these people and interview them in their homes. Because this is very expensive to do, the Institute felt it could not be done in this project. Ms. Wheeler stated if a new enrollee cannot be reached by phone, a letter is sent. It was noted not having a phone also has implications for utilizing services like Call-A-Nurse or calling to see

if a child needs to be seen by a provider. Reference was made to one state that gave enrollees cell phones as part of the cost of the program.

Doral Dental, Inc.

Gary Mandernach, Doral Dental, Inc., stated Doral Dental started the Title XXI program in July 2001 and took part of the Title XIX program over in October 2001. A Dental Advisory Board has been established, chaired by the President of the Kansas Dental Association. Having dentists on the Advisory Board has created a higher awareness of the program throughout the state.

Mr. Mandernach referred to the map and the "Kansas Dental Provider Listing" which had been distributed (Attachment 16). Initially, there were 205 providers in the state. As of September 11, there are 245 providers at 234 locations. Steps have been taken since February to increase the provider network. An article about the "take two" program in the Kansas Dental Association newsletter enlisted two new providers. A copy of the streamlined credentialing form, developed in response to complaints from providers, will be inserted in the next issue of the *Kansas Dental Association Journal*. There was a statewide press release in May followed with presentations by Dr. Wint, President of the Kansas Dental Association, in each of the Association districts. In February of next year, the state, the Kansas Dental Association, and Doral Dental are sponsoring a national program, Missions for Mercy, in Garden City. All individuals who attend will get free dental services. Working with the state agency, the fee schedules for Title XIX and Title XXI have been equalized. All nonparticipating dentists will be notified of this change next month. In response to input from dentists, claims can be submitted electronically. Payments are made twice a month with a 99 percent accuracy rate. Doral Dental is working with the Department of Social and Rehabilitation Services on some issues relating to preauthorization.

In response to a question, Mr. Mandernach stated there are approximately 1,200 dentists in the state. While the percentage of dentists participating in the program is small, it is a little higher than in most states. With the new fee schedule, reimbursement should be about 65 percent of usual and customary fees. The conferee stated he does not think the fee schedule is the main issue in determining participation. There is a shortage of dentists nationally and in Kansas, which means dentists are booked months in advance and are receiving customary or higher fees for services provided.

Mr. Mandernach continued, stating Doral Dental, through the Department of Social and Rehabilitation Services and FirstGuard, is making primary care physicians aware there is a dental benefit. A new member receives a packet relating to the dental benefit which is also listed on the membership card. Referring to the "HealthWave Dental Program Member Access Report" (Attachment 17), the conferee noted the access percentage for all services is 50 percent in Title XXI which has 25,000 members and is growing. Title XIX claims submitted to Doral Dental indicate an 18 percent access for all services. Information is not available for providers submitting claims to Blue Cross-Blue Shield.

In response to a question, Mr. Mandernach stated there are dentists in Oklahoma, Colorado, and Missouri who are licensed in Kansas and are providing services to Kansas enrollees, especially in the counties bordering those states.

The conferee, answering a question, noted Title XXI is on a capitated basis which changes from month to month. In Title XIX, Doral Dental serves as the Administrative Services Officer and the state pays the claims.

The recommendation of the Dental Advisory Board, which has been discussed with the state agency, is to have only one administrative arm for Title XIX.

Mr. Mandernach was asked to provide information to the Committee showing the number of dentists participating in Title XIX and in Title XXI by county.

The Consortium, Inc.

Marty Kennedy, Chief Fiscal Officer, The Consortium, Inc., presented written testimony (Attachment 18). Mr. Kennedy stated The Consortium, Inc. was founded by the Association of Community Mental Health Centers in 1987 to provide central management and contracting functions for the community mental health centers. Since then a variety of programs addressing community mental health needs throughout the state have been developed. The Consortium has administered the mental health carve-out for the Title XIX program since its inception in 1999. Community mental health centers are responsible for inpatient services provided through contracts with hospitals, outpatient services, and substance abuse services. The Consortium receives a per patient, per month payment. After the payment of inpatient services, input into the outpatient risk pool, and administrative expenses, the centers receive subcapitated payments for the eligible children in their catchment areas. Enrollment is about 27,000.

The Consortium entered into a contract with the state in October of 2001 to provide access and referral services for Title XIX and assurance that children receive services in a timely manner. The provider network was expanded to include all Medicaid providers of outpatient mental health services. The Consortium receives an administrative fee for the administrative services provided. Community mental health centers are reimbursed for services provided to clients on a fee-for-service basis. Other providers bill Medicaid as they would for the non-managed care population. Enrollment is about 60,000.

Mr. Kennedy called attention to the "Mental Health Quality Management Plan," which outlines the performance measures to be met and the reports to be submitted; "HealthWave Access Standards—Performance Reported by CMHCs April-June 2002;" and flow charts showing the referral process for both Title XIX and Title XXI programs attached to the testimony. There has been improvement in all of the standards and there are continuing efforts to improve and to make community mental health centers aware of what is expected of them. Plans for system improvements include replacement of statewide gathering software which is not well integrated with the community mental health center system in order to provide for more accurate reporting and an upgrade of the Statewide Area Network.

In addition, The Consortium would like to work with FirstGuard to determine how to coordinate between primary care physicians who, studies show, provide a large portion of mental health treatment and the mental health system.

Mr. Kennedy stated although there are some things to work on, The Consortium feels the mental health carve-out is a successful demonstration of how the community mental health care system can handle capitated services.

Referring to earlier testimony, Mr. Kennedy expressed surprise at the low percentage of parents who knew mental health services were covered. A mental health service handbook is included in the mailing sent out by FirstGuard to enrollees and the toll free number to call for mental health services is on the back of the card. It was noted people who had not used the service or needed the service might have indicated they did not know about the service. Mr. Allison stated survey data indicated families who had received services or reported needing services were somewhat more likely to know mental health was a covered service. However, the percentage was only in the 70s even for those who had received mental health services prior to coming into the program.

In discussion, members of the Committee expressed the belief that seeing patients within two hours of a scheduled appointment is an unacceptable performance standard. Concern was also expressed over the three-week waiting time to get a severely disturbed child in for treatment and care. Mr. Kennedy stated there is a separate children and family services program within The Consortium which deals with the child welfare contract and SED children in foster care and adoption. There has been some improvement, but the conferee did not have statistics available.

Committee Direction on Foster Care and Child Welfare Services

HB 2907, introduced during the last legislative session, makes a foster parent or parents an interested party in court proceedings; allows up to two people designated by the parent of the child to be present but not participate at any hearing, with the provision the judge may remove such persons if they become disruptive**;** and establishes a time limit for requesting and holding hearings when a child is removed from the home of a parent or relative or foster parent after having lived in the home for six months or longer based on a determination that an emergency exists. In discussion, the following points were noted. Parents are often upset at a hearing and having extra ears to listen can be helpful. Some judges allow persons to accompany parents to hearings. However, some guardians ad litem object to these observers in the courtroom. The current statute allows foster parents to request a hearing when a foster child is removed, based on the determination an emergency exists, but no time limits are established for conducting a hearing. The bill would require a request for a hearing to be made within 24 hours and a hearing held within 72 hours after the request.

A motion was made and seconded that the Joint Committee on Children's Issues recommend that HB 2907 as passed by the House of Representatives during the 2001

Legislative Session be introduced in both Houses by the Senators who are members of this Committee, by request of the Joint Committee on Children's Issues. Motion carried.

Definition Section of HB 2945

Staff referred to the comparison of definitions in current law, in HB 2945 as introduced, and in HB 2945 as amended by the House Committee (Attachment 10). HB 2945 includes sexual abuse as defined elsewhere in the statutes. Several years ago, the Legislature defined physical and mental abuse and believed it covered all circumstances. However, when a federal act authorizing some financial assistance for child welfare systems in the area of abuse was passed, states had to explicitly add sexual abuse to their statutes. So the Legislature added a definition of sexual abuse which is referred to in HB 2945.

Marilyn Jacobson, Department of Social and Rehabilitation Services, stated the Department did not take a position on the 2002 bill, but recommended the Judicial Council, which is studying both the Juvenile Offender Code and the Child in Need of Care Code, look at the bill as a part of their study. The Judicial Council is close to completing work on the Juvenile Code, but has not started work on the Child in Need of Care Code. The definition section of HB 2945 was pulled out for this Committee's consideration so, hopefully, there might be a bill ready for consideration in 2003.

Ms. Jacobson stated the Department has had a group of people who specialize in the area of child abuse and neglect meeting with other agency staff across the state and holding focus groups about what a definition of child abuse and neglect should be. Is the current definition sufficient? Are changes needed and, if so, what might they be? This group is still gathering information so no recommendations have been developed yet.

By consensus, a further discussion of the definition section of HB 2945 will be put on the agenda for the November meeting and Ms. Jacobson will be asked to report on any recommendations the state agency has developed.

Reference was made to a case in which a low-income single mother could not pay the electric bill so her child was taken away. Now the mother is being told she must go through anger management, which is costly, before she can get her child back. Concern was expressed that we may have created a cottage industry with cases like this.

Ms. Jacobson noted not everyone needs therapy. Not everybody needs anger management. There is a whole continuum of services. All players in the child welfare system need to select from this continuum what is appropriate to address the problems in each case. We need to get people in the system, including judges and county attorneys, away from the belief that all these services are necessary before a child can return home.

In answer to a question, Ms. Jacobson stated paying for the services mandated is a co-responsibility, not just the family's responsibility. A family should pay based on their ability to pay, which is happening in some areas. The judge is a key person, since the judge in a court order will usually order the extent to which the family is going to pay or participate.

The court, under the Child in Need of Care Code, is to be provided financial information on which to base court orders. For some courts this is routine. Other courts do not seem to see it as their responsibility. The ordering of services is usually done at the disposition hearing, which is about 60 days after the initial temporary custody hearing and which provides time for the court-appointed attorney or attorney to get the financial information, which is typically collected by the Department of Social and Rehabilitation Services, and make it available to the court. Although an agency social worker cannot verbally provide financial information in the court hearing unless requested by the judge, it could be standard practice that any financial information regarding ability to pay be included in the court findings.

A reference was made to family preservation, which means different things to different players. Ms. Jacobson stated that there are two separate things. One is preserving families and the other is family preservation, a service. Preserving a family may or may not require utilization of family preservation services. In preserving the family, family preservation, the service, is just one of many services on the continuum that can be selected depending on the particular needs of each family and what is needed to keep them intact. Help with the utility bills can be preserving the family.

In response to a question, Ms. Jacobson stated she would rather see the focus on preserving the family prior to judicial intervention. When the court becomes involved it changes not only the dynamics, but also what the agency can and cannot do because a third party is involved now. Reaching a solution prior to judicial intervention is critical.

Staff noted the Department of Social and Rehabilitation Services is not the only group involved in preserving families. Other programs such as Parents as Partners, Healthy Start, and Healthy Visitors are located under other state agencies. The Children's Trust Fund is supposed to be granting money to communities for prevention of abuse and neglect, and there are grants from the Tobacco Settlement for Smart Start. Doing an inventory of things being done now at both the state and local level aimed at preserving the family was suggested. One thing that may be needed is to recognize, at the state level, those things that are working in a community, and then find ways to help other communities replicate them.

Ms. Jacobson, in answer to a question, stated providing complete information on a foster child to the foster parent at the time of placement has improved, but more work needs to be done. There is a joint project in Salina between the Department of Social and Rehabilitation Service and the school district addressing educational records staying with the child. A form has been developed which is being piloted in this project. This is a good project which can be expanded across the state. In Kansas City, they are working with the University of Kansas Medical Center on a project which revolves around a portfolio of medical information that would go with the child. There is a third project in Topeka where the school district, the Department of Social and Rehabilitation Services, the Juvenile Justice Authority, the mental health center, and other agencies typically involved in a child's life have offices in a building at the old Topeka State Hospital grounds. All have access to the same computer system. The agencies have solved the confidentiality problem so there is needed protection in the system while providing the ability to share information. If a family has an

emergency in the evening, they can go there, and there is staff that can respond from the different agencies. Hopefully, this concept can be expanded, especially to larger communities.

Reference was made to continuing complaints about social workers and case managers not returning phone calls in a timely manner. Ms. Jacobson stated that one of the guiding principles established by the Secretary of Social and Rehabilitation Services relates to treating clients respectfully and being responsive to them. There is no specific effort to monitor responsiveness, but when a complaint is received, it is addressed.

Answering a question, Ms. Jacobson stated each case has an agency social worker assigned to monitor, assure the case is moving toward permanency, and assure the contractor is meeting expectations. This person is not involved in day-to-day decisions, but does attend case planning conferences as time permits. The contractor has a person called a social worker or sometimes a caseworker. Some contractors have a case worker for the foster parent who sometimes is called a family worker. It was noted when a foster parent says the social worker never sees the child, it is probably the contractor's worker.

The need for an advocate for the biological parents if reintegration is a possibility was mentioned. Such person would work with the family in conjunction with the worker assigned to the child. The biological parent seems to be left out of the equation. There is not much in the law which indicates what the role of the biological parent is and what the court's role is in regard to the biological parent. When the child is removed from the home, there is no one staying with the biological parents to explain why the child is being removed and what the next steps are. No one can tell the parent where the child is. If the child is removed on Friday, nothing happens until Monday, which can be devastating for both the parent and the child.

Another area which needs to be addressed is confidentiality. Are components of the system using confidentiality to hide behind? What are the real issues and how can they be resolved? Ms. Jacobson was asked to share what her agency has been doing and ideas relating to confidentiality at the November meeting.

Another issue mentioned for consideration is a truth-in-lending for adoptive parents, as well as foster parents. Adoptive parents, by federal law, are entitled to look at the child's entire file before adopting the child, but sometimes this does not happen until just before the adoption is finalized. Issues to focus on might be making prospective adoptive parents aware of their right to see the file and making provision for this to happen earlier in the process. Another issue is not providing potential adoptive parents with the resources they need to be able to adopt. Ms. Jacobson pointed out that the adoption subsidy is funded in part by federal funds through Title 4-E, which has consistently maintained that adoption subsidies are only for children meeting the special needs criteria. She also noted the adoption subsidy program has grown significantly, from 1,500 children to 4,500 children, since the public-private partnership was started. There are two parts to the assistance adoptive parents receive. There is a one-time cash payment for assistance with things such as legal fees for the adoption or renovations to the home. A child getting an adoption subsidy gets a Medicaid card and faces the same issues other children with a Medicaid card

face in terms of receiving services. However, if a child is eligible for a waiver, the child would have been eligible prior to adoption.

Staff called attention to the list of legislation, some of which was introduced at the last session, that the Johnson County group proposed at the last meeting.

Staff was asked to make copies available of the bill drafted last session creating a five-member committee made up of legislators that would have investigative abilities.

Minutes

A motion was made and seconded to approve the minutes for the August meeting. Motion carried.

The meeting was adjourned.

Prepared by Almira Collier
Edited by Emalene Correll

Approved by Committee on:

November 21, 2002