Approved: 1-30-96
Date

MINUTES OF THE HOUSE COMMITTEE ON APPROPRIATIONS.

The meeting was called to order by Chairperson Robin Jennison at 1:30 p.m. on January 24, 1996 in Room 514-S of the Capitol.

All members were present except: Chairman Jennison, excused

Committee staff present: Alan Conroy, Russell Mills, Susan Wiegers, Legislative Research Department
Jim Wilson, Revisor of Statutes
Tim Kukula, Appropriations Secretary; Todd Fertig, Administrative Aide

Conferees appearing before the committee: Rochelle Chronister, Secretary of SRS
Hugh Sage, Mental Health/ Retardation Services of SRS
J.G. Scott, SRS Budget

Others attending: See attached list

Vice Chairman, Representative Carmody is assuming authority of the committee in the absence of Chairman Jennison.

Representative Carmody recognized SRS Secretary, Rochelle Chronister to explain to the committee SRS budget initiatives. Secretary Chronister opened by introducing the staff present and explained the central office organizational chart. Secretary Chronister distributed a 31 page handout describing the current social and rehabilitation initiatives. She also handed out a booklet labelel "Finger-Tip Facts About the Department of Social and Rehabilitation Services" which is available for review in the Kansas Legislative Research Department. She covered areas such as KANWORK, privatization initiatives of the Children and Family Services Commission, Kansas Youth Authority and SRS, Community Care of Kansas, Health Connect, Prime Care, Hospital Closures issues, and others. Secretary Chronister, Commissioner Sage, and J.G. Scott answered many question from members of the committee until the time of the meeting expired. Secretary Chronister stated that she would be happy to answer further questions the committee may have in writing (Attachment 1).

Representative Carmody announced that Secretary of Administration, Sheila Frahm, has requested the introduction of 11 bills (Attachment 2).

A motion was made by Representative Nichols, seconded by Representative Helgerson to introduce, separately, the proposed 11 bills by the Department of Administration. The motion carried.

The meeting adjourned at 3:30 p.m.

The next meeting is scheduled for January 25, 1996.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

LEGISLATIVE BUDGET COMMITTEE

DATE 1-24-96

NAME	ADDRESS	REPRESENTING
[illegible]	Topeka	KARS
[illegible]	"	Governor's Office
[illegible]	"	SRS/MH&DD
[illegible]	Topeka	SRS
Meggan Griggs	Topeka	Kearney & Assoc.
Canda Byrne	Topeka	KMHC
Sharon Hoffman	Topeka	KCDC
Ann Koci	Topeka	SRS
Teresa Markowitz	Topeka	SRS
Susan Briggs	Topeka	Topeka Indep. Living
Eric Sexton	Wichita	WSU
Melissa Ness	Topeka	Ks. Children's Service League
Tom Bell	Topeka	KHA
Bob Harder	Topeka	—
Doug Bowman	Topeka	CCECDS
Josie Torrez	Topeka	Families Together, Inc.
Shelly Kreftine	Topeka	KCDD
Jane R[illegible]	Topeka	KCDD
David Dallam	Topeka	Div. of Budget
Alan Holmes	Topeka	Division of Budget
Bruce Linhos	Topeka	Children's Alliance
Vaughn L. Flora	Topeka 57th District	
Jason Pitsenberger	Topeka	Brad Smoot - KGC
Jim Kaup		City of Topeka

LEGISLATIVE BUDGET COMMITTEE

DATE 1/24/96

NAME	ADDRESS	REPRESENTING
Ray Hauke	Topeka	Staff, Ks Board of Regents
Patty Kinnett	Carbondale	self.
JOHN KIEFHABER		KS. HEALTH CARE ASSN.
Mary Ellen O'Brien Wright	Topeka	Assis. Tech. for Kansans
Shannon Jones	Topeka	SILCK
Carol Doss	Topeka	Topeka Independent Living Resource Center
[illegible]	"	KAHSA
Bob W. Williams	Topeka	Ks Pharmacists Assoc
Kelly Jennings	Topeka	KAPC
Dick Brummett	Kansas City	KU Medical School
Anita Aldrich	Osage City	Resource Center for Ind. Living

Kansas Department of Social and Rehabilitation Services
Rochelle Chronister, Secretary

House Committee on Appropriations
Testimony on Current Social and Rehabilitation Initiatives

January 24, 1996

Mr. Chairman and Members of the Committee, thank you for the opportunity to testify on Current SRS Initiatives.

In the past eight months many changes have taken place at SRS. Some of them were already initiated when I came on board - such as managed care for Medicaid recipients and the combining of Income Maintenance and Employment Preparation Services. Other programs have seen major changes in direction - such as Kansas Works.

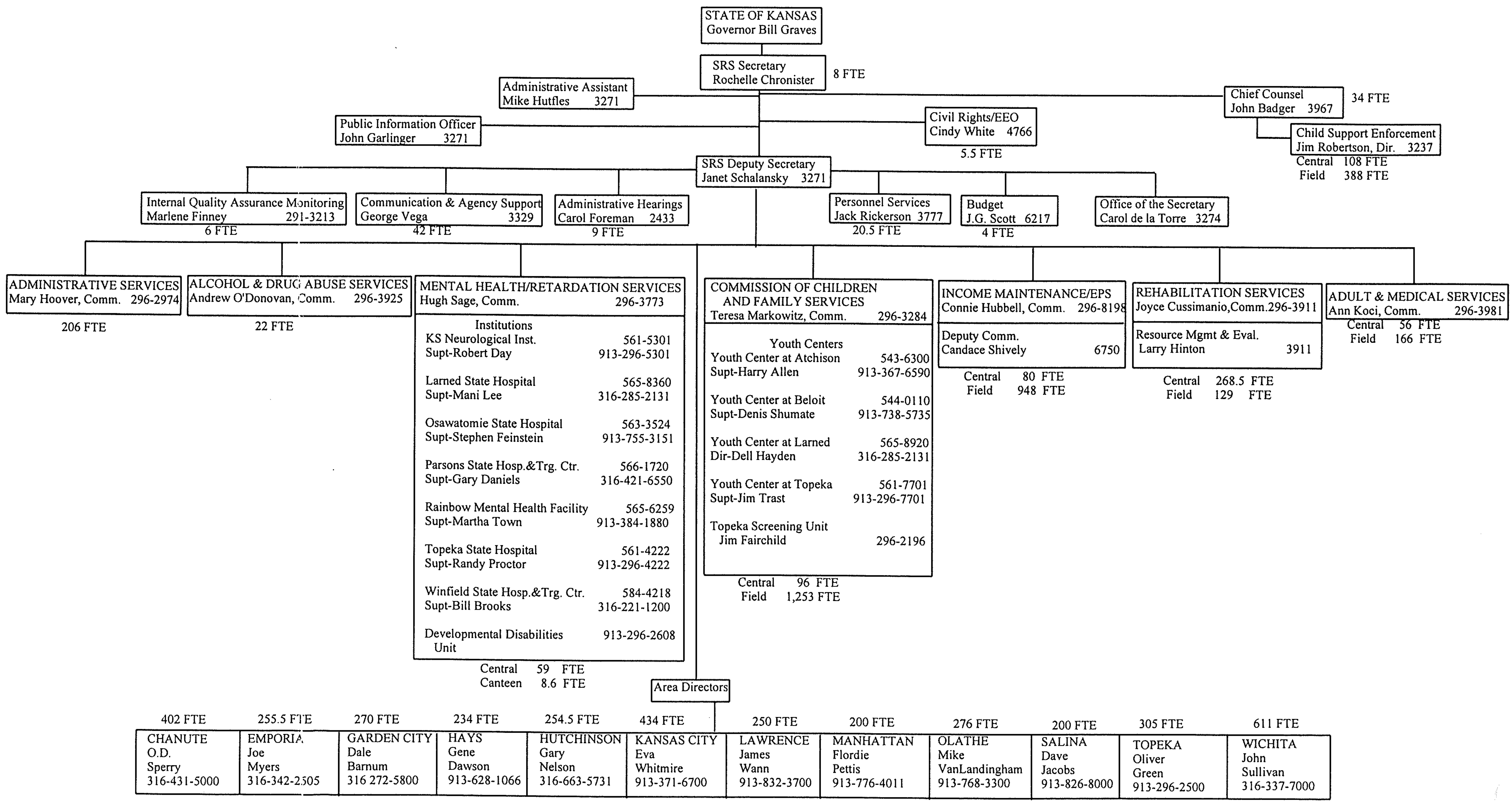
I am pleased to have the opportunity to discuss today a number of major initiatives. To begin I would like for you to look at our new organizational chart. Accompanying me today are Deputy Secretary, Janet Schalansky and my Commissioners, so that you may see who they are in relation to the areas they oversee.

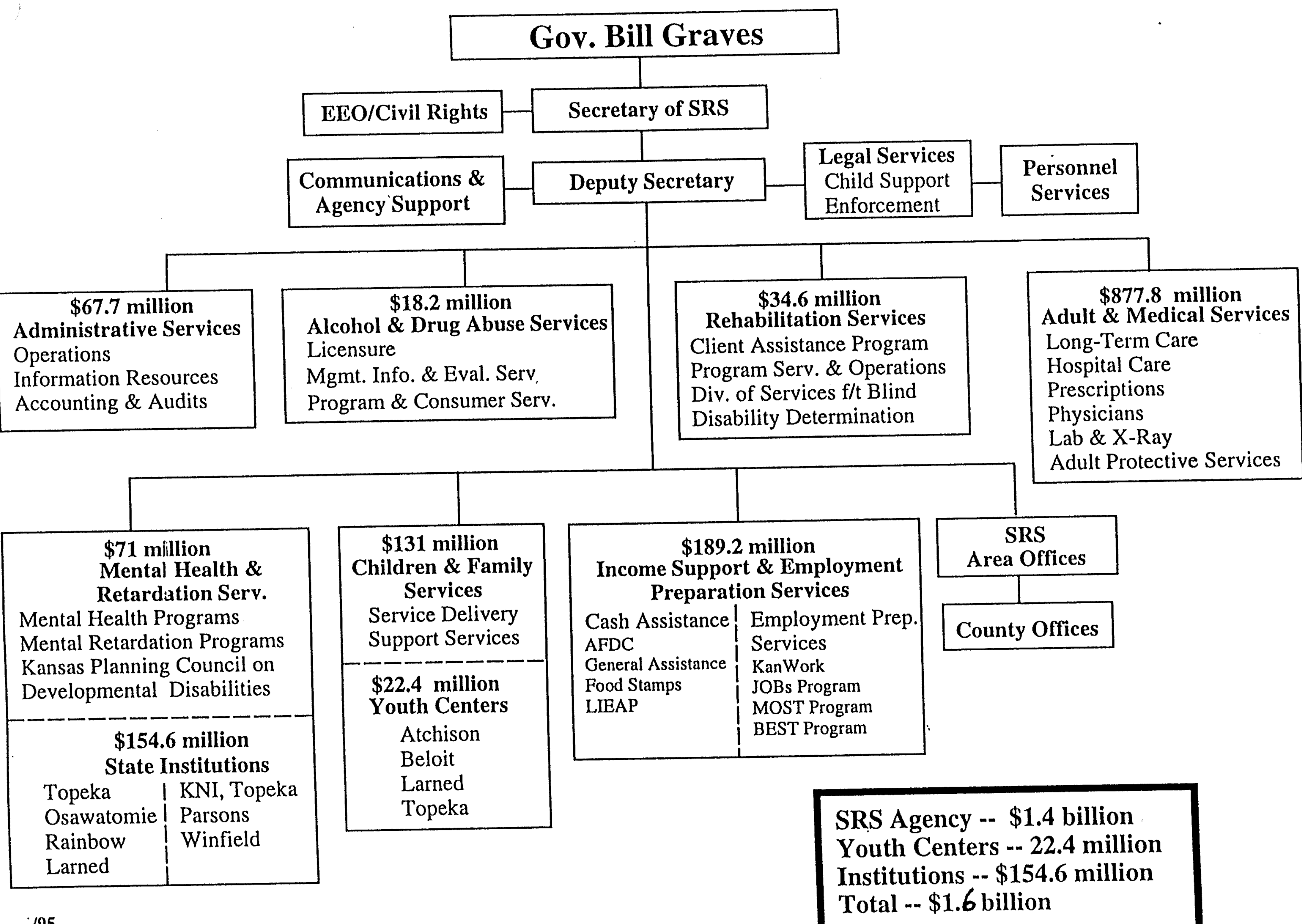
You have also received today a copy of a spiral bound book that has a great deal of information about SRS programs. Our Communications and Agency Support Division under George Vega was responsible for assembling it. I freely admit that I stole the idea from the Legislative Research Budget Division. We hope that this will give you a snapshot of most of the programs that we offer. I would also like to introduce my Chief Legal Counsel, John Badger, Mike Hutfles our Legislative Liaison and John Garlinger, Public Information Officer.

I prefer not to discuss every change that we are making since some of them may not come to this committee, and I would like for there to be time at the end of my presentation for questions. I would like however, to mention that Child Support Enforcement has major suggestions for changes in the administrative procedures proposed and in privatization initiatives that I would be pleased to discuss at another time due to the complexity of these issues.

House Appropriations
1-24-96
Attachment 1

SRS Central Office Organization Chart 11/95





/95
RS Communications & Agency Support

BACKGROUND

The **KANSAS*WORKS*** initiative is a culmination of the efforts of the state of Kansas to reform welfare through state legislation and to attain federal waivers from cash, food stamps and medical program regulations. Following enactment of Kansas welfare reform legislation, HB 2929, the state applied for federal waivers to allow the implementation of the state law. During the waiver negotiations, several events occurred that propelled the state to curtail the waiver application process and pursue reform through other means. Those events included the denial of many key waivers and the imminent passage of welfare reform law on the federal level. Despite the roadblocks, the state was determined to implement policies that focused on employment and personal responsibility. The **KANSAS*WORKS*** welfare reform plan was the result of that perseverance.

DESCRIPTION

Studies show that a work-based system of support presents the best opportunity for helping low-income families attain self-sufficiency and escape poverty. The **KANSAS*WORKS*** initiative, to be implemented in stages through January 1997, will focus on moving public assistance recipients quickly into employment. Cash and Food Stamp benefits will no longer be viewed as a permanent entitlement but as temporary assistance on the path to employment.

KANSAS*WORKS* communicates a message of high expectations. When you walk into an KanWork/JOBS office in Kansas, you are there for one purpose - to get a job. At orientation, job developers announce job openings; throughout, program staff convey an upbeat message about the value of work and people's potential to succeed. Education and training plans must be employment related. **KANSAS*WORKS*** will achieve this through the consistent application of the following principles:

- Priority placed on employment programs throughout the agency;
- Emphasis on quick attainment of jobs for all participants including those in education and training activities - even entry level jobs which will lead to greater opportunities;
- Employment- focused approach emphasizing structured job seeking and utilizing job-specific education and training opportunities;
- Strong commitment to establishing a close link with private-sector employers;
- Strict enforcement of program rules through the application of penalties in cases of non-cooperation;
- Management strategy that considers costs and recognizes the effectiveness of moving people quickly into employment;
- System of outcome based performance measurements, including job placement standards.

KEY FEATURES

- ***KANSASWORKS*** program participants will be required to work a minimum of 20 hours per week.
- Able-bodied applicants for cash assistance will be required to look for work as a condition of eligibility.
- The participants will seek employment as the first component of ***KANSASWORKS*** participation.
- Education and training plans will only be supported when job search and other work-related components are not successful.
- Child care will be guaranteed for all participants.

PROGRESS

- To move toward effecting real change, SRS has merged the divisions of Income Maintenance and Employment Preparation Services statewide.
- In November, 1995, SRS refocused employment preparation resources toward the quick attainment of employment and away from long-term education and training services.
- One of the changes to focusing on employment are service delivery pilots that combine the duties of Economic Assistance and Employment Preparation into one caseworker. Through this type of service delivery, clients are involved with only one caseworker and employment activities are stresses immediately upon application.
- To continue to strengthen the link with the private sector, the agency has implemented the *Building Employment Success Together* (BEST) program which partners with the private sector to place participants at full-time work experience program sites. These placements assist participants in obtaining recent work experience and references and facilitate the attainment of unsubsidized employment.
- To emphasize quick attainment of jobs, the agency has implemented the following:
  - Service delivery pilots that provide job search services for cash assistance applicants
  - Work-related component placements are given first priority
  - Only short-term, job-specific training is approvable
  - Education and training plans will only be supported when work-related components are not successful. Education plans are time limited with the maximum allowable being 30 months and only 9 months for a GED.

BPksworks.wpd

Child Care assistance is provided for public assistance recipients who are employed or in employment programs, children in need of care, and low-income employed families. The 1988 Family Support Act increased child care assistance to help welfare recipients obtain employment, leave welfare, and stay employed.

Benefits of Providing Child Care

- Allows parents to work without worry of children's safety.
- Allows communities to benefit from a workforce which has less absenteeism.
- In a quality setting, helps children 1) develop language, math, and social skills, 2) improve classrooom learning behavior, and 3) improve the likelihood of long-term social and economic self-sufficiency.
- Provides an opportunity for low-income children's nutritional needs to be met.
- Promotes parental responsibility by requiring family fee for income eligible families.
- Allows support for foster parents to maintain employment.
- Protection to children who are at risk of abuse or neglect.
- Essential to support welfare reform.

FY 1997 Composition of Children Served

Category	Children	Percent	Expenditures
Employment and Training Programs	4,620	31.8%	$8,573,808
Transitional (former public assistance)	2,200	15.2%	5,133,578
Income Eligible:			
Social Services	2,200	15.2%	6,309,600
Low-Income Employed	5,500	37.9%	11,660,949
Total	14,520	100.0%	$31,677,935

Welfare Reform Issues

Congressional welfare reform proposals will increase the number of families needing child care due to increased work requirements. By FY 2000, the additional demand for child care is estimated to exceed all services for the low-income employed and social services child care categories.

The following table contrasts the current work participation level to the requirements contained in the recent Congressional Budget Reconciliation Act. (The proposed requirements shown in the table reflect one-parent families only; the two-parent requirements reach 90% by FY 1999). Also shown is the estimated child care cost (in millions) of meeting the higher work requirements. A five-year AFDC time limit is assumed, consistent with Congressional welfare reform. Under the present capped JOBS funding, the five-year limit is estimated to produce an initial decline in the percent of families served, as JOBS services are constant and the AFDC caseload increases. After the fifth year (FY 2001), the current scenario indicates an increase in the percent participating in work activities, as the AFDC caseload decreases.

FY	One-Parent Work Requirement		Est Increase in Child Care	
	Current	Proposed	Children	Expenditures
1997	17%	20%	2,750	$4.8
1998	17%	25%	5,337	$9.5
1999	16%	30%	8,410	$15.1
2000	16%	35%	11,009	$19.9
2001	19%	40%	10,243	$18.7
2002	19%	50%	14,164	$26.2
2003	20%	50%	13,514	$25.2
2004	21%	50%	12,205	$23.0
2005	24%	50%	9,404	$17.9

- A key ingredient to the success of welfare reform is changing the culture of the agency, putting a focus on recipient employment and self-sufficiency. One alternative, which shows promise for accomplishing this goal while being consumer responsive as well as administratively efficient is a cross-trained worker who has responsibility for both income maintenance (IM) and employment preparation (EPS) programs. Pilots to test the feasibility of this type of service delivery are being conducted in the Emporia and Manhattan areas.

- It is a challenge for the cross-trained workers to integrate IM and EPS in their minds and actions. They have a tendency to think of their jobs as first doing IM (eligibility) work and then doing EPS (employment focused) work. Currently they have separate case files, separate supervisors, separate policy manuals, separate unit meetings, separate computer systems, and separate update training sessions. These are issues which we must resolve to have cross-trained workers statewide.

- The differences in the design of the KAECSES and KsCares automated systems are frustrating for staff. For example, the PF 12 key updates information in KsCares but deletes it in KAECSES. Therefore, if they forget which system they are in and hit the PF 12 key while in KAECSES, they lose all the updated information they have just entered. If service delivery using cross-trained workers is implemented statewide, the two systems should be integrated. This is a major automated systems project.

- While staff initially felt they spent 30% of their time on the IM case and 70% on the EPS work, they now report that their EPS time has diminished due to the time required to process the many IM case changes.. This barrier can be eliminated with welfare reform through program simplification. To get a better idea of the division of time actually being spent, we will ask the cross-trained workers to complete a time study.

- We are still in the preliminary stages of obtaining data to use in evaluating the effectiveness of the service delivery pilots. However, the preliminary data shows a marked increase in the pilot caseloads in the total number of persons working. With the combined worker, the case management services and employment counseling they receive are obviously having a positive effect.

- Clients are still reporting to staff that they like having just one worker. The staff also like the combined approach but believe things need to get simpler before the approach will work statewide. Several management areas are interested in implementing cross-trained workers but do not believe they can succeed until program simplification is available through federal welfare reform or more coordinated policy efforts at the national level.

BPcombwk.wpd

- The goals of welfare reform include coordinating AFDC, Food Stamp and Medicaid programs and promoting personal responsibility among recipients of these services. USDA and HCFA policies have made it difficult to develop a cost neutral waiver package that includes Food Stamp or Medicaid proposals.

- USDA and HCFA will not approve any waivers which may reduce or restrict benefits to any individual regardless of the state's needs, policy goals, or the benefits to recipients as a whole.

- USDA bases its position on overly rigid interpretation of Section 17(b)(1)(A) of the Food Stamp Act of 1977 which states: "No project...shall be implemented which would lower or further restrict the income or resource standards or benefit levels provided pursuant to sections 5 and 8 of this Act." It is the state's position that this section refers to the Act's nationwide standards from which all individual benefits are determined, such as the maximum resources limit, maximum gross and net income limit, and maximum benefit level. USDA's interpretation goes beyond this. They have interpreted this section to mean that any waiver which may cause an individual to be subject to a sanction they are not currently subject to may reduce the individual's benefit and is, therefore, unapprovable. For example, in response to the agency's request to make it mandatory for Food Stamp recipients to cooperate with Child Support Enforcement, USDA stated, "This waiver would sanction parents who fail to cooperate with CSE requirements. We interpret a sanction as a lowering or reduction of benefits. Section 17(b) of the Food Stamp Act prohibits the approval of any waiver that would lower or further restrict benefits."

- HCFA has developed an identical policy in regard to Medicaid waivers which may restrict benefits to any individual.

- With this interpretation of the law it is difficult for states to develop and implement Food Stamp and Medicaid policies with any consequences for irresponsible parental actions and decisions.

BPusda.wpd

- Several years ago, Kansas reduced its application from 32 pages to 12 pages. Of the 12 pages in the current combined cash/medical/food stamp application, clients are only required to complete nine of them. The other pages inform clients of their rights and responsibilities and provide the penalty warnings required by federal regulation. Based on current eligibility rules, none of the information we currently request can be omitted.

- There are states which have shorter applications. When we have contacted these states, we have found that although their cash/food stamp application is only four pages, the case workers must complete 8-15 page interview guides in order to capture the rest of the information necessary to determine eligibility. Our legal staff has advised that clients are less likely to be held accountable for fraud when they do not complete the eligibility information themselves.

- Oregon has a short application for cash/food stamp assistance with no worker guide required. There is however, a separate application for medical assistance as Medicaid is the responsibility of a separate state agency in Oregon. Both the Kansas and Oregon applications request the same basic information. The differences in the applications are cosmetic. Oregon has chosen to use smaller print, more compact spacing, and less room for multiple entries by the applicant. Kansas has chosen to use larger type with more space for writing and more complete checklists for easier client use and enhanced accuracy.

- The Kansas application was developed by a work group of both central office and field staff with input from local advocacy agencies. The application was designed to limit the questions to those necessary to determine eligibility, to limit the time an applicant must spend in an interview, to be readable by those with vision deficiencies, and to provide applicants with information regarding their rights and responsibilities. The current application accomplishes these goals and is customer friendly.

- Kansas is always open to ways to improve the application form and process. We look forward to welfare reform as a means for simplifying eligibility requirements and shortening the application form.

BPappl2.wpd

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Rochelle Chronister, Secretary

Privatization Initiatives of the Children and Family Services Commission

In 1995, the House Subcommittee reviewing SRS appropriations recommended the department move toward privatization of family foster care and a bill was introduced in the Senate asking for a review board to determine, among other tasks, what governmental functions could be moved to the private sector.

The department determined to proceed with privatization in three key service areas: intensive home-based family services ("family preservation"), Foster and residential care, and adoption. These initiatives by the department are consistent with a growing sentiment in the nation and in Kansas for a changed role for government to that of manager of human services rather than provider of services.

Objectives of Privatization:

Through contracting with private sector service providers the department intends to achieve the following goals:

- The service delivery system will become outcome-driven
- Competition will promote high-quality, cost-effective services
- Services will be provided more equally across the State and with a single point of entry
- Clinical and fiscal responsibility will be combined within same entity
- Services will be provided in the least restrictive environment as services will be community based
- The client will receive services by or through a single provider
- Reduces conflicts of interest by having clear lines of responsibility between providers and SRS
- Allows provider to make clinical decisions to achieve desired outcomes

The Role of SRS:

The move to privatization will not diminish the importance of the role of SRS. The department will continue to have a pivotal role in determining when such services are required and contracting for and monitoring the outcomes of the services. As private providers assume responsibility for the delivery of direct services, it will be increasingly important for the department to provide:

- Timely and accurate intake and assessment of family strengths and needs
- Appropriate referrals to community providers
- Monitoring for:
  - ⇨ Quality and appropriateness of services
  - ⇨ Statewide availability of service

- ⇨ Conformity with pre-established outcomes
- ⇨ Conformity with contract provisions

- Case management, ensuring the safety of the child and other family members

Privatization Initiatives:

- Family Preservation. The department began with family preservation services as they are commonly purchased from private providers in other states and because it is a concrete and relatively well defined service. In many if not most cases where family preservation services are appropriate the child will remain in the custody of the child's parents and through such services state custody can be avoided.

- Adoption services were already well on the way toward privatization through cooperation of the department with the Kansas Families for Kids (a Kellogg Foundation funded project). The department also has a long history of cooperation with and purchase of services through private adoption agencies in Kansas.

- Foster and residential care becomes a candidate for privatization as a substantial part of the services are and have historically been delivered by private providers. The current initiative expands the role and responsibility of the private services to a complete package of services and responsibility for delivery of those services.

Teresa Markowitz
Commissioner
Children and Family Services
(913) 296-4640

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Rochelle Chronister, Secretary

Kansas Youth Authority and SRS

On November 15, 1995 the Kansas Youth Authority issued its initial report recommending the Youth Authority assume responsibility for all aspects of juvenile offender programming effective July 1, 1997. The scope of this area of responsibility is very broad with approximately 24,000 annual juvenile arrests in Kansas resulting in, on any given day:

+ about 9,300 juvenile offenders under some type of custody or supervision
+ approximately 2,100 juvenile offenders in SRS custody
+ approximately 550 juvenile offenders incarcerated in the state's four youth centers

The numbers of juvenile offenders incarcerated at the youth centers have continued to grow. Over the past decade, the youth centers have experienced:

+ a 70% increase overall in admissions
+ a 250%+ increase in admission rates for the younger 13-15 year old male juvenile offenders

In addition to the numbers, the mix of admissions continue to include more serious offenders with the result that:

+ 80% of admissions are now serious/repeat direct court commitments
+ 60-80% of the resident populations at the male offender facilities are now classified as violent offenders

This year, the youth centers will admit in excess of 800 offenders.

By way of preliminary planning and working toward transfer of SRS juvenile offender programs and youth center facilities to the Kansas Youth Authority, the following steps have been taken.

1) SRS has provided staff time and/or resources to the Criminal Justice Coordinating Council Juvenile Task Force, the KOCH Commission and Kansas Youth Authority.

2) The Youth Center Operations Division has provided program briefing papers and informational data to these same organizations.

3) SRS has in place a work group to recommend a "methodology" by which the juvenile offender specific programs, staff and budget resources will be identified for transfer to the Kansas Youth Authority.

There are broad public policy decisions needing to be made. For instance, the simple splitting up of Children In Need of Care (CINC) and Juvenile Offender (JO) programs is not simple because of the overlap. Many youth are adjudicated as both juvenile offender and children in need of care . Which code and/or system should take primary responsibility for these cases?

Other significant public policy/budget resource issues needing to be dealt with in preparation for the Kansas Youth Authority taking over operational control include:

1) Development of a comprehensive intake and assessment, juvenile offender classification system.
2) Re-writing of the juvenile code and related organizational sections to operationalize the November 1995 youth authority recommendations, should that be requested.
3) Insuring that SRS and the KYA do not end up creating a competitive environment for limited community, private provider resources which increase state costs.

Rehabilitation Services
Joyce A. Cussimanio, Commissioner

January 22, 1996
Phone 296-3911

Kansas Industries for the Blind (KIB)

Rehabilitation Services is studying the feasibility of privatizing Kansas Industries for the Blind (KIB), Topeka. KIB is the only state owned and operated sheltered workshop. In investigating the potential for privatization of KIB, Rehabilitation Services has emphasized open communication including all stakeholders in the planning process. A meeting with all KIB workers and representatives of the two consumer organizations was held in November. A work group (comprised of representatives of the KIB workers, a representative of the Services for the Blind Advisory Committee, and various SRS staff) completed a comprehensive strategic review of KIB. A Request for Information meeting was held January 8 with potential private operators to seek their analysis of the feasibility of privatization.

Through our planning process, several common themes and possible concerns have been raised:

- Will a subsidy be available during a transition period to offset costs for personnel, employee benefits, re-tooling, etc.? We are investigating the possibility of using the "establishment grant" process to make a subsidy available. The private operator would provide the 21.3% match to acquire the 78.7% federal share. This could potentially eliminate the need for KRS or SRS to provide any SGF for a subsidy. There are some federal restrictions on the types of situations for which the establishment grant process can be used.
- What kind of employment security, wages and fringe benefits will be offered to the current KIB workers and civil service staff? (Employees include four classified civil service positions, 21 to 23 workers who are blind or visually impaired, and 15 other workers, some of whom have disabilities.)
- Will the real estate and building be available for transfer or long-term lease with the private operator?
- Will it be possible to privatize the Rehabilitation Center for the Blind in conjunction with KIB? Our work group is looking into the feasibility of bundling KIB and RCB in the privatization process. Further research on issues related to RCB will need to be completed in the near future. These issues relate to whether privatization would be an effective way to continue or improve services for people who are blind or visually impaired; how services could be accessed and funded under a privatization agreement; and what options the employees would have for transfer to vacant SRS positions, continued employment in other state agencies, bumping rights, or employment with the private operator.
- Is the planning process moving too quickly? Our goal has been to have privatization of KIB coincide with the beginning of SFY 1997. A longer term, similar to that proposed for the closing of state hospitals, has been suggested, particularly if RCB is included in the privatization effort.

The amount of savings to the state will depend on the agreement made with the party acquiring KIB. KIB operated at a lost of $134,794 in SFY 1995 and at a loss of $107,513 in SFY 1994. The average annual loss over the past seven years was $257,376. Past losses have been funded with SGF or SRS Fee Funds.

Facility Use

Rehabilitation Services operates three facilities: the Kansas Vocational Rehabilitation Center in Salina; the Vocational Rehabilitation Unit in Topeka; and the Rehabilitation Center for the Blind in Topeka. Rehabilitation Services has established a work group to discuss new ways of providing traditional facility-based services for Kansans with disabilities. This work group will assess the potential for privatization, contracting, decentralizing or regionalizing services, stationing staff and

services in local SRS offices, and using more mobile services rather than facility-based services. The group will also assess whether there is a need for residential services in conjunction with the vocational assessment services provided by the facilities, and assess the cost effectiveness of existing services. Recommendations are expected during SFY 1996.

Kansas Quality Assurance Screening (KQAS)

The Kansas Quality Assurance Screening (KQAS) is a system for measuring and certifying the quality of an interpreter's sign language skills. KQAS is administered by the Kansas Commission for the Deaf and Hard of Hearing (KCDHH). KCDHH plans to contract with qualified private agencies throughout the state to administer the performance testing part of this system. Private agencies will use an interactive video tape process to test each applicant. The applicant's taped test will be copied and distributed to evaluators who will rate the applicant's degree of proficiency. This new approach has two major advantages:

1. It is expected to reduce the waiting list and improve access to the testing process by creating regional testing locations throughout the state. (Testing locations are anticipated in Wichita, Girard, Dodge City, Johnson County, Hays and Salina.) Interpreters may take the test at the location closest to them, or choose to test in other locations if there is a backlog in their area.
2. It is expected to be more cost efficient for all parties involved. The cost per applicant will remain at $120. KCDHH previously paid expenses, such as hotels and per diem, for evaluators to be on-site during testing times. However, use of video-taped testing will avoid these costs. Under the new system, private operators will receive the entire $120 application fee for the performance testing. From this amount, they will pay three evaluators $20 each; the remaining $60 will be used by the private agency to cover administrative expenses and profit. KCDHH anticipates that private operators will be able to clear about $30 to $40 per applicant. Thus the cost to interpreters will not increase; KCDHH will no longer lose money on the system; and private agencies will have opportunities to earn additional income by participating.

By mid-February, KCDHH expects to formally invite qualified agencies to participate. Training will be provided for agencies and evaluators in March. KCDHH expects that private agencies will begin testing by April 1.

The privatization will not affect the status of any current employees. One employee will continue to oversee the process, in addition to other duties. KCDHH has reduced its headcount by one FTE (a previously vacant position that had been responsible for conducting the performance testing). There will be no change in state funding for KCDHH.

1-10

Kansas Department of Social and Rehabilitation Services

Division of Adult and Medical Services

Medicaid Managed Care Fact Sheet

January 22, 1996

SRS was mandated by the Kansas Legislature to implement managed care programs statewide by July 1, 1997. To meet this goal, the Secretary of SRS established a statewide Implementation Committee in January, 1994 as well as local community workgroups, to solicit input and recommendations from the community, medical providers and Medicaid beneficiaries and advocates.

Program Development

Responding to community input, the State of Kansas developed and is implementing three different programs: **Community Care of Kansas (CCK), HealthConnect,** and **PrimeCare Kansas**. HCFA has approved the HealthConnect and PrimeCare Kansas waivers. Implementation for the two approved programs began in July, 1995 and will be completed by July 1, 1997.

Goals of Managed Care

- Improve Service Quality
- Increase Access to Care
- Contain Cost Increases
- Communicate with Interested Parties
- Ensure and Protect Beneficiaries Dignity and Rights

Community Care of Kansas (CCK)

- Capitated payment model
- Research and Demonstration Project
- Benefit Package Includes Mental Health
- Four Counties
  - Sedgwick
  - Montgomery
  - Bourbon
  - Finney
- Eligibility Groups:
  - Aid to Families with Dependent Children (AFDC)
  - Poverty Level Pregnant Women and Children (PLE)
  - Children under age 6 formerly eligible for Medicaid with family incomes under 200% of poverty line

HealthConnect

- Primary Care Case Management Model
- Fee-for-service, plus case management fee
- Statewide by June 30, 1997
- Operational in Ellis, Ness, Saline, Ottawa, and Wyandotte Counties
- Phase-in to Johnson and Leavenworth effective February 1
- Phase-in to Douglas and Shawnee effective March 1
- Eligibility Groups
  - Aid to Families with Dependent Children (AFDC)
  - Poverty Level Pregnant Women and Children (PLE)
  - SSI (Aged & Disabled)
  - General Assistance

PrimeCare Kansas

- Capitated Payment Model
- Contracts with Licensed HMOs
  - Blue-Advantage+Plus
  - HealthNet
  - Horizon Health Plan
  - Humana of Kansas City
- Benefit package not including mental health
- Operational in Wyandotte County
- Phase-in to Johnson and Leavenworth effective February 1
- Phase-in to Douglas effective March 1
- Phase-in to Shawnee effective April 1
- Eligibility Groups
  - Aid to Families with Dependent Children (AFDC)
  - Poverty Level Pregnant Women and Children (PLE)

PRIMECARE
Kansas

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION

Division of Adult and Medical Services

LIVING INDEPENDENCE FOR EVERYONE (LIFE) FACT SHEET

January 23, 1996

SRS in conjunction with more than 80 representatives from consumer, provider, advocacy associations and other state and local governmental agencies have been meeting since July, 1995 to realign and refinance Medicaid LTC programs. The outcome is LIFE and will be achieved through comprehensive amendments to the HCBS/NF waiver and state plan. The waiver amendments require Health Care Financing Administration (HCFA) approval. Implementation is targeted to begin in July, 1996.

Goals
- Provide LTC services to consumers in the least restrictive setting which meets needs and is cost effective
- Separate service reimbursement from consumer's housing choice
- Expand opportunities for NF's to provide HCBS services
- Create a single system of case management for frail elders
- Provide a funding source for services in Assisted Living and Residential Care

Eligibility Group
- Individuals age 65 and older
- Meet Medicaid LTC Threshold criteria
- Meet Medicaid Financial Eligibility criteria

Funding and Reimbursement
- Only existing resources will be used
- Reimbursement rates for services are not yet established
- NF reimbursement rate structure is not being altered

Service Definition
- Consolidation of LTC Services into eight categories:
  - Targeted Case Management for Frail Elders
  - Adult Day Care
  - Sleep Cycle Support
  - Personal Emergency Response
  - Health Care Attendant
  - Wellness Monitoring
  - Respite Care
  - Nursing Facility Services

LTC Threshold Criteria
- Includes Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL), IADL Proxies and Risk Factors
- Weighs level of impairment
- Both lower and upper thresholds are monitored for care planning
- NF services are only available if upper threshold criteria are met
- Cost cap exceptions for HCBS services will be limited

Assessment Tools
- Uniform Assessment Tool (UAI) establishes lower LTC Threshold and monitors continued eligibility for all services except NF
  NOTE: First two pages of the UAI are identical to the CARE assessment and will not be a duplicate assessment
- Resident Assessment Instrument (MDS+) monitors continued eligibility for NF services

Targeted Case Management for the Frail Elderly
- Medicaid State Plan Service
- Scope of Service Includes:
  - Assessment/Reassessment Plan of Care Development
  - Monitoring/Quality Assurance
  - Resource Development
  - Gatekeeping
  - Documentation
  - Advocacy
- Requires 4 yr. college degree or Registered Professional Nurse with 1 yr. experience in human services.*
- Must be a state authorized provider and shall not be providers of other direct services.**
- Service plans require approval by Medicaid Regional Authority.

Other Service Providers
- All LTC services will be privatized
- NF, Assisted Living and other residential care homes, Home Health Agency (HHA), and other individuals or agencies qualified to provide services
- Includes option for Consumer Directed Attendant Care

Quality Assurance
- Independent audits
- Case Management
- Annual reviews by fiscal agent
- Oversight by SRS
- Consumer satisfaction surveys

c:chart4LIFE

* Individuals with at least twelve months experience on or before January 1, 1996 as a SRS LTC Case Manager in good standing shall be considered as having met education and work related requirements.

** Targeted Case Management agencies may provide other direct services if there are no other available providers in the region and prior authorization from the Medicaid authority is approved. Other agencies designated by Kansas Department on Aging (KDOA), may also be authorized as providers of case management.

18-1

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
KANSAS DEPARTMENT ON AGING
LTC TRANSITION PLAN - SRS TO KDOA

January 3, 1996

Based on the recommendations of an interagency team and review by the Secretaries of both agencies, a transfer plan for moving LTC services from SRS to KDOA has been developed.

Purpose of Transfer

- Creation of single point of entry for LTC services for adults
- Improved consumer access to services
- Consolidation of various state and federal funding resources
- Privatization of LTC services
- Eliminates duplication between state agencies for LTC services

Transfer Assurances

- Transfer will occur on July 1, 1997
- "Invisible" transition of services from the consumer's perspective
- Maintain expertise and experience of current LTC service providers
- SRS employees effected by the transfer will be given employment opportunities in the private sector
- Through interagency agreements, federal funding for LTC services will not be jeopardized
- Only Medicaid Nursing Facility, HCBS/NF, and IE Home Care services for elderly individuals will be transferred
- Cost-neutrality will be maintained. Only existing funds will be used to achieve the transfer of services

Program Specific Assurances

- Adult Protective Services will not be transferred
- Current resources available for consumers under age 60 and 65 respectively for the IE and HCBS/NF program will be retained and managed in SRS
- Consumer directed attendant care will remain an option for HCBS services
- Full administrative responsibility, including litigation, for the Nursing Facility program will be transferred
- Medicaid financial eligibility determinations will remain in SRS

Implementation Planning

- Interagency teams have been designated to design detailed implementation plans in the following areas:
  - Identification of resources to be transferred from SRS to KDOA
  - Preparation of necessary statutory, regulatory and policy changes
  - Creation of necessary interagency agreements to ensure continued FFP
  - Definition of the service delivery system before, on, and after transfer including privatization planning
  - Allocation of the identified resources to meet service delivery system design
  - Coordination and evaluation of data systems capacity to meet program and agency needs efficiently
  - Exploration of Medicaid financial eligibility models to improve service delivery

c:chart3.trans.

***Implementation planning began in October, 1995. Preliminary reports from teams are not yet available.

SEXUAL PREDATOR TREATMENT PROGRAM

- As of January 10, 1996 seven (7) persons have been civilly committed to the SPTP Unit as residents. Demographics of committed residents:
  - Age: 23 to 73 - average age being 49.7
  - White males
  - I.Q.s range from 88-126
  - Educational attainment ranges from third grade to some college courses

- Psychiatric diagnoses reflected under previous examinations have included: pedophilia, psychopathic sexual deviate, sociopathic personality disturbance, personality trait disturbance with sexual deviation, pedophilia (same, opposite, and non-differentiated), voyeurism and partialism features

- Sexual offense histories include such offenses as: incest, pedophilia, aggravated rape, voyeurism, indecent exposure and indecent liberties with a minor.

- Victim profiles include adult males, females, and children of either sex. Assaultive, violent and coercive force used in offense. In many instances, obtaining submission of victims was gained through use of force with a weapon, or threat, or threat of weapon. Psychological coercion was also a tool used against victims.

- Since the enactment of Senate Bill 525 (KSA 590-29a02-10) in 1994 to January 1996, thirty-five (35) persons have been evaluated at the Larned State Hospital to determine whether or not they met the criteria of a violent sexual predator:
  - 20 persons were reviewed and found not to be violent sexual predators by LSH psychologists.
  - 10 persons reviewed were found to fit the criteria; 1 prosecution was deferred; 1 was released at the court proceedings; 1 was released by a county court.
  - 7 persons have been committed to the SRS SPTP by a court of civil commitment.
  - 3 persons are currently being evaluated at LSH
  - 2 cases are currently pending in courts in Kansas
  - 2 are under review
  - 1 is pending for re-evaluation.

- An average of 18 persons are evaluated at LSH annually.

- The SPTP is currently located in the Larned Correctional Mental Health Facility. Half of the space is used for resident treatment meetings and activities. Thirty bed spaces of 10'x12' provide for resident needs.

- Comprehensive treatment assessment, treatment planning and implementation of holistic treatment:
  - Assessment focus used by the SRS SPTP are: nature of offenses, level of psychopathology, socio-psycho history, history of violence, cognitive distortions, social skills, sexual arousal maladaptive/deviancy, sexual history, and more.
  - Comprehensive and holistic planning involves the analysis of assessments completed, the creation and use of goal attainment scaling as a quantitative tool to measure treatment progress, treatment objectives for resident and the development of intervention techniques regarding specific behavior outcome for the treatment efforts

1/19/96

REPLACING THE STATE HOSPITAL SUBSTANCE ABUSE UNITS

The Kansas Department of Social and Rehabilitation Services (SRS) has funded a statewide network of community-based substance abuse treatment program providers who can assist clients currently being treated in the alcohol and drug units at Osawatomie and Larned State Hospitals.

The continuum of statewide substance abuse treatment services includes 42 outpatient programs, 560 residential beds, and social detoxification programs. Specially designed programs are also available for women and their children and youth. Since the new managed care practices and the assessment centers have been introduced there are virtually no waiting lists. In FY 95, 19,806 people were treated.

The profile of clients being served in community based programs is similar to those currently being treated in the State Hospital Units according to data from the SRS/Alcohol and Drug Abuse Services Management Information and Outcome System.

The Governor's budget recommendation of $500,000 will be used to provide comprehensive treatment services for the estimated 900 clients currently being treated in the state hospital alcohol and drug units. While there are virtually no waiting lists for treatment, an additional 900 clients will strain the existing community based programs and additional services will need to be purchased.

The Judicial System has relied on referring individuals to the state hospitals. Under the new system, the courts can contact their closest Regional Assessment, Utilization Review and Outreach Center and have an assessment, and a placement within 24 hours.

The Addiction Severity Index, a nationally recognized instrument, and standardized client placement criteria will insure that an accurate placement be made to a community-based treatment facility.

Social detoxification services will continue to be available in Wichita, Topeka, Kansas City, Coffeyville, Pittsburg, Independence, and Dodge City.

January 22, 1996

KANSAS ALCOHOL AND DRUG MANAGED CARE MODEL

The Alcohol and Drug Managed Care Model being implemented by the Kansas State Department of Social and Rehabilitation Services is the first major reform of treatment services in the state's 20 year history of funding substance abuse programs.

The 20 month transition from a grant funding system to a managed care process began in January 1995. The model has many positive benefits--ones that show cost benefit and getting value for the dollars spent, to an increased focus on outcomes and on providing appropriate and comprehensive treatment services so there is a better chance of recovery. Recovery is more than being sober. The outcomes are to get documented improvements in seven areas related to the addiction: alcohol use, other drug use, employment, family relationships, legal, psychological, and health. The managed care initiative provides a set of tools to give eligible persons the services they need, when they need them, in the right amounts. No more and no less.

The model includes a managed care contractor to oversee treatment and prevention subcontracts and five independent Regional Assessment, Utilization Review and Outreach centers. The driving force is the Kansas Client Placement Criteria instrument, an adaptation of the nationally recognized American Society of Addiction Medicine instrument to refer clients to the needed level of care. Treatment services are targeted and based on the independent assessment. These centers are statewide and staff travel to SRS offices, health departments, homeless shelters, treatment centers and other local sites to conduct assessments, refer clients and conduct utilization reviews. To receive services in publicly funded programs, clients must meet 200% of the federal poverty guidelines.

The pilot management organization project for Wichita/Hutchinson has been awarded $3.7 million, of which $3.4 million is for client services and $252,000 for the contractor. The five independent regional assessment, utilization review and outreach centers have been awarded a total of $1.16 million. These include the following amounts: Wichita/Hutchinson $240,000; Kansas City and Lawrence $280,000; Pittsburg and Emporia $200,000; Topeka/Manhattan $240,000; Western Kansas $200,000.

Under the previous grant system the client had to fit into the program's structure and there was not the flexibility to adapt to client and family needs; there were no standardized assessment criteria, continuing stay and discharge criteria; and, there was a fragmented provider system. These areas have been corrected in the new system.

Even in the first three months of operation in the Wichita/Hutchinson pilot project, the results are encouraging. There are virtually no waiting lists for treatment; programs are developing innovative, flexible services that address client needs; and there is an emphasis on continuing care and case management once the client leaves primary treatment. A major goal has been to have clients assessed at earlier stages in their addiction. SRS was the referral source for 48% of the people seeking help in the pilot area. The new managed care system will be fully operational before the end of 1996 with the expectation that additional clients will be served.

SRS' role is to conduct strategic planning; maintain a management information outcome system; evaluate program effectiveness; research program models; license programs and maintain counseling competency standards; monitor the management organization activities; and oversee consumer grievances.

MENTAL HEALTH & DEVELOPMENTAL DISABILITIES (MH&DD) CONTRACT WITH COMMUNITY DEVELOPMENTAL DISABILITY ORGANIZATIONS (CDDOs)

Developmental Disability Reform, HB 2458 (DD Reform) specifies, in part, MH&DD shall contract only with CDDOs who may provide community services directly or sub-contract for community services based on the choice of the person served. Regulations to implement the statute are being developed by MH&DD in consultation with key stakeholders and are scheduled to be finalized July 1, 1996.

In the interim while regulations are being finalized, a contract was developed with CDDOs which implements critical aspects of DD Reform for the period January 1, 1996, through June 30, 1996. The contract was developed in a collaborate process which allowed all CDDOs a number of opportunities to recommend changes to the contract provisions. A final contract was issued by all CDDOs on December 21, 1995.

CDDOs who had concerns about the final contract were offered an opportunity to participate in independent professional mediation on January 11 with MH&DD in an attempt to address any remaining concerns. The changes which were agreed to through mediation are being made available to all CDDOs so they are treated equitably.

The following reflect key provisions of the contract which were issued to CDDOs:

- Consistent with DD Reform, as defined in the bill, MH&DD only contracts with CDDOs. The CDDOs will sub-contact with all other community providers.

- All funding sources provided by MH&DD for community services are identified in the contract, including the maximum number of persons who may be served through the HCBS/MR waiver in the CDDO service area.

- CDDOs are required to serve persons who are unserved but needing services and who present themselves to the CDDO in the next six months. To accomplish this CDDOs are to use additional revenue from increased rates obtained through a joint effort with MH&DD to access more funds through the HCBS/MR Medicaid waiver.

- Persons currently in service who wish to seek services with a different community provider will continue to have specific contract funding made available to pay for services without interruption.

- Within available funds, the CDDOs are required to provide services to persons in a way which is responsive to their preferred lifestyle and within acceptable risk.

- The contract specifies the person has a choice regarding who provides his or her case management.

- Starting April 1, 1996, CDDOs will screen persons applying to private ICFs/MR to ensure the person is eligible for ICF/MR level of services and the placement in an ICF/MR is responsive to the persons' preferred lifestyle.

- Either MH&DD or the CDDOs may require participation in independent professional mediation to resolve any dispute regarding implementing provision of the contract.

1/19/96

HOUSING ISSUES

- **MHDD Housing Policy**
  Current practice, developed recently in conjunction with MH&DD stakeholders, is to support a full array of housing choices for persons with mental illness and developmental disabilities, based on the treatment requirements of the consumer, consumer choice, and cost effectiveness. On 12/15/95, MH&DD conducted a stakeholders meeting on housing. Participants included consumers, Community Mental Health Centers (CMHCs), Community Developmental Disability Organizations (CDDOs), and advocates from throughout the state. The results of the meeting included specific recommendations regarding housing policy and actions which MH&DD should take to create and enhance a full array of housing choices. Recommendations included subsidies for housing costs, legislation to prevent discrimination in housing based on income source, and conversion of HUD developed group living settings into more flexible living arrangements.

- **Congregate Housing vs. Individual Living**
  The perception among providers and consumers has been that MH&DD categorically disallowed small congregate settings. Current policy will be to support a full array of housing choices for consumers, including small congregate settings, without a minimum or maximum number of roommates.

- **Housing for people discharged from TSH and Winfield**
  Local CMHCs and CDDOs are currently charged with accessing and developing community based services, including housing, for clients discharged from state hospitals. MH&DD, through partnership with the Kansas Department of Commerce and Housing (KDCH), will provide technical assistance to CMHCs and CDDOs to enable them to develop and access local housing options and apply for state and federal funding needed to respond to local housing needs. In 1994 and again in 1995, the KDCH made rent subsidy money, through its HOME program, available to persons with severe mental illness and developmental disabilities. KDCH is developing the final plan for distribution of this 1995 HOME money in 1996. Individuals in the Winfield and Topeka State Hosital areas are intended recipients of these funds.

- **Inadequate consumer income to support community based housing**
  Consumers of mental health and developmental disability services are able to use state and federal funds through SSDI and SSI to cover costs associated with housing, (e.g., rent, utilities, security deposits, household expenses). Other sources of funding available to providers for these costs include Mental Health Reform funding. Additional sources of support funding may be available through the HUD Community Services Block Grant funding and in connection with specific HUD grants.

- **Insufficient housing stock and to allow community housing for disabled persons**
  Accessing and developing housing for persons with disabilities is and should be a matter for local planning and control. MH&DD will assist consumers and providers to use public-private partnership tools, like the Low Income Housing Tax Credit, development of Community Housing Development Organizations (CHDOs) and participation in local Consolidated Planning to respond to local housing needs.

COMMUNITY INTEGRATION PROJECT: A SUMMARY OF THE NUMBER OF PERSONS IN EACH STEP OF THE PLACEMENT PROCESS

One hundred sixty-four (164) persons are currently referred by State Mental Retardation Hospitals (SMRHs) for placement into community service settings. Four (4) of these persons are ready to be placed immediately. Each of the persons referred is in one of the following steps of the CIP placement process:

Step 1: The person, and/or the person's guardian, has requested community placement. The SMRH is developing an essential lifestyle plan (ELP) documenting the services the person desires. Once completed the ELP will be sent to Community Developmental Disability Organizations (CDDOs).

Step 2: The ELP has been sent to CDDOs. The CDDOs are developing community support plans to serve the person and funding requests to pay for the services which will be sent to the SMRH and MH&DD for review.

Step 3: The CDDOs proposed support plan and funding request have been submitted to the SMRH and MH&DD for review. Following their analysis, notification of the status of acceptance and funding is provided for the CDDO.

Step 4: The CDDO has been informed the support plan has been approved by the SMRH and the funding request has been approved by MH&DD. The CDDO is completing final arrangements for placing the person in the community setting such as renting housing, training and hiring staff and making any other special arrangements needed by the person.

The SMRHs have reported the following number of persons in each of the steps of the placement process as of January 12, 1996:

Facility	Step 1	Step 2	Step 3	Step 4	Total Referred
KNI	3	48	0	0	51
Parsons	2	16	0	3	21
Winfield	12	79	0	1	92
Total	17	143	0	4	164

1/19/96

MHDD FY 1997 ISSUES

Mental Health Managed Care ($2,000,000 AF, 800,000 SGF) - The 1994 Legislature reduced the SRS appropriation for regular medical assistance paid to CMHC's in anticipation of the implementation of a Mental Health managed care plan which was expected to save from 2% to 10%. No plan was implemented during FY 1995, so the 1995 Legislature appropriated $800,000 SGF for CMHC's in a special line item, but made no change to the FY 1996 appropriation. SRS did not request these funds added to the FY 1996 or 97 appropriation.

Mental Health Reform Funding ($891,297 SGF) - Larned State Hospital closed the final 30 beds required by Mental Health Reform during October, 1995. We have now closed the 270 beds planned in the original Mental Health Reform plan and the appropriate community services are in place. We are confident the Governor's budget recommendation provides adequate funding to support these services for FY 1997.

Mental Health State Hospital Beds - The budget submissions of Larned, Osawatomie and Topeka State Hospitals each anticipated closing one adult unit by July 1, 1996. Subsequent to this we have identified efficiencies in the various state hospitals which will allow us to maintain the present number of psychiatric beds with in the resources provided by the Governor's recommendation. We are currently developing a Governor's Budget Amendment which makes the necessary adjustments.

January 23, 1996

SUMMARY OF THE HCBS/MR MEDICAID WAIVER EXPANSION PROJECT

Some persons who are mentally retarded or otherwise developmentally disabled whose services were funded through state grants, were also eligible for the HCBS/MR Medicaid waiver. The waiver reimburses for services provided in the community to persons who are eligible for placement in institutions. Reimbursement under the HCBS/MR waiver is currently comprised of approximately 59% federal funds and 41% state funds. Therefore, substantial state general fund savings were achieved by switching the reimbursement for services to eligible persons from grants to the HCBS/MR waiver. The resulting savings in state general funds were used for:

- serving persons taken off the grant and placed on the HCBS/MR waiver.
- serving persons waiting for community services.
- increasing average reimbursement provided for community services.

Community Developmental Disability Organizations (CDDOs) were asked to screen all persons currently served who could potentially be HCBS/MR waiver eligible. Those who were determined eligible were included in plans submitted by each CDDO. Specific amounts of grant funds were removed from each CDDO grant based on the number of HCBS/MR waiver eligible persons identified. The savings from this process were redistributed to allow persons currently served to continue to be served using HCBS/MR waiver funds, add persons to service who have been waiting for community services, and increase HCBS/MR waiver rates. Final calculations were included in the contracts issued to the CDDOs December 21, 1995. Two CDDO refinancing plans are yet to be finalized.

SOURCES AND USES OF FUNDS

Approximate Annual Amounts		
State Funds	All Funds	Explanation
$13,164,000	$13,164,000	Approximately 761 individuals were removed from grant funding and placed on the HCBS/MR waiver. Grant funds were reduced by the amount shown and the remainder equalized between all agencies so each agency is provided the same grant amount per person served in each service area. Losses which some agencies experience from equalizing the remaining grants are more than made up through HCBS/MR waiver rate increases.
$4;758,000	$11,600,000	Savings from grant funds were used as the state match for the HCBS/MR waiver for persons currently served taken off of grant funding and placed on the HCBS/MR waiver.
$2,680,000	$ 6,520,000	Grant funds were allocated to the HCBS/MR waiver for approximately 287 persons from the community waiting list.

$ 586,000	$ 586,000	Grant funds were allocated for about 65 persons who are not HCBS/MR waiver eligible but who were waiting for community services.
$ 2,140,000	$ 5,200,000	The amount of total increased revenue as a result of HCBS/MR waiver rate increases. Increases were provided to make up for losses caused by equalizing grants, improving quality outcomes in order to more successfully serve persons with severe disabilities and act as a hedge against new persons needing community services in the next year.

THE COMMUNITY WAITING LIST

This project, plus other service expansions earlier in 1995, essentially eliminated the community waiting list for adults. However, more adults will request community services as a result of graduations from special education or due to family crisis in future years. Using the increase in funding generated by this project and no additional state funds, agencies have agreed to serve all adults needing services in the community until June 1996. This requirement was included in the contract with the CDDOs for the next six months. As a result the adult waiting list for community services is essentially eliminated at least through June 1996. The following compares this effort with what was reported by CDDOs in January 1995.

Summary of Waiting List Reductions in the Last Nine Months

Waiting List Reported by CDDOs in January 1995	798
Persons Added to Service with HCBS/MR FY 1995	-218
Persons from Previous HCBS/MR Waiver Expansion FY 1995	-102
Persons from this HCBS/MR Waiver Expansion and State Grants	-352
Persons Originally Reported by CDDOs Who Have Not Accepted Services At This Time	126

1/22/96

OVERVIEW OF STATE HOSPITAL CLOSURE PLANNING

In follow-up of the recommendations of the Closure Commission to close Winfield State Hospital and Training Center (WSH&TC) and the Topeka State Hospital (TSH) on or before December 31, 1997, MH&DD began preparation of operations plans in early November. Conceptualizing closure as a systems rather than facility-specific issue and recognizing the closure decision as a natural by-product of successful reform in the development of community services and supports for Kansans with mental illness or developmental disability, plans for the closure each are being devised to accomplish the following goals:

1. To the greatest extent possible, closure will be accomplished through the continued development of community-based alternatives, transferring to the surviving state-owned sister facilities only the bed capacity required to serve as adequate back-up to those community resources. Consistent with the statutory expectations of mental health and developmental disabilities reform, expansion of the systems' community based capacity will be pursued through the expansion of grants and contracts with the Community Developmental Disability Organizations (CDDOs) and Community Mental Health Centers (CMHCs).
2. The plans, one for the expansion of developmental disability community based alternatives and institutional back-up for the closure of WSH&TC and another regarding the mental health sector to close TSH, will be based as much as possible on the applicable (although non-binding) recommendations of the Closure Commission, the Governor's Mental Health Planning Council, and the Kansas Developmental Disability Council.
3. Adequate start-up funds will be made available with which to put suitable community based services and supports into place for the transfer of WSH&TC and TSH clients/patients requiring long term care.
4. A combination of appropriate community based services and supports and, as needed, institutional (that is, sister facility) back-up capacity will be developed and put into place before admissions are shut off at WSH&TC and TSH, assuring that the needs of no one for whom those services would have otherwise necessary are unmet following hospital closure.
5. Choice by the consumer or the consumer's advocate as appropriate will be honored regarding the transfer of clients/patients of the closing institutions.

In general, the major steps of the process to be followed in development and implementation of the closure plans will be as follows:

1. Based upon information provided by CDDO's and CMHC's regarding their needs for expanded service capacity, time lines for system expansion and the financial requirements for achievement during the next two fiscal years, SRS will:

    A. Analyze responses from the various service providers. This review will include service adequacy and a financial analysis.

B. Based upon the results of this review we will negotiate economically efficient service contracts with CDDO's and CMHC's.

C. After the agreements are developed for community services SRS will prepare and submit request for Governor's Budget Amendment for FY1997. This information will also guide the development of the FY1998 budget request from SRS.

2. Implementation of the agreements referenced above will involve the transfer of individuals from hospital to community services while simultaneously cutting off new admissions. This process will reflect the time lines agreed upon by SRS and the community providers.

3. SRS will work with the remaining hospitals to assure adequate backup capacity is maintained in the hospital system. SRS will transfer resources between facilities to support needed services.

4. Individuals who choose or are unable to be served in community settings will be transferred to one of the remaining facilities based upon family preferences and appropriateness of services offered.

SRS will monitor the process to assure the success of the process. This process is expected to need period revision to adjust to changing situations. These adjusts will be reflected as needed in the budget process.

BILL GRAVES
Governor

SHEILA FRAHM
Lt. Governor/Secretary

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DEPARTMENT OF ADMINISTRATION

January 23, 1996

Rep. Robin Jennison, Chairperson
House Appropriations Committee
State Capitol, Room 514-S
Topeka, Kansas 66612

introduce

Re: Department of Administration Legislation Proposals

Dear Representative Jennison:

I am writing to request the assistance of the House Appropriations Committee in introducing a number of Department of Administration legislative proposals. The following is a list of the legislative proposals requested for introduction.

1. Engineering Services (5 RS 1626). Amend K.S.A. 75-5804 to increase the size of projects for which a negotiating committee must be convened.

2. Use of State Telecommunications Network (5 RS 1629). Amend K.S.A. 1995 Supp. 75-4709 to permit certain nonprofit organizations to use the statewide telecommunications network.

3. Worker's Compensation Subrogation Interests (5 RS 1630). Amend K.S.A. 44-504 to clarify that an employer's subrogation interest is reduced by the percentage of negligence attributed to the employer, rather than reducing the employer's subrogation interest by the percentage of the recovery from the third party attributed to the negligence of the employer.

4. Budget Allotment System (5 RS 1631). Amend K.S.A. 75-3722 and repeal K.S.A. 75-3725 to update the budget allotment system by recognizing the Director of Budget as the state official responsible for the system and incorporating provisions currently in regulation.

5. Open Meetings Act; Procurement Negotiating Committees (5RS 1603). Amend K.S.A. 75-37,102 and K.S.A. 1995 Supp. 75-6504(c)(1) to exempt the majority of a quorum of boards and commissions from the Open Meetings Act when they are attending or serving

House Appropriations
1-24-96
Attachment 2

as members of a procurement negotiating committee.

6. Secretary of Agriculture; Deferred Compensation Plan (5 RS 1633). Amend K.S.A. 1995 Supp. 74-4911f to include the Secretary of Agriculture in the list of state officers who may elect to participate in the 8% deferred compensation plan.

7. State Employee Payroll Withholding for Savings Bonds and United Way Contributions (5 RS 1636). Amend K.S.A. 75-5330 and K.S.A. 75-5531 to broaden the definition of state employee to include any seasonal, part-time or temporary employee.

8. State Property Inventory (5 RS 1605). Amend K.S.A. 75-3516 and K.S.A. 1995 Supp. 75-3729 to decentralize responsibility for state property inventory.

9. State Agency Reports (5 RS 1583). Amend K.S.A. 46-1212c and related sections to provide a central depository for various reports to the Legislature.

10. Adoption of Regulations by Secretary of Administration (5 RS 1561). Amend K.S.A. 75-3706, K.S.A. 75-3711 and related sections to remove the requirement that all regulations of the Secretary of Administration be submitted to the Governor for approval.

11. State Building Projects; Repetitive Designs (5 RS 1610). Amend K.S.A. 1995 Supp. 75-1253 to permit in-house architects to manage projects which are based on standardized plans previously designed by state architects.

Theresa Kiernan of the Revisor's Office has prepared the bill drafts for these proposals and can make copies of each available to you upon request. Thank you for your assistance in bringing this legislation to the attention of the Committee. Please let me know if you have questions regarding the proposals or need further information prior to presenting them to the Committee for introduction.

Sincerely,

Sheila Frahm

Sheila Frahm
Secretary of Administration

SF:FL:vh

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